

**Investigation into the circumstances surrounding the
death of a man
at HMP Frankland in September 2006**

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

August 2008

This is the report of an investigation into the circumstances surrounding the death of a man at HMP Frankland on 8 September 2006. In the early morning, the man was found hanging by a ligature in his cell. The man was aged 48. He did not leave any indication why he might have taken his own life.

My colleagues and I would like to extend our sincere sympathy and condolences to the man's sons, his sisters, and all those touched by his death.

The investigation was led by one of my investigators. An independent review of the man's medical care in prison was commissioned from Durham and Chester-le-Street Primary Health Care Trust. Prisons Health Lead for the Northumberland Care Trust, carried out the review and I am grateful to him for his assistance. I would also like to thank the management and staff at HMP Frankland for their co-operation during the course of this investigation.

The man had a long history of drug addiction. At HMP Durham, he asked for help with his drug problem and completed one detoxification programme. Sadly, his wife died during the early part of his sentence. He received medication to help him with his loss. Following his transfer to Frankland, he continued to use drugs when he could obtain them.

On the day before his death, the man was described by a trainee forensic psychologist who met him as happy, talkative and responsive. To his friends he appeared to be his usual self. The man was not considered at risk of self harm or suicide and was not on any special observation regime.

This report focuses on an unexpected death that probably had its foundation in long term drug abuse and the loss of a close partner. It also highlights the need for accuracy in recording the details of prisoners' next of kin and the importance of maintaining cell safety equipment. It would appear that the computerised cell call bell system in the man's cell had not been functioning correctly for fourteen months – a fact that is all the more surprising in the context of a high security prison.

I make a total of seven recommendations all of which I am pleased to note have been accepted.

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Prisons and Probation Ombudsman

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SUMMARY

The man died during the night of 7/8 September 2006 in his cell at HMP Frankland. He had been received at HMP Durham in May 2005, having been remanded in custody. On 27 October 2005, he was sentenced to an Indefinite Public Protection life sentence, with a minimum period to serve of four years and one month in custody.

The man was 48 years old. From his initial reception into prison, he acknowledged that he misused drugs heavily and asked for help with his drug habit. He was given a detox programme immediately. He was not considered as being at risk of self harm or suicide.

Whilst at Durham, the man's wife died unexpectedly on 2 February 2006. Her death devastated him and he was prescribed medication for depression and insomnia. On 17 July 2006, he was transferred to HMP Frankland where he appeared to settle quickly.

During his time at Frankland, the man continued to use drugs when he could obtain them. On 18 August 2006, he failed a compliance drug test, testing positive for morphine. Another prisoner who was also a drug user said he was suffering from withdrawal. The man was warned for this infringement but no further action was taken.

The man was seen on 24 August by members of the prison psychology department, after referral from CARAT workers, for inclusion on the FOCUS programme to assist with stopping his drug use. He admitted daily use of heroin during that meeting. He was accepted for the programme but died before the course started.

On the morning of 7 September, a trainee forensic psychologist saw the man. She described him as happy, talkative and responsive during their meeting, but noted that his mood dropped when they discussed his wife. He said that he had not used heroin for about a week before the meeting. He said he had not taken drugs since then because he had no money to pay for them, but added that he might use some the next day because that was pay day. He also said that he was in debt, but that it was manageable.

During the evening of 7 September, the man was socialising with two friends in cell G2-23 from 5:00pm until about 7:20pm. He was described as being alright by both of the other men, who added that no drugs were taken by the man in their presence. One of them recalls that the man had said that he could not go through another night like the one before and believes that he was withdrawing from drugs at that time. Just prior to the man going into his cell for the night, he met his immediate neighbour and exchanged a few words with him. The man appeared to be quite normal to the other prisoner and they went into their respective cells for the night. He heard no noise from the man's cell during that evening and night.

The man was not on any special observation regime and was therefore observed at the normal roll check at around 7:30pm by the night patrol officer. Nothing drew the attention of any staff member on duty during that night to the man's cell (G4-7).

At 5:50am on the morning of 8 September, the man was again observed during the early roll check by the officer support grade (OSG) night patrol. He saw the man hanging by a ligature from the cell window at the rear of the cell. He shouted to the officer night patrol that there was a man hanging and to get the ligature knife from the wing office. Whilst in the office (at about 5:55am), The night patrol officer told the Emergency Control Room (ECR) staff and the Night Orderly Officer (NOO) what had happened and that he and the other night patrol were going to go into the cell. ECR staff called for an emergency ambulance, the duty doctor and the duty Governor.

On entry to the cell, the night patrols cut the ligature and laid the man on the floor. They found that he was cold and stiff and formed the opinion that he was dead. They did not attempt resuscitation, but instead left the cell and waited for the NOO and the duty Healthcare Officer (HCO). On arrival at the cell at about 6:05am, the HCO went into cell G4-7 and attempted unsuccessfully to find a pulse. He attached a pulse oximeter and a blood pressure cuff to the man but no signs of life were detected. He noted the condition of the man's body and concluded that he was dead and had been so for some hours. At around 6:35am, paramedics confirmed the man's death and the doctor certified the death at 6:45am. The police were informed, and the prison's contingency plan for responding to a death in custody was initiated.

Because of confusion about the man's next of kin (his prison record still showed his deceased wife as next of kin), the news of the man's death was broken to his sister in law by police late that morning. She spoke to the Governor and he offered support to the family. She then broke the news to the man's sisters who became the liaison point between Frankland and the family. At this point the offer of support was not repeated to the man's sisters by Frankland. His sisters then went on to arrange and finance the funeral. On discovering what had occurred, my investigator brought the matter to Frankland's attention and it was rectified some weeks after the funeral.

On 10 September, two days after the man's death, the NOO discovered that the computerised cell call bell system in G4-7 was faulty and informed the Governor. The faulty unit was replaced by the supplier on 12 September. Examination showed that the cell call bell computer recording function and the audible alarm signal did not work on 7/8 September. The red indicator light on the unit did work, but both night patrol staff said they did not remember seeing the indicator go on for cell G4-7 during the night of 7 /8 September. They said that they regularly check the indicator panel during the night and thought they would have seen the light for G4-7 had it been pressed. Maintenance staff were unable to say how or when the fault developed. From the results of a sampling exercise undertaken by the investigator, it is likely that the cell call bell equipment for G4-7 had not recorded cell call activity since May 2005.

I make seven recommendations all of which have been accepted.

THE INVESTIGATION PROCESS

1. My investigator visited HMP Frankland first on 15 September 2006 and met the duty governor. He was given a full briefing about the circumstances surrounding the man's death. Offers to meet representatives of the Prison Officers' Association and the Independent Monitoring Board were accepted.
2. Notices to staff and prisoners were published inviting anyone who might have information relating to the man to make themselves known to the investigator. Four prisoners spoke to the investigator immediately, and one provided further information but refused to be formally interviewed. The investigator met with relevant prison staff including members of the Independent Monitoring Board (IMB), psychology and safer prisons departments. The police conducted their initial investigation, but were not involved in the Ombudsman's investigation.
3. Copies of the man's prison and medical records were provided. Durham & Chester-le-Street PCT was requested to carry out a clinical review and they commissioned a review on their behalf by the Northumberland NHS Care Trust.
4. One of my family liaison officers (FLO) visited the man's sisters, with the investigator. During the visit, the family raised several questions about the circumstances of the man's death and the way that Frankland handled their loss.
5. The queries relevant to this investigation were:
 - Despite visiting the cell in which the man died, his sisters were at a loss to understand how it was possible for him to have taken his own life given that he was a fairly tall man and the height of the ligature point appeared to them to preclude this method of suicide.
 - In the period between the man's original imprisonment in Durham and his move to Frankland (a period of about 15 months), he went from being apparently "clean" of drugs, and seeming to be coping well, in Durham to his sisters seeing a "shocking change" when they visited him in Frankland. They believed that he was taking drugs and that something had happened to him on the wing whilst he was there.
 - Was all of the man's cash returned to his next of kin?
 - Was the man's treatment for severe toothache prior to his death appropriate?
 - The man's sisters felt that they were not given help, guidance or sympathetic treatment from some staff at HMP Frankland following his death.
6. Other queries raised by the man's sisters concerned whether the man was rightly convicted of the crime for which he was serving his sentence. It was explained by the FLO and the investigator that this matter was outside the Prisons and Probation Ombudsman's remit and should properly be addressed elsewhere.

HMP FRANKLAND

7. Frankland was opened in 1980 and is a high security training prison on the outskirts of Durham. It has an operational capacity of 733 prisoners held in seven accommodation wings. The population is made up of high and standard risk category A prisoners, including those remanded in custody by the courts, and category B prisoners. There are also a small number of category C prisoners awaiting transfer.
8. Healthcare at Frankland has been provided by the Durham and Chester-le-Street Primary Care Trust since April 2004. The healthcare centre has inpatient facilities for up to 18 prisoners.
9. Frankland has an active Safer Custody Unit which has ownership of the Anti Bullying Policy dated February 2005 and a Suicide Prevention Policy & Strategy Document dated 29 March 2006.
10. Frankland's last announced inspection by HM Chief Inspector of Prisons, Ms Anne Owers, was in March 2003. In her subsequent report, Ms Owers found that Frankland was a generally safe and decent environment based on the good relationships between staff and prisoners. The report recommended the development of the anti bullying strategy to ensure that there was identification of the more subtle forms of bullying that may occur. It also recommended improvements in the management of the drug strategy and the prioritisation of drug testing.
11. Overall, Ms Owers recognised that Frankland was seen as a high performing prison by the Prison Service, a fact that the 2004/2005 Independent Monitoring Board Annual Report reflects.

EVENTS LEADING UP TO THE NIGHT OF 7/8 SEPTEMBER

12. On 29 and 30 May 2005, following his arrest, the man was seen by police doctors who noted on the custody record that he was a heroin addict and had been prescribed Dihydrocodeine (DHC) and diazepam. They also noted that he was not at risk of self harm above the normal standard.
13. The man was remanded in custody at HMP Durham on 31 May 2005. On reception into Durham he stated that he was generally well, but acknowledged that he was addicted to heroin and that he was not on any detox programme. He indicated in his first reception screening interview that he used heroin daily, but had not had any in the previous two days and was withdrawing slightly. He also acknowledged that he used cocaine and benzodiazepines occasionally and "all or any barbiturates". He said he needed help with his drug habit and that he did not have any mental health problems. He was referred to the doctor and to Counselling, Assessment, Referral, Advice, Throughcare (CARAT) staff. In answer to questions about self harm, he denied ever attempting to do so or that he felt suicidal or was at risk of harming himself.
14. The man saw the doctor the same day. The doctor noted that he was a long term intravenous drug user who had last used drugs on 29 May 2005. He also noted that the man had mastoid problems on both his right and left sides. His urine was tested and proved positive for morphine, tetrahydrocannabinol (THC) and benzodiazepines. The doctor noted that there was nothing physical or mentally concerning the man, and planned for the detox team to see him on the following day. He prescribed the man a 'Rescue Pack' to relieve the symptoms of withdrawal until he started his detox programme. The 'Rescue Pack' was issued on 1 June 2005 and, as is normal, this was given in possession.
15. The Pack contains a variety of medications:
 - Zopiclone (7.5mg) 1 nightly for 7 days to help insomnia
 - Loperamide (2mg), for 10 days as necessary to help diarrhoea
 - Mebeverine (100mg), 3 times daily for 10 days as necessary to reduce abdominal cramps
 - Domperidone (10mg), 3 times daily for 10 days to reduce nausea and vomiting
 - Ibuprofen (200mg), 1 or 2 tablets 3 times daily for 10 days as necessary to reduce muscle aches and pain
 - Paracetamol (500mg), 1 or 2 tablets 4 times daily for 10 days for pain relief
16. The man started a 10 day detox programme on Wednesday 1 June. This involved him taking two or three tablets of Lofexidine (200mcg) four times daily for five days, and then one or two tablets four times daily for the remainder of the programme. This medication is for opiate withdrawal and was also given in his possession, although only 30 tablets were issued on that Wednesday. A note on the Detox Programme form indicates that a second pack of tablets should be issued between Saturday and Monday.

17. On 3 June, the man was seen for a physical health screen. He said he had been tested within the previous 12 months for HIV and Hepatitis C which had both been negative. He was also offered and accepted a course of vaccinations for Hepatitis B. These were given over a period between 3 June and 4 July 2005.
18. By 13 June, the man was complaining that he could not sleep at night. He was asked to complete a sleep diary for seven days, in preparation for an appointment with the prison doctor on 30 June. At this appointment he was prescribed a further course of Zopiclone for four days.
19. On 13 October, he complained of ear pain for which he was prescribed Sopradex and a repeat prescription of Zopiclone for a further three days. The man's Pre-Sentence Report of 21 October 2005 concluded that he posed no current risk of self harm. On 27 October 2005, he was sentenced to an Indefinite Public Protection (IPP) life sentence, and received a tariff of four years and one month after adjustments were made for time already spent in custody.
20. On 19 December 2005, a Multi Agency Lifer Risk Assessment Panel (MALRAP) meeting was held at Durham to discuss the man's case. (MALRAP meetings are convened to determine risk factors that may arise either during the sentence, or after release, and to share information.) During this meeting, the Security Department staff identified that three main intelligence reports existed concerning the man, all of which were drug related and his relationships with people inside and outside of prison who were involved in the supply and use of drugs. One report dated 23 August 2005 reports that an attempt had been made to smuggle a brown powder into Durham in correspondence to the man. The man was also reported at the meeting to have been screened for drugs, but had tested negative.
21. The risk factor comments recorded at the meeting were:

“Self Harm – There is no indication of self harm and that he poses no risk to himself.”

“Drugs – There is clear evidence that the man is a heroin user, and that he has contacts within the drug networks and these networks are concerning as it gives the man access to all sorts of things. There are no drugs issues whilst in prison, however once returned home, there will be.”
22. The man was prescribed Zopiclone on 1 January 2006 for seven days to help his insomnia. He also saw an optician for a sight test on 4 January. The optician referred him for blood tests for hyperlipidaemia. Blood samples were taken on 24 January and the test results were returned on 27 January indicating that all was normal.
23. On 11 January 2006, a letter was sent from the National Offender Management Service (NOMS) to the man informing him that the specified part of his sentence (tariff) expired on 27 November 2009, and that his suitability

24. In January, the man requested a transfer to Frankland so that he could remain close to his family. In any event, he could not remain at Durham on a long term basis as the prison does not run the offending behaviour courses that indeterminate sentence prisoners need to complete prior to being considered for release. The Life Sentence Plan document identified the progress he was making towards a transfer. He was also placed on the transfer lists for Gartree, Liverpool and Manchester prisons.
25. The man's wife died unexpectedly on 2 February 2006. No cause of death was established at her post mortem and to date the reason for her death has not been established by an inquest. An entry on the man's medical record dated 3 February says that he was fairly controlled and that he would see his wing Principal Officer and the chaplain. The entry goes on to say that Zopiclone was prescribed for seven days and diazepam, three times daily for seven days. An entry on 10 February describes him as "In bits" and that diazepam was not helping. He also reported that he was not sleeping for long. The entry concludes by noting that he had seen the chaplain and that he remained quite shell shocked. Diazepam was re-prescribed for ten days and Zopiclone was prescribed for a further seven day period. Durham arranged for the man to attend his wife's funeral under escort on 13 February.
26. On 21 February, a medical record entry records that the man's head was still "in bits", but that he appeared calm and denied any thoughts of suicide. He was prescribed Zopiclone and diazepam for another seven day period.
27. On 22 February 2006 an external Probation Officer, wrote in a Post Sentence report that the man was responding to his bereavement as part of the normal process of grief. Although she believed him to be drug free at the time of interview, the risk of further drug use was increased because of his loss. She said this risk should be addressed by the medical services and CARAT team. She concluded the report by saying that there were no mental health difficulties and that she did not assess the man as being at risk of self harm.
28. On 26 February, following the death of the man's wife, the man requested that his transfer to Frankland be expedited. On 1 March, the man was given Ibuprofen for a muscle injury to his ribs and Zopiclone was again prescribed on 2 May to combat his recurrent insomnia. An entry by a doctor was made that this dose was to be for seven days only.
29. On 1 June a registered nurse, saw the man and discussed with him his use of night sedation. The nurse noted that the man realised that night sedation was not the answer but that he felt low and tired, just wanting a night's sleep. An appointment with a Registered Mental Nurse (RMN) to discuss coping with bereavement was suggested, and the man agreed. A note of a plan to prescribe three further doses of Zopiclone was made, but only after discussion

30. A signed, but undated, Prisoner Fit for Transfer form shows that the last time The man had been in contact with Durham Healthcare Centre was on 1 June. The only outstanding issues were the complaint of insomnia and an outstanding referral to an RMN. No mention is made of the man's bereavement on this form. The man was transferred to HMP Frankland on 17 July 2006. On arrival at Frankland, the medical record shows that he complained of toothache and was prescribed paracetamol and ibuprofen for ten days and notes that he saw the dentist on 21 July. He also stated on reception that he had no thoughts of self harm or suicide. He said he had been a heroin addict, but had been clean for 17 months.
31. Initially, the man was mistakenly located on D wing, a unit for vulnerable prisoners. On discovery of the error, he was transferred to normal location on G wing where he was allocated cell G4-7. According to a security report dated 17 July, it is apparent that several prisoners on the exercise yard overheard the transmission of a message announcing that a transfer was taking place from D to G wing. The Safer Custody Unit was informed on 2 August and the possibility of repercussions as a result of the error was investigated. (In other words, that the man might have been mistakenly identified as a sex offender and targeted as a result.) They found no evidence that the man suffered any bullying or abuse following this unfortunate error.
32. On arrival on G wing, the man met up with some prisoners he already knew. One of them had known the man for some 15 years and was a friend to the man and his wife. The prisoner said that the man had had a heroin habit for a long time before coming into prison. He said that he did not use heroin every day, but when he did use it, "he really used it". The prisoner said the man was very depressed after coming off drugs. This, he said, was all playing on the man's mind. He felt he was in a vicious circle following the death of the man's wife.
33. The prisoner had been in Durham with the man prior to them both being transferred to Frankland, albeit the prisoner arrived one month earlier. He described himself as being the man's closest friend when his wife died. The prisoner saw him daily throughout that time. He described the man as having "lost it" following the death and said he had talked a lot about his wife. He added that during those conversations the man had said that his wife was in a good place and that he would be with her soon. The prisoner also said that there was not much contact between the man and his sons. They did not visit him and this hurt him. He added that it was a big issue for him that they did not keep in touch. The prisoner also said that the man had written to a friend in an attempt to borrow money.
34. Soon after his reception into Frankland, the man had a short informal psychology induction meeting with the trainee forensic psychologist. She discussed with him the FOCUS Programme and CARAT scheme which would offer him help in his attempt to stop using drugs. He seemed interested and

35. A second and fellow G wing prisoner and self-acknowledged drug user, got to know the man after his reception. He said at interview that he was aware that the man was using both heroin and Subutex on an almost daily basis. He said that on G wing drugs are available if you know where to go. He added that the wing is not awash with them, but they are available. He also said that during all of the time he knew the man (about four weeks), he was cold, had cramps, diarrhoea, muscle spasms and was unable to sleep. The man went through a rough patch when he was unable to get drugs.
36. On 18 August, the man provided a Compliance Drug Test urine sample which tested positive for morphine. He explained the result by saying that he had taken the drug for pain relief purposes. He retracted this at an interview with a CARAT worker on 22 August, when challenged. No action was taken, but he was warned that it could affect his Incentives and Earned Privileges enhanced status.
37. Later the same day, he was seen by a prison doctor who noted in the medical record that the man complained of a problem with his left mastoid and of long term back pain. He was prescribed an Otomize spray, paracetamol and physiotherapy.
38. Soon after 21 August a G wing officer became aware that he was in fact the man's personal officer. He had been working on other duties since the man's arrival at Frankland and did not know him. He introduced himself to the man and explained that, should he have any issues that needed resolving, his first point of contact should be his personal officer. Following this conversation, the G wing officer formed the opinion that the man was a man who kept himself to himself and would only interact with staff when the need arose. This proved to be the case. The G wing officer placed the man on a Governor's Adjudication (an internal disciplinary hearing) on 26 August for being in possession of a bottle of home made alcohol. The case was heard by the adjudicating governor on 28 August when the man asked for an adjournment so that he could consult a legal adviser. The adjudication was adjourned for two weeks. The man died in the interim period.
39. On 24 August, following the positive drug test, the man was interviewed by members of the Psychology Department for possible inclusion on the FOCUS programme. This is a Prison Service substance misuse treatment service. It has a multi disciplinary approach and includes doctors, psychologists, probation officers and CARAT (Counselling, Assessment, Referral, Advice, Throughcare) workers. The programme is aimed at reducing the risk of re-offending, by identifying specific needs which may require additional support. The course is of six months duration. The man was interviewed for possible inclusion on the next suitable course which started on 10 October 2006. The man was accepted for the programme and signed the necessary forms consenting to information sharing between departments and the use of

40. During the interview on 24 August, the man said that he was “habited up”. When asked by the interviewers what that meant, he confirmed that he was using heroin on a daily basis. According to the trainee forensic psychologist, disclosures of this type do not necessarily warrant a referral to healthcare for consideration for detoxification treatment unless specifically requested by the prisoner. The request would then have been referred to the CARAT team. No referral was made.
41. The man went on to complete the FOCUS Programme Semi Structured Interviews on 25 August. Final selection for the course participants was held after the man had died.
42. On 1 September, the medical record shows that the man was complaining of back problems. The note adds that he was using opiates on the wing. He was prescribed Gabapentin capsules (300mg), an anticonvulsant medication, three times daily. The note adds that the man was not keen on Ibuprofen.
43. A security report dated 4 September indicates that the man had sent a letter making reference to the adjudication that was pending and that he was in debt for the sum of £200.
44. The prisoner who knew him at Durham said that the man felt he was being left to rot at Frankland and was not progressing in his attempt to get “clean and straight”, having applied for a detox course to do so. The prisoner added that the man had written to his probation officer some three weeks prior to his death to the same effect. However, there is no evidence either in his medical record or in his prison record that such an application was made or that it was discussed with him. The prisoner said at interview that, about four days before his death, the man had looked really stressed. He had asked the man if he was going to do anything silly to himself, to which the man had replied that he would not.
45. The trainee forensic psychologist’s second meeting with the man was on Thursday 7 September between about 9.30 and 10.45am. This was the final assessment prior to him being put forward to the assessment board in preparation for joining the FOCUS programme. The final assessment included a Weschler Abbreviated Scale of Intelligence (WASI), an assessment of intellectual ability. The trainee forensic psychologist described the man as being talkative and responsive. He was very polite, happy and interested in the whole assessment process. He had many queries about the FOCUS programme and how it would help him. After the WASI had been completed, he then spoke about how problematic his heroin use was. It was whilst he was speaking about this that the trainee forensic psychologist became aware that the man’s wife had died recently. He told her that he used heroin with his wife in order to get away from his problems. The trainee forensic psychologist said that she could see that he was upset when speaking about his wife, not in a tearful way, but more in a dropping of his mood.

46. The trainee forensic psychologist asked the man when he had last used heroin. He said that it was about a week before the meeting and that he had not used any since because he had no money to pay for it. He added that he might use the following day because that was pay day. She then asked if he was in debt, and he replied that it was manageable without giving her a figure. They also spoke about a detox programme, but the man thought that FOCUS or other drug counselling would be of more benefit to him because he said he would always be returning to the wing where drugs were available. They also discussed the possibility of moving to a wing for vulnerable prisoners to assist in this area. No resolution of this issue is recorded. At this meeting, the man asked the trainee forensic psychologist to find out who his CARAT worker was. She did so after the meeting and spoke to the CARAT worker, who contacted G wing and made an appointment to see the man on 11 September (the following Monday).
47. The trainee forensic psychologist said that the man appeared to be focussing on the future. At the end of the meeting he said he appreciated what she was doing for him and said goodbye. Soon after the man's death, she submitted a security report about their meeting.
48. Listeners are prisoners trained by the Samaritans to assist other prisoners in distress. A Listener at Frankland knew the man and met him just after his arrival, though not in his capacity as a Listener. He last saw the man on the morning of 7 September during workshop movements, at about 11:00am. He asked the man if he was alright and the man replied that he was. That was the extent of their conversation.
49. On the evening of 7 September, the man, the two other prisoners were together on association with others in cell G2-23 from about 5.00pm up until about 10 minutes before 'lock up' at 7.30 pm. The second prisoner recalls that the man had seemed alright, but said during the course of the evening that he could not go through another night like the one before. The second prisoner added that he believed the man was withdrawing at the time and maintains that the man took no drugs during that evening whilst he was with him. The second prisoner recalled on the following day, that during a conversation about his wife that evening, the man said "Never mind, I'll be with her soon." The second prisoner took no notice of the remark. Later on 8 September he spoke to a member of G wing staff about this conversation and security report was submitted immediately.
50. The man's Personal Officer spoke to him some time between 6 and 7:00pm about the adjourned adjudication which was to be heard on 11 September. The man said he had forgotten about it, laughed and left the landing. The personal officer said he seemed perfectly alright.
51. At about 7.20pm, the man said goodnight to his two friends and went to G4-7, his own cell. On the way to his cell he met his immediate neighbour (G4-6), with whom he exchanged a few words, said goodnight and went inside his cell. The immediate neighbour told the man he would see him in the morning,

52. The OSG on night patrol says that he started his night duty on G wing at about 7.30 pm. On his arrival at the wing a night patrol prison officer was in the process of checking the roll, ensuring that all prisoners were accounted for. He completed the roll check which was correct and signed for the numbers in the G wing office. The OSG as is usual at the start of a night duty, checked the handover book for any relevant information. It contained no reference to the man.
53. The OSG explained that part of his job as night patrol includes pegging on the wing. (Pegging is the system used to ensure that all parts of the wing are patrolled adequately by staff during a night. It involves pressing a button, which registers on the wing computer that it has been pushed and at what time.) There are four designated pegging points on G wing, one on each landing. On G4 landing, the pegging point is located at cell nine in the far right hand corner of the wing.
54. The pegging order is pre-determined on one of eight sequences which are numbered one to eight. The Night Orderly Officer (NOO) designates which of the eight sequences is to be used as the starting point at the beginning of the week of night duties, and the pegging sequences then cycle through the remainder of the week. On the night of 7 September, sequence two was in use.
55. The OSG explained that, in addition to the pegging sequence, more frequent checks are required on individual prisoners when they are designated as either high risk prisoners, category A prisoners or those with open Assessment, Care in Custody and Teamwork (ACCT) documents. (ACCT documents are opened when a prisoner is felt to be at risk of self harm or suicide.) High risk prisoners are checked every hour. Category A prisoners are checked five times during the night. Prisoners with open ACCT documents are checked as designated in the ACCT documentation. All of these checks are recorded by the pressing of the external call bell on the outside of the cell occupied by the prisoner being checked which, like the pegging sequence, registers on a computer in the wing office.
56. The OSG added that, if there is only one night patrol on duty in the wing, pegs are legitimately missed during meal break periods. The exception to this rule is where a prolonged incident precludes the peg from being made. Such missed pegs are detailed and accounted for on the night duty documentation

57. The G wing Officer said that on G4, on the night of 7 September, there were no high risk prisoners, no open ACCT documents and one category A prisoner located in G4-6, the cell next to the man who died. He commented that the category A prisoner being located in that cell, and the pegging point also being nearby, ensured that this area was visited more frequently than would normally have been the case had the only check been the pegging sequence. However, it did not mean that the man's cell, G4-7, was visited any more frequently than normal, only that staff were in the vicinity of his cell more frequently during the night
58. The man who died was a category B prisoner and did not fall into any of the other special watch categories. He was therefore not identified as needing to be checked during the night, except when the normal roll checks were made in the evening and again in the morning. The OSG added that, during the night and morning roll checks, each external cell call bell button is pressed as the prisoner inside the cell is counted. This provides a check that all cells have been visited and all prisoners have been accounted for.
59. The OSG and prison officer both said that at no time during the night of 7 September was their attention brought to cell G4-7.

8 September

60. The normal routine at Frankland is that the wing rolls are counted by the night patrols from about 5:45am and are reported to the Emergency Control Room (ECR) at about 6:00am.
61. At around 5:50am on the morning of 8 September, the OSG and prison officer began the routine of counting the prisoners on G wing prior to the day shift personnel arriving to take over from them. The OSG started at G4-1, working up the landing towards cell G4-8 and, as is normal routine, pressed each external cell bell button by way of a test as he counted the prisoner in each cell. The prison officer in a similar manner, was about to start on the opposite side of the landing working, from G4-16 down towards G4-9.
62. When the OSG arrived at G4-7, he opened the observation flap on the door and switched on the cell's night light. On doing so he saw that the man was hanging from his cell window. He was in the kneeling position facing the window, which is in the back wall of the cell opposite the door. He had what looked like shoelaces around his neck and attached to the window latch. The OSG could see the ligature quite clearly, but cannot remember whether the man was kneeling on the floor of the cell or the heating pipes running along the back of the cell. He shouted to the prison officer that he had a man hanging and to go and get the knife.
63. A ligature knife is kept in the wing office for such emergencies. It is in an unlocked Perspex fronted box on a shadow board. The prison officer, who

64. The duty Healthcare Officer (HCO) was informed by ECR staff at 5.55am and was asked to go to G wing with the night orderly officer. He took with him the emergency trolley which contains a resuscitation kit, a defibrillator, a blood pressure machine, a pulse oximeter and oxygen. On the way to G wing, the duty healthcare officer asked the night orderly officer what the emergency was. He was told it was a “code black” (the code used at Frankland for a patient who has lost consciousness).
65. The prison officer then went straight back to G4-7 with the knife. The OSG explained that for safety and security reasons two staff members are required to open a cell during the patrol state at night. The OSG estimated that from discovery to entering the cell no more than two minutes had elapsed. When the prison officer returned to the cell he opened the door and went straight to the man. He tried to get the man to respond by putting his hand on his shoulder, but realised because he was cold and stiff that he was probably dead. At the same time, the OSG joined him and lifted the man’s body to enable the prison officer to cut the ligature away. They then laid the man on the floor of the cell on his front with his head towards the door and the prison officer cut the remaining ligature away and left it on the floor. He checked the man for life signs and found no signs of breathing and formed the opinion that the man was dead. He and the OSG then left the cell, pulling the door closed behind them, to await the arrival of the night orderly officer and the duty healthcare officer. The OSG said that all the observation flaps on the landing were shut so other prisoners could not see the man. He also said that only a few seconds had elapsed after they left the cell when the night orderly officer and duty healthcare officer arrived on the wing at around 6.05 – 6.10am. They were briefed as to the situation and taken to G4-7. The OSG then continued to count the prisoners in the rest of the wing.
66. On arrival, the night orderly officer opened the cell door and the duty healthcare officer went into the cell immediately to check the man. After entering the cell the duty healthcare officer tried to find a pulse both on the man’s wrist and neck, but was unable to do so. He then attached the blood pressure cuff to his right arm and the pulse oximeter to a finger on his left hand. When the duty healthcare officer switched the equipment on it

67. The ECR Occurrence log notes that an ambulance was en route at 6:10am. At interview, the night orderly officer said he thought they were called at around 6:15am.
68. The night orderly officer obtained the padlock kept on the wing and secured the cell door so only properly authorised people would have access. (This is standard practice throughout the Prison Service. Under these circumstances the cell is treated as a scene of crime, until released by investigating police officers.) As the senior member of staff on duty, the night orderly officer kept the key personally.
69. By around 6.15am, the doctor had been informed and was on his way to Frankland, as were the paramedics and the duty governor. The ECR Occurrence Sheet notes that the ambulance arrived at Frankland at 6:18am. The night orderly officer unlocked the padlock on the cell door to allow the paramedics access. They confirmed the man's death at around 6:35 and left the cell. The night orderly officer relocked it at 6.37am. Some five minutes later, a doctor arrived with the principal officer, the oncoming day shift Orderly Officer. The doctor certified death at 6.45am. Immediately after death had been certified, the duty healthcare officer removed all his equipment from the man's body, returning it to the trolley. The cell was relocked at 6:50 when they left. The duty healthcare officer and the doctor went to the healthcare centre and completed the necessary documentation. The night orderly officer briefed the duty governor and the day shift Orderly Officer when they arrived. He remained on G wing, unlocking G4-7 again at 7.35am to allow access to the police.
70. Whilst on G wing, the duty governor read the man's computerised record which identified his next of kin as his wife. He was aware from conversations with staff on the wing that morning that the man's wife had died earlier in the year. The computerised record had not been amended to reflect this. The duty governor was aware that the man's last correspondence was to his sister in law, which indicated to him that she was probably his next of kin. He passed her address to Durham police. The ECR Occurrence Sheet notes that he also instructed them to pass her details to Northumbria police, and asked them to contact her. He said at interview that, between this time and when the police actually contacted the man's sister in law, he had become aware that the PIN telephone system contained other registered telephone numbers that the man had used.
71. The duty governor said that he then left G wing, meeting the head of residence, on the way out. He briefed him on the current situation, and then

72. After handing control of the incident over to the day duty orderly officer, the night orderly officer went to the Adjudication Room where he, the duty healthcare officer, the night duty prison officer and the OSG were asked to write their reports. On completion of his report at about 8.45am, he walked with the prison officer and OSG to G wing to make statements to police. On the way, the night orderly officer asked the other two how they were. They said that they had been uncomfortable during their report writing because some of the senior staff were also in the room and were advising them on the content of their reports and questioning them about what had happened.
73. When the staff had finished their reports, the principal officer carried out a mini debrief with them. Police then interviewed the relevant staff and, whilst they were being interviewed, the acting Governor was brought up to date by the duty governor, after which he completed the relevant death in custody documentation. The senior officer carried out a review later that day, which included looking at a number of security reports that had been submitted by staff.
74. At 9:25am, the ECR Occurrence Sheet notes that next of kin information was passed to Northumbria police.
75. At 9.28am the man's personal officer, formally identified the man's body for the police. CID officers and photographers arrived and searched G4-7 and the man's body. A member of Frankland's Dedicated Search Team (DST) took the police Scenes of Crime Officer (SoCO) outside the wing to search the area around the window of G4-7. They found a piece of shoe lace attached to a shaving brush that was in situ, caught in the window catch from which the man was found hanging. It was very evident from outside the cell, but not so from inside the cell. The SoCO photographed the item and placed it in an evidence bag, handing it to one of the police officers on his return to G wing. The police search was concluded at 10.20am. At 10.30am they left, releasing the man's body for removal. No letter or note was found on the man's body, in the cell or outside the wing.
76. A hot debrief is a procedure where staff involved in a serious incident are seen by senior managers soon afterwards to establish what has happened. A hot debrief took place at 10.15am in the prison boardroom chaired by the acting Governor. It lasted 45 minutes. All open ACCT documents at Frankland were reviewed following the debriefing and a meeting took place in the chapel to inform the Listeners. Samaritans, who support Listeners, were also informed by the principal officer.

77. After the debriefing, ECR staff told the duty governor that the police had been delayed in informing the man's sister in law and that, at around 10.30am, her husband was given brief details by Northumbria police. The man's sister in law contacted Frankland at around 11.11am and the Deputy Governor spoke to her at 11:15am. She indicated that she was willing to act as the liaison point for the family and the Deputy Governor told her that the prison would be supportive and would assist with funeral expenses and the prompt return of the man's property. He offered to facilitate a visit to the prison, but then left her to come to terms with the news and to inform the rest of the family. The duty governor says he left it to her to contact the prison in her own time.
78. After the debriefing, the acting Governor spoke to the duty healthcare officer, the OSG and the night orderly officer who were offered the following night off duty. All except the night orderly officer took up the offer. All staff involved with the man's death were seen and supported where necessary by members of the Frankland Care Team.
79. Throughout the morning, members of the Independent Monitoring Board (IMB) and the chaplain were on G wing. After police had completed their work and before the cell was re-secured, the chaplain went into the cell and said a prayer over the man's body. After the chaplain had left the cell, the cell furniture and personal property were replaced and the cell was re-secured.
80. The man's body remained in place in G4-7 until lunch time on 8 September when, at 12.48pm, funeral directors removed him from Frankland. The man's personal effects were removed from the cell two days later and logged. They were then packed ready for return to his next of kin when they visited the prison.

After the man's death.

81. A governor at Frankland and a Family Liaison Officer (FLO) was contacted by the man's sister in law over the days following the man's death regarding the return of the man's property. On 14 September, members of the man's family paid a visit Frankland, spoke to the Governor and went onto G wing to visit G4-7. The man's money and property were returned to his sister, on that day but a query remained about a £100 sum of money that might have arrived at Frankland for the man on the day of his death.

ISSUES CONSIDERED DURING THE INVESTIGATION

Use of illicit drugs

82. During the man's time at Durham, a number of security reports were received by the prison's Security Department detailing attempts to acquire drugs. In August 2005, drugs were sent to him hidden in correspondence. The reports also indicated that the man was still very much in touch with people in the drug networks. No action was taken against him because there was insufficient information to do so. The man was screened for drugs and the results were always negative.
83. On reception at Frankland, it is normal for all prisoners to be tested for drugs, but the man was not in fact tested on arrival. It is likely that this was because Mandatory Drug Testing (MDT) personnel were redeployed into other areas of the prison to cover staff shortages. By chance, the man was also not included on the random MDT list.
84. The regime of testing for drugs at Frankland falls into one of two elements Mandatory Drug Testing (MDT) and Voluntary Drug Testing (VDT):

MDT

- a. Suspicion drug test – where a suspicion exists that a prisoner is using drugs and a security report is submitted. An evaluation is made by Frankland security staff and, where evidence is strong enough; a test is approved and carried out by MDT staff. The man was not tested under this regime.
- b. Risk assessment drug test – the prisoner is an orderly or cleaner usually working without the direct supervision of staff or is in a job that requires him to work to a particular standard. The man was not employed in these areas and was not subject to this type of testing.
- c. Frequent test programme – here a regime of regular testing is instigated by a positive drug test followed by a disciplinary charge and a finding of guilt. The frequency of the testing is dictated by the independent adjudicator or governor hearing the charge. This type of testing was not applicable to the man.
- d. Reception testing - all prisoners are tested for drugs on reception into Frankland. The man was not in fact tested on arrival.

VDT

VDT is wing based and undertaken by the Programmes Group. This level of testing is not the responsibility of the MDT group. This testing is performed using a dip and read urine test. In the event of a positive reading for drugs, the matter is dealt with by the wing management and the individual's CARAT worker. Rehab programme graduates seeking assistance with drug abstinence as part of their throughcare, individuals

wishing to establish a degree of self discipline or those wishing to prove drug abstinence can apply to join a VDT programme.

VDT was also known as a Compliance Drug Test (CDT). Prison Service Safer Custody Group clarified this level of testing as forming part of the incentives and earned privileges criteria and is conducted where an individual wishes to provide proof of drug abstinence. Regular dip and read tests are able to demonstrate compliance with the enhanced criteria. In the event of a positive reading for drugs, the matter is dealt with by the wing management. The man was subject to this type of test, and gave a positive test for morphine on 18 August 2006 for which he was warned and referred by CARAT staff for inclusion on the FOCUS programme.

85. Between his arrival at Frankland on 17 July and 4 September 2006, four intelligence reports were received by the Security Department indicating that the man was involved in drugs networks and involved in the transfer of money between his and other prisoners' relatives and friends outside of prison. The man's sisters confirmed, during discussion with the investigator, that they had sent money to people outside of prison at the man's request.
86. The man had a long term drug habit of which he made no secret. He sought help for his addiction and, with assistance from both Durham and Frankland, made attempts to get clean from drugs. The apparent availability of drugs at both establishments, combined with his personal circumstances following the death of his wife, made it extremely difficult for him to do so.
87. By his own admission, the man used drugs at Frankland when they were available to him, and tested positive for morphine based drugs whilst on G wing during a CDT. He was warned by wing management and referred by CARAT workers for assessment to join the FOCUS programme. During an interview on 24 August, he told psychologists that he was "habited up". There is no evidence that psychologists referred the man to healthcare staff regarding his statement. It is not current practice in these circumstances that such a referral is made, but as a consequence no detox programme was considered at the time.
88. On 7 September, the man told a psychologist during his final assessment that he had not used drugs in the previous week, but might do so the next day because that was pay day and he could then afford them. They also spoke about a detox programme, but the man thought that FOCUS or other drug counselling would be of more benefit to him because he would always be returning to the wing where drugs were available. They also discussed the possibility of moving to a wing for vulnerable prisoners where drugs are much less common. He had been accepted for the programme, and at his death was about to be put forward for a final assessment to join it.
89. There is a perception amongst prisoners interviewed by the investigator that detoxification programmes are difficult to obtain at Frankland, and ineffective.

The Head of Healthcare at Frankland should ensure that systems are in place to identify prisoners who may require a detox programme at any stage during their sentence.

Clinical review

90. The clinical review included an assessment of the care provided for the man at Durham and Frankland.
91. The clinical reviewer found that the man's substance misuse was identified and dealt with appropriately when he entered Durham prison. He was given a Lofexidine detox programme and referred for CARATS support.
92. The clinical reviewer believes that communication between Durham and Frankland at the time of the man's transfer should have referred specifically to the death of his wife and not just to insomnia. Although this information is contained within the medical record, it would have been good practice to have flagged it up prominently rather than assuming that the Frankland team would pick it up. The clinical reviewer points out that there is no mention of the man's wife's death in the transfer notes or in the reception record. It is not possible, therefore, to make a judgement about whether his wife's death had been identified during his reception into Frankland or at any time prior to his meeting with the trainee forensic psychologist on 7 September. The trainee forensic psychologist did not submit a security report about her meeting until the day after the man had died. .

The Governor of Durham should remind staff that important information about a significant event(s) that affects a prisoner, and which potentially raises the level of risk of self harm or suicide, should be specifically referred to in the transfer documents by the transferring prison.

93. The clinical reviewer says that the man had apparently been smoking opiates on the wing in the days before his death. This information is derived from an unsigned note, dated 1 September 2006, in the man's medical record. However, the man had told psychologists at a meeting on 24 August that he was using drugs daily and subsequently told the trainee forensic psychologist on 7 September, the day prior to his death, that he had not used drugs for about a week because he was unable to pay for them. The post mortem report revealed no illicit drugs or alcohol in his body at the time of death.
94. The clinical reviewer does not speculate in his report whether substance misuse was a contributory factor in the man's death. However, it is likely that, given the man's own account of not using drugs for about a week prior to 7 September and the accounts of other prisoners, he was indeed suffering from withdrawal from drugs.
95. The clinical reviewer notes that the duty healthcare officer did not attempt to resuscitate the man because he was cold and stiff when found, and there were no signs of breathing, no pulse and his blood pressure was unobtainable. The clinical reviewer feels that this was the correct decision

The Governor of Frankland should ensure that the wording of the local Suicide Prevention Policy and Strategy Document concerning the issue of resuscitation is amended to reflect national guidance.

Self Harm and Suicide Risk

96. Throughout the man's imprisonment, he consistently denied any thoughts of self harm or suicide. He had no history of any previous self harm or suicide attempts, and specifically denied thoughts of self-harm or suicide on his reception into Frankland. The clinical reviewer writes in his review that it was reasonable to assume, at that time, that the man's denial of suicidal intent was genuine. He also writes that he was clearly very distressed at the unexpected death of his wife, and this would be compounded by feelings of guilt at not being with her and helplessness resulting from his incarceration. This is a risk factor for suicide, but the man was not put on any form of suicide or self-harm plan. However, he was seen relatively frequently by GPs, and on 1 June 2006 was referred to an RMN to discuss support through his bereavement. There is no evidence to indicate that the man was seen by an RMN at Durham or, after his transfer on 17 July, at Frankland. At Durham, the chaplain and wing officers supported him.
97. The clinical reviewer says that it is not clear whether, after four months, the man was felt to have settled following his bereavement. He did not seek medical help in Frankland for either insomnia or distress, which suggests that he may have settled. The clinical reviewer goes on to speculate that it is possible that the man had made a decision to attempt suicide when an opportunity presented and did not wish to be frustrated by increased surveillance.
98. It is equally possible that the man had settled and made a decision just before his death that his unsupported and unstructured withdrawal from drug use and the loss of his wife made life unbearable for him. Both of these events are risk factors.
99. There were no indications to any member of staff at Frankland that the man was feeling suicidal. The trainee forensic psychologist, who interviewed the man during the morning of 7 September, described him as being talkative and responsive, happy and content with the assessment process about the FOCUS programme. She said that the man became upset when talking about

100. Several prisoners spoke to the man during the remainder of that day and none felt that the man appeared suicidal. One prisoner said that, although the man appeared alright, he had said he could not go through a night like the one before. The prisoner felt this referred to the man's withdrawal from drugs.

Informing next of kin.

101. The man's prison records still showed his deceased wife as his next of kin. However, the man's sister in law was identified by the duty governor on the morning of his death as his surviving next of kin. This was on the basis that she was the last person to whom the man had written, although details of his telephone contacts were seen later by the duty governor and showed other people who were close to him.

102. It is of concern that the man's next of kin information was out of date. As a result, the decision about whom to inform of his death appears to have been taken on incomplete information.

The Governor of Frankland should ensure that the accuracy of next of kin data must be maintained throughout a prisoners' sentence to ensure that appropriate action is taken without delay should the need arise. It is suggested that an annual check of the information held by the prison is carried out as the same time as the sentence planning process.

103. Durham police were given the man's sister in law's address and asked to break the news of the man's death to her. The ECR Occurrence Sheet notes that at 7:25 am, on the duty governor's instruction, details were also passed to Northumbria police. Northumbria police finally broke the news to the man's sister in law's husband at around 10:15am, because his wife was not at home. The man's sister in law contacted the duty governor at Frankland at 11:15am.

104. The good practice guidelines contained within PSO 2710, FLO Guidance paragraph 4.7 to 4.11, regarding who should break the news to the next of kin were not followed. Frankland should have arranged for suitable staff from the prison to break the news of the death in person to the man's sister in law.

The Governor of Frankland should ensure that the guidance about breaking the news to the next of kin outlined in Prison Service Order 2710 is followed.

Staff statements.

105. The night orderly officer said in his interview with my investigator that the two night patrols on G wing, the prison officer and OSG, had told him shortly after making their incident reports that they had felt uncomfortable because senior staff were present, were advising them on the content, and questioning them about what had happened. The OSG mentioned what he saw as added pressure in his interview with my investigator. The prison officer did not.

106. In their interviews with my investigator, the principal officer and duty governor said that they had gone to the Adjudication Room where the staff involved were making their post incident reports. The principal officer said she supported them at this time. The duty governor said that a number of staff involved had not experienced a death in custody before. He felt he was supporting all of the staff there, and said that the principal officer held a mini debrief after the reports had been completed.

107. I think I need say no more than that care must be taken to allow staff to write statements of their recollections without interference.

The Governor should ensure that all staff are aware of the need to produce a relevant and accurate statement of facts as they remember them as soon as possible following a reportable incident.

Cell call equipment

108. During a conversation on 10 September between the night orderly officer and the night patrols, the prison officer and OSG, it was suggested that the cell call bell system in G4-7 might be faulty. It was apparent after subsequent checking that information regarding the use by prisoners and staff of the system was not being recorded by the computer in G wing office. Examination of the recorded information revealed that use of the in-cell call bell button or the external button on the night of 7/8 September had not registered on the computer. It is to the night orderly officer's credit that he promptly brought the matter to the attention of the Governor on 11 September.

109. Further examination by the contractors' engineer and a staff electrician at Frankland on 12 September established that the cell call bell system installed in G4-7 was faulty. When pressed from inside the cell, the button did not register on the computer system and the audible alarm failed to sound in G wing office. However, the red indicator light did show outside the cell. Similarly, when the external button was pressed it did not register on the computer. The cell unit was changed immediately, restoring the proper functioning of the unit. The staff electrician could not identify when the unit developed the fault.

110. From the results of a sampling exercise on the computerised records conducted by my investigator, it is apparent that no cell call bell activity had been recorded by the unit in G4-7 since 5.53am on 26 May 2005. It is likely that a fault had existed in the unit for a very long period of time and, although in this instance it had no bearing on the man's death, indicates that checking of the recorded data and maintenance was not sufficiently rigorous.

111. During interview, the OSG said that he did not know whether the audible signal had been affected in the G wing office, but did know that the red light that shows on the outside of the cell was working. He added that, if the bell had been pushed by the man inside the cell, he or the prison officer would have seen it clearly and would have responded. He explained that G4 is a

112. The cell call bell equipment associated with G4-7 was faulty and appears to have been so for many months. It is a credit that the night orderly officer discovered the problem and reported it on discovery, ensuring that the matter became part of the investigation. I am satisfied that, had the bell been pressed, the staff on duty would have responded appropriately upon seeing the red light. However, it is a matter of concern that equipment at Frankland - a high security prison - may be faulty for several months before being discovered.

The Head of Works should implement a programme of regular checking of computerised recording of cell bell usage. This should include a check of the audio and visual indicators of cell call bell use.

Issues raised by the man's family

113. During their visit to the man's family, my Family Liaison Officer and the investigator were told of concerns the family had about the man's apparent deterioration between his time at Durham and Frankland. When they saw him on a visit at Frankland, they say that it was obvious that he was on drugs. They are struggling to understand how he had seemed alright for many months until his transfer to Frankland. They believe that something had happened to him on the wing whilst he was there.

114. It is evident from security information, the man's friends and the man himself, that he used drugs when he could obtain them, both at Frankland and Durham. But the types, quality and quantity of those drugs is not known. The man was in a small amount of debt that, according to his friends, appears not to have been a major issue and there is no evidence that he was being bullied as a result. It is apparent, however, that money was sent by the man's family and friends at his request to other prisoners' family and friends.

115. The family also have a concern that, following a toothache, the man had to wait for three weeks to see a dentist. Medical records show that the man reported the toothache on reception into Frankland on 17 July 2006 and was seen by a dentist on 21 July. No detail of the treatment is recorded in the continuous medical record. The man did not report any further dental problems.

116. The man's family said that, despite having visited the cell in which he died they were at a loss to understand how he was able to take his own life. They expressed a wish to be told how he had done so and the investigator was able to explain that a shoe lace had been tied around a shaving brush and the other end tied around the man's neck. The cell window was opened, the shaving brush put outside, the window being shut with the shaving brush and

117. The man's next of kin still recorded the details of his late wife who had died some months earlier. Efforts were made by senior staff at Frankland to ensure that close family members were told of the man's death; this was initially to the man's sister in law. The duty governor said that the man's sister in law was offered financial help with the funeral when he spoke to her. It appears that, in the transition between the man's sister in law and the man's two sisters who assumed liaison on the part of the family, a failure of communication occurred. The offer of help with the funeral expenses does not appear to have been communicated to the man's sisters who financed the funeral. Once this situation was made known to Frankland by the investigator, it is to the prison's credit that the error was speedily rectified.
118. The man's sisters described the visit to Frankland they made after his death as "horrible". They felt that the prison had not given them enough information or support. A meeting with the No 1 Governor appears to have been unsuccessful. The sisters said it was very short and they felt they were treated insensitively. I make no judgement on the facts, but it is always disappointing if a bereaved family believe they have been treated with a lack of candour or kindness. .
119. During the visit to Frankland, The man's property was returned to them. The sisters were concerned that the amount of money they were given did not include £100 that was sent to him by a friend immediately before his death. The man's sisters raised their concern about the money at the meeting with the Ombudsman's family liaison officer and investigator on 7 December 2006. The investigator brought this concern to Frankland's attention on 14 December 2006 and a subsequent investigation by Frankland resolved the matter. The money was returned to the man's family on 16 February 2007.

RECOMMENDATIONS

I make a total of seven recommendations:

1. **The Head of Healthcare at Frankland should ensure that systems are in place to identify prisoners who may require a detox programme at any stage during their sentence.**

Accepted

2. **The Governor of Durham should remind staff that important information about a significant event(s) that affects a prisoner and which potentially raises the level of risk of self harm or suicide should be specifically referred to in the transfer documents by the transferring prison.**

Accepted

3. **The Governor of Frankland should ensure that the wording of the local Suicide Prevention Policy and Strategy Document concerning the issue of resuscitation is amended to reflect national guidance.**

Accepted

4. **The Governor of Frankland should ensure that the accuracy of next of kin data must be maintained throughout a prisoners' sentence to ensure that appropriate action is taken without delay should the need arise. It is suggested that an annual check of the information held by the prison is carried out as the same time as the sentence planning process.**

Accepted

5. **The Governor of Frankland should ensure that the guidance about breaking the news to the next of kin outlined in Prison Service Order 2710 is followed.**

Accepted

6. **The Governor should ensure that all staff are aware of the need to produce a relevant and accurate statement of facts as they remember them as soon as possible following a reportable incident.**

Accepted

7. **The Head of Works should implement a programme of regular checking of computerised recording of cell bell usage. This should include a check of the audio and visual indicators of cell call bell use.**

Accepted