

**Investigation into the circumstances surrounding  
the death of a man at  
HMP Manchester in October 2007**

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

**June 2008**

This is a report into the circumstances surrounding the death of a man at HMP Manchester in October 2007. He was 42 years old. He was from Sudan and had been in the UK for only a matter of months before he was remanded into custody. I believe that the man came to the UK to seek asylum from the conflict in his home country. My lack of knowledge about his life illustrates one of the many problems faced by the Prison Service in managing and caring for foreign national prisoners who speak little English.

The investigation was led by one of my senior investigators. Regrettably, I have been unable to contact the man's family to offer them the opportunity to contribute to the investigation. A representative of the local Primary Care Trust undertook an independent review of the man's clinical care in prison. I am grateful for her assistance. I am also grateful to the Governor and staff of HMP Manchester for their co-operation.

In 2007, foreign national prisoners accounted for a quarter of all apparently self-inflicted deaths in prison. As yet the reasons behind this statistic are unclear. What is in no doubt is that the care and treatment of prisoners who do not speak English poses a large and growing problem for the Prison Service. Communication is at the heart of effective risk assessment. The inability to talk with prisoners in a meaningful way removes from prison staff their best method of understanding those to whom they have a duty of care. One prisoner told my investigator that the man, "could not make himself heard". I hope this report can help the Prison Service to ensure that the foreign nationals in its charge can indeed be heard.

I have made six local recommendations and one national recommendation. I have also been very pleased to highlight five examples of good practice.

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**Prisons and Probation Ombudsman**

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## SUMMARY

The man died, apparently by his own hand, on 6 October 2007 in his cell on a wing in HMP Manchester. He was a remand prisoner. I know little about his life and have been unable to contact his family. The little I do know has been gleaned from the staff and prisoners who knew him in Manchester.

It is believed that the man came to the UK some time during 2006 to seek asylum from the conflict in his home country. He told other prisoners that his family were dead. In February 2007, he had an argument in his flat with another man who received a knife wound. The man was charged with wounding with intent and remanded to HMP Forest Bank. He told other prisoners that he was defending himself and thought he had been unjustly imprisoned.

The man was transferred to Manchester on 1 August. He spoke little English and completed the induction process with the help of a prisoner who could speak some Arabic. He transferred to a wing on 12 September. He was unemployed and on the waiting list for education. He was a devout Muslim and spent most of his time in his cell, only getting up to eat or pray. Other prisoners described him as quiet and gentle but also frustrated and upset that he was in prison.

During Ramadan, staff noticed that the man was not eating. They asked the Imam to talk to him and the Imam told the man to relax his fast as he appeared ill. At the same time the man asked for an appointment with the doctor. A locum doctor examined him on 13 September. The doctor had difficulty in understanding the man and asked for another appointment to be booked when an interpreter could be present. This appointment did not take place.

On 6 October, during lunchtime unlock, the man was found hanging from his bunk bed. The reaction of staff was timely and efficient and a determined and sustained attempt was made to revive him. Sadly he was pronounced dead at the scene. I praise the prison's response and draw particular attention to the care offered to the man's cellmate. I make two local recommendations designed to improve staff confidence in emergency equipment.

The clinical review undertaken by a representative from the local Primary Care Trust (PCT) is critical of the lack of use of the Big Word (language line) by healthcare staff. This is an issue that was also raised in my investigation into the death of a prisoner on a wing in October 2006. The clinical reviewer makes a number of recommendations designed to encourage and improve use of this service when examining prisoners who speak little English. I endorse these recommendations.

The management of foreign national prisoners who do not speak English poses an enormous and increasing problem for the Prison Service. I note that the HM Chief Inspector of Prisons, made a number of recommendations (in a report of a short unannounced follow-up inspection in May 2007) designed to improve the management of and services for foreign national prisoners in Manchester. These recommendations have been accepted and the prison is working towards implementing them. I offer recommendations of my own.

## THE INVESTIGATION PROCESS

1. I was notified of the man's death on 6 October 2007. The case was allocated to one of my senior investigators on 8 October. Notices were issued to staff and prisoners at Manchester telling them that an investigation would be taking place, and inviting those who wished to see the investigator to make themselves known. Four prisoners asked to be interviewed. My investigator visited Manchester on 25 October. She met with the Governor and with a representative of the Prison Officers' Association (POA). She visited K wing and saw where the man had died. She also spoke informally to wing staff about the investigation.
2. My investigator was provided with copies of all the documents relating to the man's time in Forest Bank and Manchester. These included his prison record, Inmate Medical Record (IMR), and the staff incident reports written following his death. My investigator wrote to the Coroner to inform him of the investigation. She also wrote to the local PCT to request a clinical review of the healthcare given to the man in Manchester. On 14 November a representative of the PCT contacted my investigator to say that she would be supervising a colleague who would conduct the review. Her colleague was later appointed to undertake the clinical review.
3. My investigator visited Manchester on 5 November to interview four prisoners. She returned to the prison on 20 and 21 November to interview staff. Further information was obtained from the prison's liaison officer and by talking to staff on the telephone.

## HMP MANCHESTER

4. HMP Manchester is a local prison holding sentenced and unsentenced adult men. Because it also holds category A prisoners, it is part of the high security estate. Manchester is a Victorian prison that was partly re-built after riots in 1990. It is a large and complex gaol operating under a service level agreement. (This is a contract between the Prison Service and Manchester that specifies the responsibilities of the prison and the services it will provide.)
5. The wing on which the man died is the largest wing in the prison and holds a maximum of 222 prisoners on four landings in double cells. It is situated in the part of the prison known as the 'top gaol'. The wing mostly houses unsentenced prisoners who are not employed in the workshops. This makes for a fluid and unsettled population. In March 2008, 41 of the 205 prisoners on the wing were foreign nationals. The prisoners interviewed told my investigator that the wing was loud and busy and that there were too few staff and activities. At the time my investigator interviewed staff, she was told that the wing was 15 officers below complement. This meant that staff from other wings often worked on the wing. There must be at least two officers per landing in order to be able to unlock the prisoners for association. Sometimes the staff shortages meant that association did not take place. Manchester operates a 'group' personal officer scheme. On the wing each personal officer is responsible for about 20 prisoners.
6. The HM Chief Inspector of Prisons, inspected Manchester in an unannounced short follow up inspection between 21 and 24 May 2007. She found that Manchester continued to provide a range and quality of purposeful activity well beyond that in most local prisons. Staff-prisoner relationships were judged to have improved and were supported by the new group officer scheme. However, she said that services for the increasing number of foreign national prisoners were underdeveloped. Several recommendations were made for improving this situation – all of which have been accepted by the prison.
7. The man's death was the eleventh apparently self-inflicted death at Manchester since I took on responsibility for investigating all fatal incidents in prison in April 2004. There has been one more death since the man died. The three most recent apparently self-inflicted deaths were all of foreign national prisoners. I highlight some parallels between the death of the man who is the subject of this report and the death of another Muslim prisoner on the wing almost exactly a year earlier in October 2006.

## THE EVENTS LEADING UP TO THE MAN'S DEATH

8. On 27 February 2007, the man was arrested and charged with wounding with intent. He appeared at court on 1 March and was remanded into custody at HMP Forest Bank. He completed his induction on the same day. His name is not recorded correctly on the paperwork and he refused to sign it. The reason for this is not recorded.
9. The man's wing file from Forest Bank shows that he was a very quiet, polite and well-behaved prisoner who could not speak very good English. On 9 March, it is recorded that he had not eaten for two days and the next day he was unwell and vomiting. On 22 June, he complained of chest pains and trouble breathing. He was taken to outside hospital on 29 June and returned on 3 July. The man was transferred to HMP Manchester on 1 August.
10. In Manchester, the man was located on the induction wing. All new wing prisoners undergo a first night assessment and induction and a booklet is completed. A second interview takes place on the prisoner's second day in the unit. An officer completed the man's first night assessment. The man said that he was Sudanese and that all of his family were dead. He told the officer that he was receiving medication and gave the name of his medicine. His first language was recorded as Fur (a language spoken in Western Sudan); his second language was Arabic, which he spoke a little. The officer recorded that the man was polite and co-operative but did not speak much English and did not understand some of the questions. In particular, he did not understand the questions concerning his feelings about self-harm and suicide. The officer said the man would need to use language line (a three way telephone translation service also known as the Big Word). The officer was also unable to make the man understand the Listeners scheme (Listeners are trained by Samaritans to provide confidential emotional support to fellow prisoners in distress), the Samaritans phone (a phone with direct access to the Samaritans), or the emergency cell bell. No risks of self-harm or suicide were identified.
11. Another officer interviewed the man on his second day. Another prisoner who spoke Arabic, was appointed as the man's 'induction buddy'. He also attended the interview as interpreter. The man said that he had no concerns about being in Manchester and did not feel at risk of harming himself. The induction booklet was explained to him. The interviewing officer wrote in the man's wing history file that he had understood some of their session but struggled with parts of it. He signed his compacts (written agreements signed by the prisoner about behaviour in prison) and seemed happy to have the other prisoner as his induction buddy.
12. The man had his induction close off interview with the interviewing officer on 10 August. The form shows that the man agreed he had completed the full induction programme, understood it and found it useful. On 14 August, he was moved to another wing. On 21 August, a third officer wrote in the man's wing history file that he had failed to attend work. The third officer told the man to go to work in the afternoon. The man again refused to go and told the officer that

he wanted to go to education instead. The officer explained that the man would have to go to the workshops first, but he again refused.

13. The man also refused to attend work on 24 August. On 5 September, he was again transferred to another wing. The reason for this move is not recorded. He refused to attend work on 6 and 7 September and was removed from his job. On 8 September, he was transferred back to the induction wing as part of a "one for one swap". On 12 September, he returned to his last wing. This wing is the usual destination for unemployed remand prisoners.
14. On 13 September, the man asked for an appointment with the doctor. The same day he was examined by a locum GP. The man complained of belching and feeling sick. The locum GP wrote on the medical record that it was hard to understand the man's problem because of his poor English. He said he appeared to be complaining of pain all over his body originating from his upper abdomen. The locum GP wrote: "to get Arabic translator and re-book for review". The man was not seen by a doctor again.
15. Also on 13 September, the month-long Muslim fast of Ramadan began. The prison's Imam told my investigator that an officer on K wing told him that the man was not eating or drinking at all during Ramadan. (Muslims are only required to fast between dawn and dusk during this period.) The Imam said he went to see the man and found him to be weak. He told my investigator he pointed out to the man that the Qu'ran allowed people who were weak through sickness to observe Ramadan less strictly. He said he persuaded him to have a sandwich and he ate it. The man told the Imam that he wanted to observe Ramadan because he was a devout Muslim.
16. The Imam said that the man's cellmate was a servery worker on the wing and had promised to take an extra sandwich for the man to make sure he ate. He promised to keep an eye on him. (His cellmate was released before my investigator first went to Manchester and she was unable to speak to him.)
17. On Saturday 15 September, an officer wrote in the man's wing file that the man had not been eating or drinking since being "taken off Ramadan" by the Imam. The officer said the man was refusing to get out of bed and this was disturbing his cellmate. The officer contacted the healthcare centre and was told that the man would be seen the following Monday. The officer also wrote an entry in the the wing observation book, asking staff to monitor the situation and report to the wing Senior Officer (SO). Later the same day, the man was taken to the treatment hatch on I wing where a member of healthcare staff advised him to drink plenty of water and eat when his fast allowed. Another officer wrote in the man's wing file that the man refused to break his fast despite feeling unwell. There are no other handwritten entries on the wing file.
18. An officer was allocated as the man's personal officer. He told my investigator the man had wanted to go to education and was on the waiting list. The personal officer said the man had spent most of his time sleeping when he first came back to the wing. He described him as a very quiet man who kept himself to himself. During Ramadan, he appeared to "shut himself down". The

personal officer said that he stopped taking water and the officer became concerned about him. He contacted the Imam and sent the man to the healthcare centre. The personal officer said the Imam told the man to drink water and to stop fasting if he was ill. He had been put in a cell with another Arabic speaking prisoner who spoke better English, and this prisoner was asked to keep an eye on him.

19. The personal officer said that, because the man's English was not very good, he tended to communicate with him through his cellmate. The personal officer said he asked the cellmate how long the man was sleeping for and how he seemed. The personal officer said that he had no personal experience of using the Big Word (language line), and thought that the main way language difficulties were overcome was by finding prisoners who spoke the same language and had better English. The officer said that about two weeks before his death the man started looking a lot better and appeared to be taking more care of himself. He smiled more and started playing chess with another prisoner.
20. The man received social visits on 17 and 18 August, 29 September and 4 October. He had legal visits with his solicitors on 24 August and 17 and 28 September. He did not write any letters while in Manchester. Neither does he appear to have made any telephone calls.
21. CCTV footage recorded on 6 October 2007 shows that the man went for a shower at 10.10am. At 10.31am, he went to another prisoner's cell and stayed there for about 20 minutes. He returned to his cell and shortly afterwards this prisoner went into the man's cell. At 11.04am, an officer asked the prisoner to return to his own cell and locked the man's door (all prisoners are locked up before the lunchtime meal). The man's then cellmate had left the wing earlier for a visit and the man was alone in his cell.
22. On Saturday 6 October, an SO who is a fully qualified nurse and who usually works in the healthcare centre, asked to do a shift as a landing officer to have a break from his duties in healthcare. Shortly before noon he began unlocking the prisoners on the landing so they could collect their lunch. At 11.54am (the timing is from CCTV pictures), he unlocked the man's cell and saw him hanging from the bars at the end of the bunk beds.

## THE PRISON'S IMMEDIATE RESPONSE

23. The following account is taken from staff incident reports, interview notes, CCTV footage from the landing, the control room incident log, the scene incident log and Manchester's death in custody contingency plans.
24. The SO said that he immediately shouted for help and for an ambulance, and tried to take the weight of the man's body. He noticed a sheet around his neck with blood on it. Two officers entered the cell immediately behind him and began to untie the ligature from the bed frame. As a third officer was entering the cell, a fourth officer took his radio and called the Emergency Control Room (ECR) for an ambulance. The third officer then helped take the man's weight and he was laid on the floor.
25. The SO said he checked for signs of life but could find none. One of the officers produced a breathing mask and offered to do mouth to mouth resuscitation. The SO said the mask consisted of a piece of plastic with a circle of gauze in it and looked "cheap". He said he told the officer not to begin mouth to mouth as there was blood around the man's mouth and he was not convinced the mask offered sufficient protection. While this conversation was taking place, the SO started chest compressions. He said he was initially unsure of the man's condition because he was very dark skinned and it was difficult to see whether he was cyanosed (a blue colouring to the skin caused by reduced oxygen in the blood). He said the man was still warm, but when he had been put on the floor he could see that his pupils were fixed and dilated.
26. One of the first officers on scene said he entered the cell immediately behind the SO. The officer said the SO grabbed the man around the waist while he tried to undo the ligature. The officer described the ligature as a bed sheet tied to the top of the frame of the bunk bed. He said the second officer on scene had to help him because it was difficult to undo. The task became easier when the third officer helped the SO take the man's weight.
27. The third officer said when he entered the cell he saw the SO struggling to hold the man's weight. He helped him lift the man. He remembered the man had blood coming from his nose and his head looked "swollen". He said the two officers who were first on the scene, untied the ligature with some difficulty and the man was placed on the floor. A mask was produced but was discarded because blood was present. The third officer said the SO worked tirelessly on the man.
28. The emergency response nurse received the emergency call on her radio at 11.55am. She made her way to the wing and collected the emergency bag from the central rotunda (the 'top gaol' is in a Victorian radial pattern with wings leading out from the centre). She entered the cell at 11.57am. The nurse carried her own breathing mask that incorporated a plastic tube as an airway. The nurse said she noticed blood coming from the man's mouth and used her mask to begin mouth to mouth. The SO continued to do chest compressions. The nurse said she used her pen torch to check the man's pupils and found that they were fixed and dilated. After a couple of minutes they swapped roles.

The nurse said that the man was warm when she entered the cell. She thought his death was quite recent but was certain that he was already dead when she arrived.

29. The SO and the nurse continued CPR. At 12.08pm the locum doctor on duty that day entered the cell. At 12.13pm, paramedics arrived at the cell. They attached a defibrillator but found no signs of life. The locum doctor pronounced the man dead at 12.17pm.
30. The the wing senior officer on 6 October said that he was staffing the servery in preparation for the lunchtime meal when the fourth officer on scene ran down from the landing and told him that a prisoner had been found hanging. The the wing senior officer ran up to the man's cell with two officers. He said the ligature had been removed and the SO on scene was giving the man cardiac massage. He decided that the most qualified person present was dealing with the situation and turned his attention to managing the incident. He asked one of the officers who accompanied him to begin a log and checked that an ambulance had been called. He returned to the wing office on a landing to check on the medical response, and passed the emergency response nurse on the way.
31. The the wing senior officer said that the Duty Governor had also arrived by this time. She wrote a notice for the other prisoners explaining the reason for the disruption and apologising for it. The man's cellmate returned from his visit and was relocated to a cell. This cell is next to the wing office. The the wing senior officer said he wanted the man's cellmate to be near to staff. He asked the Imam to break the news of the man's death to his cellmate. The man's cellmate was put on the list to see the doctor on Monday 8 October and an appointment was made for him to see the mental health team for an assessment. The man's cellmate was allowed to choose his next cellmate and asked to share the cell with the prisoner who had known the man well. The Imam was asked to talk to both the cellmate and other prisoner. The Imam and his assistant made a follow up visit to both prisoners the next day. All the prisoners on open ACCT (Assessment, Care in Custody and Teamwork – the Prison Service's self-harm monitoring process) documents were reviewed in accordance with PSO 2700.
32. A hot debrief was led by the Duty Governor. The the wing senior officer said the chaplain and the care team spoke to the staff who had responded to the SO's call for help. They were advised that their adrenaline levels would drop after about two hours. The staff were kept in the prison for this two hour period and then allowed to go home. They were asked to call their families to make sure they were expected, and to call the prison to let them know they had arrived home safely.

## WHAT OTHER PRISONERS SAID

33. The prisoner who spoke arabic told my investigator he had met the man on 2 August on the induction wing. He had introduced himself because he thought the man appeared to be under stress. The prisoner said he spoke a little Arabic and this helped the man open up to him. The man told him he was from Sudan and was an asylum seeker. The prisoner said the man did not speak English well and “could not make himself heard”. He was worried about his future and told the prisoner that he was not getting justice in the UK. The prisoner said the man “tried to be happy on the outside but was not happy on the inside”. He said he did not think the man was the type to commit suicide because he was a religious man. He did not see him apart from on the wing.
34. Another prisoner said he shared a cell with the man on the wing for two weeks in September. They were both moved to at the same time but did not share a cell again. He described the man as “stressed and depressed”. He said he did not speak much and rarely initiated conversation. This prisoner said he spoke to the man in English and thought his English was “OK”. He thought the man was happier speaking Arabic. This prisoner said the man told him he did not like it on the wing. He read the Qu’ran a lot and did not seem interested in food. He did not think the man would commit suicide because he was a devout Muslim.
35. A third prisoner said he knew the man on after he moved from the induction wing. Because he worked as a Listener and spoke several languages, staff often asked him to speak to new foreign national prisoners. The man could speak English but “not brilliantly”. The third prisoner said he helped the man with phone calls to his solicitors. He said the man was “never upset, never disappointed” except for when he spoke about his offence. He was worried about the likely sentence he would receive. The prisoner said the man was a devout Muslim who prayed five times a day. He was surprised when he was told of his death because he was “an older mature man”. He had spoken to the man’s cellmate after the man died and the cellmate had told him that he was shocked that the man had taken his own life.
36. The prisoner whom the man knew well said he met him on the last wing when they both had cells on the second landing. He said he spoke in Arabic to the man who told him he was from Sudan but did not talk much about his family there. The man told him he was an asylum seeker and had been staying in a house provided by the Home Office. He said he had been in the UK for only seven months. This prisoner said the man told him that he had made complaints about another man who lived at the property. One day the man had attacked him and he had defended himself but wounded the man. This prisoner said the man was very frustrated at being put in prison because he said he was innocent. He was also frustrated because he was sick and had no translator. He was unhappy with his solicitors and wanted to change them.
37. The prisoner whom the man knew well said that the man slept a lot of the time and only got up to eat or pray. He thought the man spent too long in his cell with nothing to do. He did not work because he was ill and did not go to

education. He said he played chess with the man every day apart from the day he died. The prisoner said he was not worried the man would commit suicide because he was a Muslim and was fasting. He speculated that the man had not meant to kill himself but had wanted to make a gesture as a cry for help. He said the Imam broke the news to him that the man had died. He said he could not believe that he had done it.

38. The Imam was asked to talk to the man's cellmate and the prisoner who knew the man well after the man died. The cellmate was released before my investigator went to the prison but, after he had spoken to the cellmate, the Imam wrote a statement. In this statement the Imam said that the cellmate was very upset and shaking when he spoke to him. The cellmate was emotional but told him that the man had never talked about suicide and he could not believe it had happened. The cellmate said the man had not been feeling well but had continued fasting. The prisoner who knew the man well told the Imam that the man was not happy with his solicitor and had been worried about his family as most of them had been murdered in his home country. The prisoner who knew the man well said the man had given no indication that he would take his own life.

## ISSUES CONSIDERED DURING THE INVESTIGATION

### Communicating with foreign national prisoners

39. The man was a quiet and religious man who did not present an overt risk of self-harm or suicide. His death was met with shock and surprise by the staff and prisoners who knew him. He spoke little English and Arabic was his second language. The people to whom he talked most were prisoners who knew some Arabic. It does not appear that he was able to speak in his first language during his time in prison. I do not know whether the man would be alive today had he been able to communicate better with staff and prisoners, but the ability of staff to spot prisoners at risk is diminished greatly if they cannot talk to them. It is also likely that prisoners will feel less anxious if they are able to talk about their situation and air any concerns about their future. It is therefore imperative that the Prison Service enables staff to increase their chances of communicating with prisoners who do not speak English.
40. The management of foreign national prisoners who speak little English poses a major challenge for the Prison Service. There is no simple solution, especially for a busy local prison like Manchester with a tight budget and staff shortages. In her report of a short unannounced follow-up inspection in May 2007, HM Chief Inspector of Prisons made a number of recommendations designed to improve the management of foreign national prisoners in Manchester. I do not need to revisit them here in detail, but they included monthly foreign national prisoner support and information groups and access for staff to guidance on immigration and other matters of concern. I am pleased that the prison has accepted all of these recommendations and has already acted on some of them.
41. My investigator found the foreign national co-ordinator at Manchester to be enthusiastic and committed to his job. He is learning to speak Urdu in his own time. However, he is also the Principal Officer on the induction unit, undertakes Orderly Officer duties, and has responsibility for discharging category A prisoners and undertaking investigations. I believe it is imperative that the role of foreign national co-ordinator is made full-time. I understand that he currently receives support from an officer who has part responsibility for offender management. If it is not immediately possible (and I fully understand the pressures Manchester works under) to make the role full time, then urgent consideration should be given to offering this member of staff further assistance.

**I recommend that the role of the foreign national co-ordinator is made full time as soon as practically possible. In the meantime, urgent consideration should be given to ways of increasing his administrative support.**

**In light of the number of deaths of foreign national prisoners in 2007, I recommend that the Prison Service reviews the implications for staff resources and staff training. In particular, it**

**should review whether the role of foreign national co-ordinator can be enhanced.**

42. Much of the work done to support foreign national prisoners in Manchester is carried out on the induction wing. Efforts are made to ensure that everyone receives the induction package appropriate to them. Prisoners who are familiar with the prison environment can be 'fast tracked', but decisions are made on a case by case basis. Because he had spent five months in Forest Bank, the man was initially considered for a fast track induction. When it became obvious that he struggled to understand the first and second night interviews, he received the full induction programme. This was good practice. Prisoners are paired with induction buddies who speak the same language. In the man's case his induction buddy helped him understand the second day follow-up interview. This was also good practice. The Big Word is also used regularly on the wing, especially when there are no other prisoners who speak the same language.

**Giving the man a full induction was good practice.**

**The employment of prisoners who speak the same language as 'induction buddies' is good practice.**

43. Once prisoners are allocated to a main wing, the use of the Big Word appears to decrease. Staff interviewed who worked on the man's last wing said they had used it very rarely or not at all. Much reliance is placed on finding a prisoner who can speak the same language. Although this is a practical and sensible solution, it brings with it the problem of things becoming 'lost in translation'. In some cases it could lead to bullying. There may also be issues of confidentiality. A conversation via another prisoner is not comparable to a conversation with a qualified translator. Although it is clearly impractical to suggest the Big Word be used for every conversation, staff should be encouraged to consider whether there are more occasions when it will help them do their job. Foreign national prisoners on remand have little idea what to expect from the British criminal justice system. Manchester has a comprehensive Foreign Nationals policy which reinforces this point and outlines the particular anxieties and stresses faced by foreign national prisoners. An uncertain future can lead to anxiety frustration and despair. Proper communication with the help of the Big Word may reduce these feelings.

**I recommend that the Governor issues a notice to all staff explaining how to access the Big Word and encouraging them to use it.**

44. The ability of staff to communicate with prisoners who speak little English would be improved by increasing the number of staff who are able to speak other languages. (I appreciate that the Fur language, spoken by the man, is a rare one.) I understand that Manchester is currently piloting a scheme designed to help staff learn another language. This is a good scheme but will take time to bear fruit. The recruitment of staff who already speak other languages would make sense and offer a speedier solution. Greater Manchester and the

surrounding towns are ethnically very diverse and provide a local market for the prison to tap into. More immediately, it would seem sensible to increase the number of foreign national or multi-lingual Listeners throughout the prison. I understand that the Safer Custody Officer has made attempts to induct new Listeners and there have been problems on security grounds. I make no formal recommendation about this but it is important that the prison perseveres with these attempts.

**I recommend that the Governor of Manchester considers how best he can recruit staff who speak more than one language.**

### **The man's clinical care**

45. A detailed account of the man's clinical care while in Manchester is contained in the clinical review. One of the issues considered by the reviewer is the question of the man's lack of English. The doctor in reception at Forest Bank identified that the man had language problems and conducted a reduced screening. A more detailed screening took place at a later date with an interpreter present. His medical notes from Forest Bank clearly show that his first language was Arabic and he needed an interpreter. The clinical reviewer could find no evidence that the member of healthcare staff who carried out the man's first reception health screen at Manchester on 1 August 2007, saw this information or read it. The member of healthcare staff was also unaware that he needed to complete an additional form because the man was a transferred prisoner.
46. The man had a secondary health screen on 3 August. This is a general health assessment that is offered to every prisoner in the week following their first reception. It provides an opportunity for gathering further health information and, very importantly, for checking how a prisoner is settling. The clinical reviewer notes that the nurse who undertook the secondary screen was experienced and met all the requirements of the process. However, she did not recognise the need for an interpreter herself, and did not notice the previous references to the need for an interpreter. The reviewer concludes there is no evidence that the man's care was compromised as a result. But had a translator or the Big Word been used, more relevant information might have emerged.
47. The man asked to see the doctor on 6 August. He saw a locum GP on the same day. The locum GP told the reviewer that the man spoke very little English. He said he could not fully understand the man but was able to identify some of his problems. The man complained of wind and heartburn. The man was seen again, at his request, on 13 September. On this occasion he complained of belching and feeling sick, pains in his arms and legs and pain emanating from his upper body. The doctor wrote an entry on EMIS (the prison's electronic medical record). He recorded his difficulty understanding the man, and said he needed an interpreter for the next consultation to make sure he was not missing any underlying problems. The doctor told the clinical reviewer he was not aware he could use the Big Word and was under the impression that the administrator would arrange an interpreter. He said he did

not have access to the man's medical notes from Forest Bank. The man was not seen again by healthcare staff at Manchester.

48. The clinical reviewer concludes that there was a failure on the part of all the clinical staff who came into contact with the man to identify the need for and implement access to an interpreter. However, she concludes that there is no evidence of any detrimental effect on the man's physical health. Had an interpreter been used, "more information would have been available and that information may have influenced the care he was given". I am concerned that he was clearly unwell and in a weakened state on 13 September but was not seen again, as intended by the locum doctor, before his death. Physical health can often have an effect on a person's state of mind. The reviewer makes several recommendations designed to improve the awareness and use of the Big Word in health screening. I draw the attention of the Head of Healthcare and the PCT to these recommendations.
49. In October 2006, I investigated the death of a prisoner on the man's last wing whose English was described as "poor". In that investigation, the clinical review drew attention to the fact that translation services were not used to support consultation. The reviewer concluded that further assessment with a translation service would have given additional opportunities to better understand the prisoner's mental state. I recommended that a system be devised for the effective use of the Big Word during healthcare assessments. My report had not been issued at the time of the man's death, but a recommendation that the prison devise a system for the effective use of the Big Word in healthcare consultations has since been accepted. I do not make a further recommendation about this but draw the Governor's attention to the comments and recommendations made by the clinical reviewer.

## The prison's response to the man's death

50. A comprehensive analysis of the prison's emergency medical response is contained in the clinical review.
51. The man received prompt and appropriate medical assistance from the SO. The emergency response nurse arrived three minutes after the man was found. The SO decided not to begin mouth to mouth immediately because he did not consider that the breathing mask provided offered sufficient protection. Mouth to mouth resuscitation was started when the nurse arrived. The nurse told my investigator that she carries her own breathing mask that she purchased on e-bay. Like the SO, she does not think that the masks provided by the prison offer sufficient protection. It appears that the man was already dead by the time the SO discovered him. Despite this, staff made a serious and sustained attempt to revive him. I consider that all the staff who responded to the discovery of the man hanging acted speedily and efficiently and made every effort to save his life. I am pleased that the Governor recognised their efforts by writing to them all individually on 10 October.
52. I consider that the SO was right to stop staff using the breathing mask first provided. The man was bleeding from his nose and mouth and staff knew nothing of his medical history. However, I am very concerned that staff are being provided with masks they have no confidence in using. In most cases of hanging, bodily fluids are present and it is therefore important that the equipment provided is fit for purpose. I am partially reassured by the latest guidance from the Resuscitation Council that cardiac massage is as effective on its own as when combined with mouth to mouth resuscitation. The version of PSO 2700, modified by PSI 32/2006, that was in operation when the man died advised that it was good practice for staff to be issued with first aid pouches containing breathing masks with a non-return valve. The revised version of PSO 2700 (issued on 26 October 2007) advises that staff in all residential areas should have ready access to a sealed pack containing both CPR face masks with a non-return valve and resuscitation aids with a non-return valve. It clearly does not make sense for the prison or PCT to spend money on masks that staff will not use. (I make no formal recommendation, but trust that the Prison Service's Safer Custody and Offender Policy Group will consider if the recommendation below has national implications.)

**I recommend that the Head of Healthcare in conjunction with the PCT ensures that staff have ready access to face masks and resuscitation aids that are fit for purpose and have the confidence of staff.**

53. The nurse told my investigator that the emergency bag in the top gaol contains a lot of equipment for every type of emergency. She said this makes it very heavy to carry. Although not a problem for her, she expressed concerns that some staff would not be able to carry it to an emergency on one of the higher landings. One of the pieces of equipment it did not contain, however, was a defibrillator. This had not been replaced when the nurse was interviewed.

**I recommend that the Head of Healthcare establishes with emergency response staff whether the emergency bag is too heavy to be carried to all emergencies. If it is found to be so, consideration should be given to splitting it into smaller bags for specific types of emergency.**

**If there is still no working defibrillator in the top goal one should be placed there with immediate effect.**

54. PSI 32/2006 made it mandatory for prisons to provide their staff with personal issue cut down tools by 30 April 2007. When I investigated the two previous apparently self-inflicted deaths in Manchester in August and October 2006, the prison had obtained 'fish' knives for staff but these had not been distributed. These had still not been distributed a year later when the man died (although they had been by the time my investigator interviewed staff in November 2007). This delay does not appear to have had fatal consequences, but I share the view expressed by HM Chief Inspector of Prisons after her inspection of May 2007 that it was unacceptable.

None of the issues addressed above affected the outcome in this case. I consider that the prison's response was timely and efficient. I am particularly impressed with how the man was cared for. Moving him to a cell away from the one he shared with the man and near to the wing office, and allowing him to choose a cellmate to support him, was excellent practice. Although the version of PSO 2700 in operation when the man died advised that prisoners in the cellmates situation should be put on the list to see the GP and be seen by the mental health team, I rarely see this put into practice. I am similarly impressed with the efforts made to inform the other prisoners on the wing and the fact that the Imam and his assistant spoke personally with the man's cellmate and the prisoner who knew the man well, on 6 and 7 October.

**Moving the man's cellmate to a different cell with a cellmate of his choice was good practice.**

**Asking the Imam to speak to the man's cellmate and the prisoner who knew the man well was good practice.**

55. I have also been impressed by what I have learned about the consideration given to Manchester's staff after this tragedy. All the staff spoken to by my investigator said that they felt fully supported after the man's death. The Governor wrote personally to the key staff involved. Again, this is not often the case.

**The support offered to staff after the tragedy was good practice.**

## CONCLUSION

56. The man was a prisoner with an uncertain future and an uncertain past. He had come to the UK to seek asylum from the conflict in his homeland. He said his family had been killed. He found himself in prison and felt unjustly treated and frustrated. He was not familiar with the British justice system and did not know what to expect. He was feeling unwell and might have been anxious that he could not make his health needs properly understood. He had persisted, against medical and spiritual advice, with a radical fast during Ramadan. He was unemployed (through choice) and on the waiting list for education. This might have been another source of frustration. He had a lot of time to brood on his situation. Although there was no reason for staff to suppose that he was considering suicide, viewed with the benefit of hindsight it is easy to see that the man may have felt despairing.
57. The man's last wing is a busy and boisterous wing and staff shortages mean that personal officers are not always on duty on the landing where their allocated prisoners live. The personal officer clearly knew who the man was and had observed him and tried to communicate with him through his cellmate. When the man was found not to be eating, staff enlisted the support of the Imam and made sure he saw a member of the healthcare team on I wing. I think staff treated the man with consideration. However, the man was a quiet and religious man who spent much of his time in his cell. It is likely that only someone with appropriate skills who could talk to him in his own language would have been able to identify his risk to himself.
58. The number of foreign national prisoners is increasing. They now represent around one-in-seven of the entire prison population in England and Wales. In 2007, foreign nationals made up one quarter of all apparently self-inflicted deaths in prison.
59. Perhaps the most poignant comment during this investigation was made by the prisoner who spoke arabic, who said that the man "could not make himself heard". In a small way, I hope this report will help the Prison Service rise to the challenge of ensuring that the voices of foreign nationals can indeed be heard.

## RECOMMENDATIONS AND GOOD PRACTICE

### Local recommendations:

- 1. I recommend that the role of the foreign national co-ordinator is made full time as soon as practically possible. In the meantime, urgent consideration should be given to ways of increasing his administrative support.**

Manchester partially accepted this recommendation at draft stage. The prison responded:

“A full time foreign national support officer post has been created within the diversity team. The duties of this post will include co-ordinating all the foreign national work across the establishment.

The foreign national support officer will work closely with the diversity team and foreign national co-ordinator.”

- 2. I recommend that the Governor issues a notice to all staff explaining how to access the Big Word and encouraging them to use it.**

The prison accepted this recommendation at draft report stage. They responded:

“A Notice to Staff will be issued explaining how to access the Big Word and will encourage them to use it.”

- 3. I recommend that the Governor of Manchester considers how best he can recruit staff who speak more than one language.**

The prison accepted this recommendation at draft stage. They responded:

“The HR Business partner working closely with the Diversity Manager will consider new and innovative ways of targeting potential new recruits who speak more than one language.”

- 4. I recommend that the Head of Healthcare in conjunction with the PCT ensures that staff have ready access to face masks and resuscitation aids that are fit for purpose and have the confidence of staff.**

The prison accepted this recommendation at draft report stage. They responded:

“The Director of Healthcare will liaise with the PCT and review the provision of face masks and resuscitation aids ensuring that they are fit for purpose, that staff have ready access and which have the confidence of staff.”

- 5. I recommend that the Head of Healthcare establishes with emergency response staff whether the emergency bag is too heavy to be carried to all emergencies. If it is found to be so, consideration should be given to splitting it into smaller bags for specific types of emergency.**

The prison accepted this recommendation at draft report stage and responded:

“The Director of Healthcare will consult with healthcare staff and consider any issues raised concerning the emergency bag.”

**6. If there is still no working defibrillator in the top gaol, one should be placed there with immediate effect.**

The prison accepted this recommendation at draft report stage and responded:

“A working defibrillator is now in place in the top prison.”

**National recommendation:**

**7. In light of the number of deaths of foreign national prisoners in 2007, I recommend that the Prison Service reviews the implications for staff resources and staff training. In particular, it should review whether the role of foreign national co-ordinator can be enhanced.**

The Prison Service partially accepted this recommendation at draft report stage and responded:

“A revised PSO 4630 Immigration and Foreign nationals in prisons was issued in January 2008 and this makes it mandatory for all prisons to have a local policy for managing foreign national prisoners in place.

The Prison Service abolished the principle of central prescription of training in February 2003, believing that decisions on training should not be imposed, but made locally by managers based on an assessment of local business needs, priorities and resource constraints.”

***Good practice:***

**8. Giving the man a full induction was good practice.**

**9. The employment of prisoners who speak the same language as ‘induction buddies’ is good practice.**

**10. Moving the man’s cellmate to a different cell with a cellmate of his choice was good practice.**

**11. Asking the Imam to speak to the man’s cellmate and the man’s companion was good practice.**

**12. The support offered to staff after the tragedy was good practice.**