

**Investigation into the circumstances surrounding the
death of a man at HMP Whatton
in October 2006**

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

January 2007

This is the report of an investigation into the death of a man in October 2006 at HMP Whatton. He was found that morning in his single cell, hanging by his belt from a clothes rail. The man, who was a former soldier, was 39 years old.

I offer my sincere condolences to his family. I know that theirs was a close family relationship, and this must be a particularly harrowing time for them all.

One of my investigators led the investigation from my office. My thanks also go to Nottinghamshire County Primary Care Trust, particularly the doctor who assessed the clinical care that the man received while in custody.

I am grateful for the assistance my colleagues received from the staff and management of Whatton prison. I also acknowledge the help of Nottinghamshire Police who carried out their own enquiry into the man's death and readily shared their information with me.

A self-inflicted death is a very rare event in a jail like Whatton. And I fear this investigation has revealed very little that would help the authorities reduce still further the chances of such a death recurring. The man gave no indication that he was intending to take his life, and his mood and behaviour was little different from that of many thousands of other prisoners. However, the prison emerges well from this investigation and, in sad circumstances, I hope the Governor and staff will take some comfort from that.

Stephen Shaw CBE
Prisons and Probation Ombudsman

January 2007

CONTENTS

SUMMARY	4
THE INVESTIGATION PROCESS	5
HMP WHATTON	6
Healthcare Centre	6
Suicide Awareness	6
Offending Behaviour Programmes	7
Roll Checks	7
Follow-up to Deaths in Custody	7
KEY FINDINGS	8
22 June 2005 to 6 October 2006	8
7 October 2006	9
8 October 2006	10
Events After The Man's Death	11
ISSUES	13
Suicide Awareness	13
Medical Care	13
Emergency Response	13
Events After The Man's Death	13
Conclusion	15
GOOD PRACTICE	15

SUMMARY

The man was aged 39 when he was found dead in his cell at HMP Whatton. A leather belt was around his neck and tied to a clothes rail.

Staff decided that resuscitation was futile as there were no signs of life. This was confirmed by the paramedics who said that rigor mortis had started to set in. The post mortem concluded that the cause of death was asphyxiation.

He had been sentenced to six and a half years imprisonment on 22 June 2005, and had been at Whatton since 3 January 2006. He knew that he was going to prison, and viewed it as an opportunity to address the reasons why he offended. Over time, his view of prison changed. He began to think that he would not be able to put the past behind him and, no matter how hard he tried to change, the offences would still be on his record.

In the community, the man had twice attempted suicide but was never considered to be at risk of self harm or suicide whilst in prison.

This report focuses on the man's time in prison custody and evaluates the systems in place to establish whether they were (and are) fully effective. I make no recommendations and commend the prison's support for the man's family and for prison staff.

Staff and prisoners remember the man as a humorous and likeable man, and he had a reputation for being strong and positive.

THE INVESTIGATION PROCESS

1. The investigation was conducted by one of my investigators. He visited the prison and saw various locations including healthcare and the wing where the man was located.
2. The investigator issued notices to staff and prisoners, inviting anyone with information relating to the man's death to make themselves known. He spoke to a number of prisoners who responded to the notice.
3. The investigator also spoke to the Chair of the prison's Independent Monitoring Board (IMB), a representative of the local branch of the Prison Officers' Association (POA), one of the prison chaplains, and various other members of staff including the Safer Custody Manager. The investigator formally interviewed prison staff and healthcare professionals involved in the events surrounding the man's death. In addition, he spoke informally to a number of staff and prisoners. These conversations confirmed what he had learned from the formal interviews.
4. The prison gave my investigator full access to all the documentation surrounding the man's time in prison. The police also provided copies of the documents and statements in their possession.
5. My investigator and one of my Family Liaison Officers visited the man's family. The family gave detailed background information, and raised a number of concerns which I hope have been addressed by the investigation.
6. A Consultant in Public Health at Nottinghamshire County Primary Care Trust (PCT) undertook a clinical review of the man's care while in prison.

HMP WHATTON

7. HM Prison Whatton is a category C prison which currently holds 761 adult male prisoners. Since May 1990, it has held male offenders to enable them to participate in Offending Behaviour Programmes. Whatton has recently undergone a large expansion programme that saw the prison more than double in capacity.
8. Whatton was last inspected by Her Majesty's Chief Inspector of Prisons (HMCIP) in February 2004. The Chief Inspector found that: "Whatton ... provided a respectful environment with good standards and cleanliness, food and healthcare. Staff-prisoner relationships were excellent which ... speaks volumes for the professionalism of the staff." A further inspection took place in January 2007, and the report has yet to be published.

Healthcare Centre

9. Provision of healthcare within the prison is the responsibility of Nottinghamshire County Teaching Primary Care Trust. The Trust provides a range of services including GP clinics. It contracts out the out of hours service to a private contractor.
10. If emergency medical assistance is required, the member of the healthcare team detailed with the 'hotel' radio call-sign responds, taking the emergency equipment bag with them. They assess the situation and commence any emergency treatment before deciding on the next course of action. The person detailed as 'hotel' is available throughout day and is contactable from the communications room via the UHF radio.

Suicide Awareness

11. Prison Service suicide and self-harm procedures are set out in Prison Service Order (PSO) 2700. The Assessment, Care in Custody and Teamwork (ACCT) system is used when a prisoner is identified as being vulnerable to self-harm or suicide. The aim of the ACCT process is to enable staff from all disciplines to work together, creating a safe and caring environment, where distress is minimised and those prisoners who are distressed feel able to ask for help. It should identify individual need and offer individualised care and support before, during and after the crisis period.
12. Staff are taught to recognise the signals that a prisoner who is in distress may display. When a member of staff is concerned, they open an ACCT document which triggers a care planning process. The prisoner is encouraged to talk about their problems, which staff attempt to diminish using a care planning process combined with extra support and possibly observation.
13. Each member of uniformed staff is issued with a tool specifically designed to cut through ligatures known as a 'fish knife'. It is a knife shaped rather like a fish and has a one sided blade which is shrouded for safety.

Offending Behaviour Programmes

14. These are rehabilitation programmes designed to identify the reasons why prisoners offend. As well as reducing risk of re-offending, programmes help with the assessment and management of prisoners. One of the most widespread programmes is Enhanced Thinking Skills (ETS). This is a relatively short programme which tries to address the thinking and behaviour associated with criminality. This includes impulse control, reasoning, flexible thinking, social perspective taking, values and moral reasoning, and inter-personal problem solving.

Roll Checks

15. Whatton prison carries out the mandatory morning roll check at 7.30am, which is in accordance with the following instructions extracted from the security section of the Prison Officer training manual with regard to the roll checks:
 - Count the prisoners in their cells and get a response.
 - This means that you physically check the presence of the occupants in every cell. You must ensure that you receive a positive response from them by knocking on the door and await a gesture of acknowledgement.
 - If you fail to get a response you may need to open the cell to check. The purpose of this check is to confirm that the prisoner has not escaped, is not ill or dead.
16. There is an earlier check at 6.00am, which is in excess of national standards, when night staff check the numbers of prisoners before going off duty, and are not expected to disturb them.

Follow-up to deaths in custody

17. PSO 2710 gives instructions on action to be taken following a death in custody, including the support arrangements for staff and prisoners. The order says that priority must be given to communicating the facts about the death to prisoners and staff. It says it may be useful to issue a written statement to prisoners to defuse rumour and myth, but that this will depend on local judgement. Any prisoner who may have been particularly affected by the death should be offered support.
18. A record should be kept of all those entering where the prisoner died. There should be an immediate post-incident debrief (a 'hot debrief') of staff involved before they go off duty. A senior member of staff should act as a de-briefer and a duty care team member identified and, if necessary, called in on duty (PSO 2710, Chapter 5.)

KEY FINDINGS

22 June 2005 to 6 October 2006

19. On 22 June 2005, the man appeared in court and was sentenced to six and a half years imprisonment. He was then taken to HMP Birmingham. On reception, it was noted that he had attempted suicide on two occasions earlier in the year. However, on entering custody he was not considered to be vulnerable to self harm or suicide.
20. The next day, as part of the induction assessment, the man said that he was expecting to be in prison, and that he was not concerned by the prospect. He said that he did not feel vulnerable to self harm or suicide. The only concern that he raised was visits, explaining that his father's poor health would make it hard for him to make visits to Birmingham.
21. Following induction, the man settled well into prison life with no apparent problems. He was transferred to HMP Stafford on 5 August, and again settled with no concerns reported. Being at Stafford made all family visits difficult, so the man and his family asked if he could be transferred to a prison nearer to home.
22. On 3 January 2006, the man was transferred to Whatton, the closest suitable prison for his family. The next day, he was assessed by the medical staff and was described as being pleasant, calm, positive and not depressed. He said that he wanted to complete courses to address his offending behaviour, whilst he was at Whatton. He was located on C wing for induction.
23. During January, a probation officer, who had written the man's pre-sentence report, started working at Whatton as an offending behaviour programme facilitator.
24. During the induction period, the man was assessed for offending behaviour programmes. It was decided that he should complete the ETS course before being considered for further programmes. He was placed on the ETS waiting list but, as he was considered to be a low risk for re-offending, his priority for a place on the programme was low. A place would be offered in six to eight months. On 11 February 2006, he moved to B2 which is one half of B wing.
25. When the man arrived at Whatton, he said that he had no religion despite his prison record saying that he was Church of England. On 1 March, he formally changed his religion to Buddhism. On 31 March, he had minor eye surgery at the Queen's Medical Centre in Nottingham, returning to the prison later that day without any problems. This was his last contact with healthcare.
26. On 6 June, the man applied to speak to the psychology department about attending offending behaviour programmes. The application was dealt with the next day, and he was told that he was still on the waiting list for ETS. The psychology department told him that, after he had completed ETS, the suitability for future programmes would be known and planned.

27. Following a visit in late July or early August, the man's sister said that she noticed a slight change in his attitude towards the probation department. He said that he wanted to complete his sentence, and had given up hope of getting parole. This was a change for him, as he had been previously positive about his progress. His sister could not explain this change, but she was not left with a feeling that he was vulnerable.
28. The man had a letter published in the September edition of the prisoner's newspaper, *Inside Time*, which was entitled "Carrot and Stick". In the letter, he criticised the system of offending behaviour programmes, saying that he felt compelled to complete them yet he viewed the outcome as inadequate. On release from prison, he would still be subject to restrictions and a period of supervision. He said that the system provides the "stick" but he could not see the "carrot".
29. Another prisoner became friends with the man over a period of six months. They had been in the same army regiment, but did not know each other before meeting at Whatton. Early in September 2006, the man told his friend that he was getting really annoyed by the contents of his pre-sentence report.
30. The man had a visit from his parents on 25 September. His father told my investigator that his son seemed to be his "usual self", but on reflection a little sad when they left him. He had also lost weight recently, but his father explained that this could be because he had been in serious training for running a marathon.
31. Around the beginning of October, the man and his friend had a discussion about parole and offending behaviour programmes. The man said that he thought the programmes were not worth completing as, when he was released from prison, the authorities would still judge him for his crime even if the risk of re-offending was diminished by the completion of the programmes.

7 October 2006

32. Over a period of four or five months, the man spoke each day to a second prisoner. At 8:10am on Saturday 7 October, this prisoner went to the man's cell and had a brief chat. He thought that the man was "his usual self". The prisoner told my investigator that the man was a strong and positive man, and they talked a lot about the future and about the Open University.
33. The man sent a letter to his parents. In the letter, he said that he was very much looking forward to the visit which was planned for 8 October. He also said that he was in good health and was applying for an Open University course.
34. The first prisoner chatted with the man on the exercise yard, and remembered him saying that he was looking forward to a visit the following day. His friend said that the man seemed a little down, but he did not think too much of it at the time and did not think that he was vulnerable to suicide.

35. At 4:30pm, the second prisoner went to the man's cell and found the door locked from the inside which was thought to be unusual. The prisoner looked in the cell and saw the man lying on his bed, facing the wall. The prisoner said that it was dinner time, and that he might miss his meal if he did not go to the serving hatch soon. He banged on the door until the man let him in, and explained that he was not hungry and wanted some time alone. Although this was unusual for the man, the prisoner accepted that it was not a rare occurrence in prison. He left the man in his cell. He did not think that he might be thinking about taking his own life.
36. The man was in the habit of calling his father on the telephone each Saturday afternoon. That day he did not make a call, although at the time this did not worry his father.
37. At 5:00pm, the man was locked in his cell for the evening by a prison officer. They chatted for a couple of minutes which again was perfectly usual for the man. The officer had supervised the man at the servery for a number of months and him knew reasonable well. He did not consider that anything was unusual and was not in any way concerned for his welfare.
38. The officer completed the evening roll check on B2, at 7:55pm. He cannot specifically recall checking the man's cell, but remembered that there was nothing unusual at the time. The officer was satisfied that he had a response from 137 prisoners who were safely locked in their cells.
39. A senior officer was the Orderly Officer (known as Oscar 1) that night. The Orderly Officer role involves taking initial operational control of any incidents. At night, Oscar 1 is the most senior person on duty.
40. Two Operational Support Grades (OSGs) arrived on B wing at about 8:30pm for night duty and conducted a roll check. The handover from the day staff and the roll check revealed no discrepancies or concerns. The first OSG works nights regularly, but this was only the sixth night duty worked by his colleague, and her first on B wing. Although the OSG was relatively new to night duties, she was confident and aware of procedures. Comprehensive written instructions provide night staff with support. Neither OSG could remember which of them actually checked the man's cell, but neither remembered anything unusual about the roll check. Overnight, the staff heard nothing unusual on B wing, and they were not called to his cell for any reason.

8 October 2006

41. At 6:00am on Sunday 8 October, the OSGs conducted the morning roll check on B wing. The more experienced OSG briefly switched the light on in the man's cell. She told my investigator that she looked through the observation panel of the door and thought she saw him sitting on his bed facing the window. She was not tall enough to see his feet or the floor, and she presumed that he was sitting on the edge of his bed but could not be sure. The OSG did not get a response, but she was not concerned and moved on to the next cell. She

explained to my investigator that it is not unusual for prisoners to be out of bed at that time of the day.

42. At 7:25am, a Principal Officer (PO) came on duty and relieved the SO as Orderly Officer. Around 7:30am, two officers conducted a roll check of B wing. The natural light was low, but the officer could see clearly into the man's cell. He was kneeling on the bed, slumped slightly forward and hanging by a leather belt attached to a clothes rail on the side wall.
43. The officer shouted to his colleague for assistance, and the second officer used his radio to raise the alarm and gain permission to enter the cell. The PO was told, via his radio, that the man had been found hanging and he should go to the cell. The PO told the SO and another officer to accompany him to B wing. Unfortunately, there were no healthcare staff on duty at that time, and a nurse was due to start her duty at 8:00am.
44. The two officers entered the cell where the man's radio was playing music. The first officer supported his shoulders, taking the tension out of the ligature and the second officer cut through the belt with his 'fish knife'. The officer said that the knife cut the belt very easily and quickly.
45. On arriving at the wing, the PO, SO and the third officer also entered the cell, where they found the first two officers still supporting the man. The PO used his radio to instruct the communications room to call for an ambulance. This was logged at 7:41am. The PO checked for signs of life but found none and attempted to place him in the recovery position. He found that this was difficult as rigor mortis had started, and he decided that any attempts at resuscitation would be futile.
46. The nurse arrived at the prison at 7:45am and was directed to B2, arriving at the man's cell at 7:55am. The nurse checked for signs of life but could not find any. The nurse was certain that he was dead, and agreed that any attempts at resuscitation would be ineffective. The paramedics arrived at the cell at 8:07am, and they were content with the nurse's assessment. The paramedics pronounced death at 8:10am.

Events after the man's death

47. The cell door was secured with a security lock, and the cell was treated as a potential crime scene until the police arrived. The staff involved submitted comprehensive statements to the Governor, providing a detailed account of the discovery and management of what had occurred. Other paperwork was later completed in accordance with the local contingency plans for a death in custody.
48. All staff involved attended a hot de-brief at 10:00am which was chaired by the Duty Governor. Staff were able to talk through the sequence of events and were offered support.

49. The post mortem concluded that the man died from asphyxia. It also showed there were no defensive marks or evidence that a third party had been involved in his death. The police investigation also confirmed that there is no third party involvement and they are not pursuing any criminal issues.
50. The man had registered his parents as next of kin, and they had a visit booked for that afternoon. In order to tell them quickly of his death, and stop them travelling to the prison, the local police visited the family.
51. The family have nothing but praise for the prison and how they have been treated, both as visitors before his death and subsequently. Liaison with them has been sensitive and warmly welcomed. Particularly noteworthy has been the facilitation of a Buddhist funeral ceremony which they found a positive and healing experience. Similarly, the invitation to visit the prison and meet some of the people who had known and valued the man was much appreciated.
52. The man's education tutor said that over time he had progressed well and they had become close. She was totally shocked as she thought that she understood him, and would not have predicted that he was contemplating suicide. She saw him as being very positive and was sure that he was able to cope.
53. In response to the notices published about my investigation, another prisoner asked to speak to my investigator. The prisoner said that he and the man had become close over the last year. He suspected that the man was deeply troubled and hid it with bravado which nobody could see through. The prisoner said that the man thought his pre-sentence report was unfair, and the probation officer had misjudged him. He said that the man believed that, as the officer now worked at the prison, it would prejudice a parole application. In fact, the probation officer told my investigator that she had not met the man at the prison and was unaware of her connection with him until she learnt of his death.

ISSUES

Suicide Awareness

54. Whatton prison's local Suicide Prevention Strategy is a comprehensive policy document which is consistent with national policy. The man disclosed two previous suicide attempts whilst in the community. He was assessed and staff decided not to open up an ACCT document. This decision seems entirely justified as he was positive and realistic about being in prison. His family knew of his depression, but did not see anything that made them concerned at the time or subsequently.
55. The man's father said that his son was a little sad when he left him on 25 September. One of his friends in the prison described him as being deeply troubled, but hiding it bravely, and another prisoner found him in his cell on 7 October wanting to be left alone. I can find nothing in this that would differentiate the man from many thousands of other prisoners. Indeed, everybody else found him to be a positive and strong person who was coping well with his sentence.
56. I have not been made aware that the date he died was significant to the man, and I do not think his death could have been predicted or directly prevented. It is clear that he chose a time when he knew with certainty that he would not be disturbed.

Medical Care

57. The clinical review concluded that there were no identifiable problems with the man's care and that his healthcare needs were met. The only element of concern surrounds minor discrepancies in the record keeping. The clinical reviewer concludes that there is no element of healthcare that contributed to his death.

Emergency Response

58. Once staff were alerted to the man's condition, officers responded immediately and appropriately. Although Whatton has 24 hour emergency on-call healthcare cover, the nurse had not arrived for duty when the alarm was raised. However, I am satisfied that any slight delay had no effect on the outcome. The decision not to attempt resuscitation was also appropriate and consistent with national guidelines. The nurse was not due to start her duties until 8:00am. Fortunately, she arrived early at the prison and went straight to the man's cell.

Events after the man's death

59. PSO 2710 only requires that the hot debrief includes staff involved in the incident itself. On this occasion, it appears that all staff involved were able to contribute. Support to officers, healthcare team members and other prisoners

was also offered. I judge that this was especially well managed by Whatton in sad and demanding circumstances.

60. The staff involved submitted reports to the Governor which contained detailed accounts. This was particularly helpful to my investigator who was readily able to identify the sequence of events. It also prevented some staff being formally interviewed unnecessarily.
61. I am pleased to note the comments of the man's family about the way they were treated by the prison, both before and after his death. Again, this redounds to the credit of the Governor and his staff.

The Governor should commend staff for their good practice in supporting the family, preparing prompt and timely reports and arranging a hot debrief for staff.

CONCLUSION

62. Before the man went into prison, he told his family that he was going to get help in understanding and challenging his offending. However, apart from his agreement to the ETS programme, which was identified as a starting point in his sentence plan, there is no evidence that he asked for additional counselling or any other psychological or psychiatric interventions.
63. In conclusion, it is clear that the man's view of offending behaviour programmes changed over time. As time went by, he started to think that the pre-sentence report was unfair and felt that he could never put his offences behind him because he would be judged no matter what he did. However, it is not apparent why or whether this change of heart offers any explanation for him taking his life.

GOOD PRACTICE

1. The Governor should commend staff for their good practice in supporting the family, preparing prompt and timely reports and arranging a hot debrief for staff.