

**INVESTIGATION INTO THE CIRCUMSTANCES
SURROUNDING THE DEATH OF A MAN
IN HOSPITAL IN OCTOBER 2004 WHILST IN THE CUSTODY OF
HMP KINGSTON**

**PRISONS AND PROBATION OMBUDSMAN
FOR ENGLAND AND WALES
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The man who is the subject of this report died in hospital in October 2004. I would like to extend my sincere condolences to his family.

The man was a prisoner at HMP Kingston so it fell to me to investigate the circumstances of his death to discover what happened, whether it might have been prevented, and whether there were any lessons to be learned that might help prevent a similar death in future.

The investigation was carried out under transitional arrangements in which the Prison Service nominated an experienced investigator to act on my behalf in collaboration with a member of my staff. I am grateful to the Head of Resettlement at Albany, who conducted the investigation and to the Medical Director of the Portsmouth City Teaching Primary Care Trust, who conducted a clinical review of the man's care. I also extend my thanks to the Governor and staff of Kingston prison for their cooperation and assistance and their readiness to learn from the investigation.

The man was in the Segregation Unit at the time of the events leading to his death. This followed an episode of disturbed and self-destructive behaviour. Much of this report is concerned with the incompatibility of caring for someone who is at risk of self-harm and keeping them in Segregation Unit conditions. Such a practice is always difficult and undesirable. Indeed, the Prison Service Order says it should only happen in exceptional circumstances. It presented a special problem at Kingston where no member of staff is based in the Segregation Unit overnight.

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Summary

The man who died was 32 years old and serving an automatic life sentence with a minimum term (tariff) of 2 years 5 months. He was sentenced in April 2001. His tariff expired in September 2003. He had been refused release on licence and was required to take numerous offending behaviour courses intended to reduce the risk of him re-offending. His next parole review would have been in March 2006. He was transferred to HMP Kingston in March 2004 from HMP Swaleside.

The man had a history of abusing alcohol and drugs. He was being treated for depression and reported that he had been on medication for this since the age of twelve. He was a talented artist and was going to paint a mural in the visits room.

The man was moved to the Segregation Unit at Kingston under restraint late in the evening on Saturday 9 October. He had asked to go to the Segregation Unit saying that he was feeling suicidal. When told that he could not take his property with him, he barricaded his cell and was removed to the Segregation Unit under control and restraint. There he smashed a toilet seat and glass observation panel injuring himself and threatening staff. A locum doctor attended and examined him. He was removed to another Segregation Unit cell.

Next day, he complained of stomach pains and was taken to hospital as a precaution. He refused treatment and was returned to the Segregation Unit.

That evening, at 11.00pm, the man was found hanging by a ligature from window bars in his cell. Staff and then Paramedics administered Cardio Pulmonary Resuscitation. He was taken to Hospital, where he died on Tuesday morning, 12 October.

A F2052SH (Self Harm at Risk Form) had been opened on 9 October soon after the initial episode. The man had been subject to F2052SH procedures regularly throughout this sentence. He had self-harmed whilst on remand in HMP Norwich then on four occasions in July and August 2004. He was temporarily transferred to HMP Winchester which has more extensive healthcare facilities than Kingston. A consultant psychiatrist saw him, most recently in September 2004, and advised that he was at high risk of suicide in the long term, though not immediately.

The procedures for the management of prisoners on open F2052SH and located in Segregation Units were not properly followed. The safety algorithm was not completed fully or within the specified time limits. F2052SH procedures were not complied with in that a doctor had not completed the relevant section in the file.

There is no evidence that consideration was given to moving him out of the Segregation Unit once he had settled down during 10 October.

The man gained access to the bars by removing a perspex security screen that covered the bars to prevent anything being passed through the window. The prison's "safer cell" was occupied by a prisoner who was not at risk of self-harm and was not available at the time.

The man who is the subject of this report was a difficult person to care for in prison. He was well-known to many staff who had tried to help him. His difficulties were recognised and managed with compassion within the scope of the services available at Kingston. His mental health needs may not have been adequately addressed.

He was held in the Segregation Unit without means of occupation or distraction. No staff are based within the Unit during the night shift. Segregation Units are not a suitable environment to care for the suicidal. Where *in extremis* they must be used because of the lack of a suitable alternative, that must be with stringent safeguards. Staff should exercise discretion as to the conditions and regime that are appropriate. The usual rules of the Segregation Unit should not be applied automatically.

The clinical review advises that the man might have benefited from input from a trained mental health worker or from structured Psychological Therapy in the form of Cognitive Behavioural Therapy, to address his ability to cope with stress, anger management problems, recurrent depression and repeated self harm. No provision of this kind was available at Kingston.

The report makes 15 recommendations.

HMP Kingston

HMP Kingston only holds life sentence prisoners. It has a certified normal accommodation of 138 prisoners. At the time of the man's death, there were 137 prisoners. The prison gives an impression of being well run, clean and orderly with a high level of prisoner care. The Segregation Unit is located on the ground floor and forms part of a larger wing, but is divided from the main wing by a door which is left open overnight. Night staff visit the Unit when it is occupied but no member of staff is based there. The location of the Segregation Unit compared with other Segregation Units is not unusually austere or isolated.

The sequence of events

On Saturday 9 October 2004 at about 10.30pm, the man rang his cell bell. Staff attended. The man told them he felt like hanging himself and they should move him to the Segregation Unit or he would do it.

The night staff contacted the duty governor who gave permission to move him. The duty doctor was also contacted and asked to attend.

When staff entered the cell, with the intention of walking him to the Segregation Unit, there was a disagreement when the man was told he could not take his property to the Unit for safety reasons since he had threatened to kill himself. He then refused to move, staff withdrew and the cell was locked.

Staff decided to await the arrival of the duty governor before determining what to do. In the meantime, the man barricaded his cell and blocked the observation panel. He also made further threats to self-harm. A member of staff maintained dialogue with him and attempted to reason with him.

The duty governor arrived at 11.06pm. It was decided to move him. The anti barricade plate was removed from the door and a three officer team entered the cell. According to staff, the man was asked if he would walk to the Segregation Unit, but he refused, saying the staff would have to take him. The team took control of him and he was walked under restraint to Segregation Unit Cell S1. Once there, he was asked to remove his own clothes in order to be strip searched. He said he would comply, but when the control and restraint locks were removed, according to staff, he attempted to punch one of the escorting staff.

The man was restrained and strip-searched whilst remaining under restraint. Staff retreated and he was locked in cell S1. As soon as staff went out of the cell, he smashed the toilet seat and used the broken part to smash the observation panel, threatening to assault staff. Staff reported that he had cut himself with pieces of the toilet seat. It was decided to remove him from this cell because he now had a weapon (the broken toilet seat) and had been observed eating glass from the observation panel.

Another three-officer team was assembled and the man was removed from S1. The doctor arrived and examined him who by now was observed to be calmer and more compliant.

The doctor was satisfied that there were no serious injuries and the man was located in cell S2. An F2052SH (risk of self-harm file) was opened and he was placed on a half hourly watch. He was observed overnight and entries were made half hourly in the F2052SH and Segregation Unit log.

The nurse saw him at 8.20am on Sunday morning. The man told the nurse that he had taken his Valium for the weekend all at once and that the Valium had caused the incident. The nurse doubted that the Valium was the cause.

The nurse filled out the Segregation Safety Algorithm and the duty governor countersigned this form at 8.40am.

During the morning the man complained of stomach pains. Because it was thought he might have eaten glass the previous night, it was decided that he should go to hospital for a check up. (The post mortem report confirmed that he had eaten glass.) At first he refused to go, but eventually he was persuaded after being given 5mg Diazepam by the nurse. He refused to wait for treatment in the hospital and was returned to the Segregation Unit at 1.45pm.

In the meantime, the duty governor contacted his counterpart at Winchester to see whether he could be transferred to the healthcare centre there. He recorded in the journal that Winchester Healthcare declined to take the man in since they felt they could do little more than Kingston and it was not a purely medical matter.

Staff reported that the man was quiet and reasonably co-operative during the escort and throughout the rest of the day.

The man asked to see a doctor at 7.45pm, but this was refused by the orderly officer as a result of his earlier refusal of treatment at hospital and because he had been given medication for the weekend. (I note that this decision is not criticised in the clinical review.)

The man was quiet for the rest of the evening. He was given some Gaviscon tablets at 9.30pm. Half-hourly watches continued. It was reported that he was awake until 10.00pm when he was seen smoking. He was seen again at 10.35pm when he appeared to be asleep.

At 11.00pm, when staff were doing their checks, the man was found hanging from a ligature from the cell window bars. Staff entered the cell as quickly as possible. The man was cut down and CPR was administered by two members of the night staff (the night officer and the night senior officer SO). An ambulance was called and Paramedics arrived quickly at 11.10pm.

The man was taken to hospital. He died on Tuesday 12 October 2004.

The actions of staff after the man was found

Once the man was found, staff acted promptly and professionally. The night officer and the night SO administered CPR quickly, which probably extended the man's life albeit by a few days only. Help was summoned and the ambulance arrived within 10 minutes.

Staff complied with their emergency orders and promptly informed relevant parties including the Police.

We could find no evidence that a debrief had taken place. We do not believe that staff or prisoners were provided with sufficient aftercare. All staff reported that they were given the opportunity to talk to the Care Team but during interviews with staff and prisoners, some time after the man's death, they were clearly upset and were pleased to talk to someone about what happened.

Compliance with authorised procedures

The F2052SH was opened correctly on 9 October by the night orderly officer following the man's threats to self-harm. The entries in the 2052SH were, on the whole, good and informative and showed a high level of care. However, visits by the chaplain, healthcare staff and others were recorded in the F2052SH by segregation staff but not by the person visiting the man. It is good practice for those who visit vulnerable prisoners to record their own impressions in the F2052SH for the information of other staff caring for them subsequently.

The two removals by force were carried out by the approved methods and with minimum force. All documentation was correctly completed.

Once the man was located in the Segregation Unit, a safety algorithm was not completed until the next day at 8.20am. This could have been done by the doctor at the time of the man's location in the Segregation Unit. This was compounded by the fact that he was now on a F2052SH and it was common knowledge by at least two of the staff present that he had a history of self-harm.

There was no documentation to support the risk assessment that the man should be placed on a half hour watch. He should have been placed on a minimum of five watches an hour in accordance with the instructions in PSO 2700 until an assessment had been done using the algorithm.

The safety algorithm started at 8.20am was not completed correctly. Question 3 "*Does the prisoner show signs of being acutely unwell (e.g. psychotic) at the present time*" was not answered. Had it been, it might have indicated the need for a mental health assessment.

The F2052SH page 5, Section 2, was not completed by a doctor.

There was no formal Case Conference to determine how to manage him. This was particularly important because of his location in the Segregation Unit. This could have been carried out during the day on Sunday 10 October.

Although the man had appeared to be calmer during Sunday there is no evidence of consideration being given to relocating him.

Kingston has good resources in terms of safer cell provision. They have a “buddy cell” and a “safer cell” constructed to a high standard to reduce the risk of self-harm. The safer cell was occupied by a prisoner who was not at risk of self-harm. This was apparently normal practice because of a shortage of space. The man would have been an ideal candidate for this cell, perhaps not at first, but certainly once he became calmer.

Findings directly related to the circumstances of the man’s death

The man was located in the Segregation Unit on 9 October at 10.30pm after it was reported that he had threatened to hang himself. Once in the Unit, he continued to be disruptive and vandalised one cell by breaking the toilet seat and smashing the spyglass. He was moved to a second cell where he remained.

The man was found by the night officer hanging by means of a ligature, constructed from bedding, to the bars of the Segregation Cell S2 at 11.00pm on 10 October 2004. He had removed the perspex screen to gain access to the bars. This screen was installed primarily to prevent items being passed to prisoners. In our opinion, it could have been removed without staff hearing. The night officer called for assistance. A second night officer and the SO attended the scene and the ligature was removed.

CPR was administered by the officer and the SO until the Paramedics arrived 10 minutes later.

The man died in hospital on Tuesday 12 October 2004.

He was an open F2052SH. There was no suicide note.

Findings indirectly related to the circumstances of the man’s death

Prison files indicate that the man had a history of depression and had self-harmed several times during 2004. He was reported to be finding it difficult to accept his life sentence.

The man was sent to Kingston to undertake offending behaviour courses, many of which were not actually available at that prison. His Life Sentence Plan lists a large number of programmes for him to complete in order to reduce his risk of re-offending. It is noticeable that many of those identified were not accredited programmes and many were duplicating areas of treatment need. It is possible that he may have perceived this long list of programmes as unachievable, with a possible result of feelings of hopelessness.

It was reported by staff and prisoners that the man was misusing drugs, by buying other people’s medication or illegal drugs. He was considered to be more content

when he was at other prisons, including his temporary stay at Winchester. It was said that illegal drugs were perceived to be more freely available than at Kingston.

Ombudsman's conclusions

One of the purposes of my investigations is that all concerned may draw lessons for future practice. I am grateful to the investigation team and to the Portsmouth City Teaching Primary Care Trust Team for the insights they have brought to this report. I know that the staff of Kingston prison, too, have thought deeply about this man's death. There are lessons to be learned from this tragedy that I hope the prison will find valuable and that may help others in future.

First, I recognise that the man who died was a difficult person to care for in prison. Several members of staff had made concerted efforts to help him and were very upset about his death.

The sequence of events leading to his placement in the Segregation Unit is worrying. Segregation Units are not a suitable environment for people who feel suicidal. Had the safer cell been available, the man might more appropriately have been located there when he first approached staff. The safer cell should not be used as normal accommodation. Despite population pressures it should be kept in reserve.

If, in exceptional circumstances, Segregation Units are used for people at risk, that must be with stringent safeguards. Staff should exercise discretion as to the conditions and regime that are appropriate. The usual rules of the Segregation Unit should not be applied automatically.

The man became agitated, self-destructive and violent. Those are common signs of distress. Isolated, without means of occupation or distraction, his distress was unlikely to reduce. No member of staff is based in the Segregation Unit overnight and there were no other prisoners housed there.

A prisoner told the investigators of an occasion in the past when the man had self-harmed. He said he noticed that the next day the man had asked to get his pencils and drawing things from his cell but had been told that he could not have them because he might use them to hurt himself. The man was a talented artist. I have not investigated the circumstances of the occasion in question but, if it happened as the prisoner relates, I find it hard to believe that depriving him of an alternative means of self-expression was a wise judgment.

There may have been no alternative to housing the man in the Segregation Unit for a time. But the safety algorithm should have been completed by a doctor or Registered Nurse within two hours of segregation. This could have been done at the time of the initial examination. Failing that, the man should have been placed on a minimum of five times an hour watch at irregular intervals. Prison staff were more focussed on segregation procedures than self-harm procedures. In the circumstances, this was perhaps understandable. But staff appeared not fully aware of procedures for the segregation of prisoners on an open F2052SH.

The doctor called out on Saturday night was a locum. There is no record that he assessed the man's mental and physical health at the time. The doctor did not complete Section 2 of the Healthcare Assessment on Page 5 of the F2052SH as

required. Kingston's doctor attends three days a week and the prison regularly uses locums. It is possible locum doctors are not familiar with self-harm procedures.

The safety algorithm was used on 10 October. The nurse signed to say that she was satisfied for the man to be segregated but did not enter an answer to the question *"Does the prisoner show signs of being acutely unwell (e.g. psychotic)?"*

There was no formal Case Conference on 10 October, with the result that no formal support plan was developed. The man's history was well known to the nurse, duty governor and other staff on duty in the Segregation Unit. There appears to have been an informal discussion about how to manage him. From their knowledge of him, the nurse and the duty governor decided that the man should be kept in the Segregation Unit and on a 30-minute watch. The duty governor was sufficiently concerned about the risk of self-harming that he tried to transfer him to Winchester. Winchester was unwilling to take him.

When completing a support plan there should be consideration of contacting the prisoner's family and discussion with the prisoner. There should be at least one daily entry, which includes a dialogue with the prisoner to assess the support plan. Furthermore, the unit manager should check for any previous F2052SH's and any relevant information added to the current document, to enable effective care and support planning. The documentation and interviews with staff indicate that none of these courses of action were contemplated or carried out.

Once the man became calmer, there appears to have been no real attempt, to move him out of the Segregation Unit, although some staff say it was considered. Reasons given for him remaining in the unit were partly that the safer cell was occupied by a prisoner who was not at risk of self-harm and partly that it was felt he could be managed more easily in the Segregation Unit.

The man might have been relocated to the safer cell even if that meant temporarily furnishing a Segregation Unit cell and relocating the other prisoner.

One member of staff interviewed identified a lack of training in Prison Service Suicide Awareness procedures and systems. The member of staff was not unduly concerned by this, citing length of service and experience as being compensatory. This may indicate some level of complacency.

The clinical review advises that the man might have benefited from input from a trained mental health worker or from structured psychological therapy in the form of Cognitive Behavioural Therapy, to address his ability to cope with stress, anger management problems, recurrent depression and repeated self-harm. No provision of this kind was available at Kingston.

The man was an automatic life sentence prisoner with a short tariff. However, he had already been in prison beyond his tariff and would not have had a further review until March 2006. We were told that he seemed not to have come to terms with his life sentence, and the need to face up to his violent behaviour, but tended to attribute all his problems to his drugs habit. His Life Sentence Plan included non-accredited programmes and courses that were not available at Kingston.

Targets within a Sentence Plan should aim to address specific treatment needs via accredited offending behaviour programmes, education, employment and resettlement. Non-accredited programmes should not be set as targets since there is no evidence that these approaches reduce risk. The Psychology Department should attend annual Sentence Planning Boards in order to provide an objective assessment of risk and treatment need and any other areas of psychological concern.

Recommendations

I make ten recommendations. I also endorse the five recommendations from the clinical review as set out below.

Local recommendations:

R1 All staff should receive regular training on self-harm procedures including, whenever possible, doctors who are likely to attend the prison.

R2 If locum doctors attending prisoners at risk of self-harm are unfamiliar with procedures, staff should take responsibility for ensuring that they are briefed as to what is required or that arrangements are made quickly for alternative medical input, if necessary. This should be incorporated into local training on suicide prevention.

R3 People who visit vulnerable prisoners should record their own impressions in the F2052SH for the information of other staff caring for them subsequently.

R4 The safer cell should be kept in reserve and not used as part of the normal capacity of the prison.

R5 If, in exceptional circumstances, a prisoner at risk of self-harm is held in the Segregation Unit, staff should exercise discretion as to the conditions and regime that is appropriate. The usual rules of the Segregation Unit should not be applied automatically.

R6 If, in exceptional circumstances, a prisoner who is at risk of self-harm is held in the Segregation Unit, an officer should be detailed to staff that area full-time even if this means calling in extra staff.

R7 There should be formal arrangements between Kingston and Winchester to enable Kingston to transfer prisoners at a serious risk of self-harm to Winchester's Healthcare as a priority.

R8 The night SO and the night officer should be commended for their efforts to save the man's life.

R9 Staff involved in tragic incidents of this kind should be seen as a matter of routine by the Staff Care Team. They should be fully debriefed, with access to an independent counselling service in order to protect their psychological well being.

National recommendations:

R10 Special attention should be given to structuring life sentence plans to meet the needs of short tariff automatic life sentence prisoners. Non-accredited programmes should not be set as targets. Psychologists should attend annual reviews.

Clinical review recommendations:

R11 Where a prisoner has been clinically assessed as posing a high risk of suicide in the long term, a system should be adopted where this high risk at times of stress or disturbance is readily communicated or “flagged” to staff so that appropriate actions can be taken as the situation demands.

R12 In accordance with the Prison Service Order intermittent observations must be undertaken and documented no less than 5 times an hour in cases where there is identified risk of self harm until this risk is assessed by a person who has undergone specific training in the assessment and management of deliberate self-harm.

R13 In all cases where there is a risk of self-harm, thoughts and intent on suicide should be enquired about actively.

R14 If a risk of self-harm or suicide is identified in the Segregation Unit, urgent consideration needs to be given to transfer to a dedicated healthcare facility.

R15 There should be a review of the current mental health provision at HMP Kingston to establish if it meets levels of need.