

**INVESTIGATION INTO THE CIRCUMSTANCES OF THE DEATH OF
A MAN AT HMP LEICESTER
IN OCTOBER 2004**

PRISONS AND PROBATION OMBUDSMAN FOR ENGLAND AND WALES

FEBRUARY 2006

This is the report of an investigation into the death of a man who was found hanging in his cell at HMP Leicester in October 2004.

This investigation was carried out under the terms of transitional arrangements agreed with the Prison Service. An investigator was appointed from within the Prison Service and she was supported by a colleague from my office. I am grateful to them both. I am also grateful to the Governor and staff of HMP Leicester for the assistance they received. I regret the delay in completing this report.

It is not known who mourns for the memory of the man. It is likely that he came from Kenya, although this is not certain and he himself claimed to come from Swaziland. It is also probable that both his parents are alive. He had made one phone call while he was in custody, but it is not known if this was to a friend or a relative.

It is also not known what may have caused him to take his own life. The man seems to have made no impression on the majority of staff who came in contact with him. But while I am critical of the operation of the personal officer scheme at Leicester prison, I have found nothing to suggest that what may now reasonably be supposed to have been the man's distress should have come to the attention of staff.

Every death in custody is a human tragedy. All the more so as here, when the man who died was thousands of miles from his home, family and friends and when his motivation can only be guessed at.

This version of my report, published on my website, has been amended to remove the name of the man who died and those of staff and prisoners involved in my investigation.

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Prisons and Probation Ombudsman

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Summary

1. This is a report of the inquiry into the circumstances surrounding the death of a man Leicester prison in October 2004.
2. He was first placed in to prison custody in September 2004 after being remanded from a Magistrates' Court. He was charged with possession of a false instrument and fraud. It is believed that these charges were related to the man's passport, which he had sent away with an application for a United Kingdom driving licence.
3. On reception into prison, the man gave an address in Leicester, where he said he had been living with an unnamed friend. He said that his place of birth was Swaziland, although it later emerged that he was in fact from Kenya. In his core prison record, under "next of kin" is written "Nobody in this country".
4. An Immigration Service form IS91 dated 21 September authorised the man's detention as "An illegal entrant..." the man would, therefore, have been aware that he was likely to be subject to removal from the United Kingdom.
5. On reception into Leicester prison, the man was seen by a duty nurse who interviewed him and completed the First Reception Health Screen and part of the Cell Sharing Risk Assessment form. The nurse recorded that the man had no immediate medical or health problems, did not suffer from any allergies and did not take drugs. On both documents, it was recorded that the man had no thoughts of suicide or of wanting to harm himself.
6. The nurse was one of the few staff able to recall having a meaningful conversation with the man. He said that, during the reception process, they discussed the fact that they both originated from African countries. The man said he was from Swaziland and had left home about a year before to pursue educational opportunities in the United Kingdom. He said that he had lived in London before moving to Leicester because he wanted to do a course at University. The man told the nurse that his next of kin was a friend in London and that he had not informed anyone back home that he was in prison because he wanted to deal with the situation on his own. The nurse recalled that, although the man was naturally concerned to be in prison for the first time, he did not show any particular anxiety.
7. For his first two nights in prison, the man was located in Leicester's First Night Centre, where he would have undergone a basic induction into the prison. There are no comments relating to the man's stay on the First Night Centre in the staff observation book and staff working there could not recall him.

8. After the first two nights the man was moved to L3 landing in the main prison. L3 landing is used to house new remand prisoners and those waiting to be allocated work. He returned to court on 29 September and was remanded in custody until 27 October. On his return to the prison he was located back on L3.
9. From 29 September until 14 October, the man was located on L3 landing and shared a cell with a prisoner. The prisoner was interviewed but could recall nothing of the man. The L3 staff observation book from 24 September to 14 October contains no entries at all about the man. The only member of L3 staff who could remember anything about his stay there was an officer. The officer remembered the man because of his unusual name and that he had used the prisoner telephone once, but was unable to recollect anything further.
10. On 14 October, the man was moved from L3 to L4 landing. L4 landing is used to house prisoners who have jobs in the prison, or those who regularly go to education. There is no evidence to indicate whether the man had been allocated a job, but staff interviewed assumed that he would have been moved in preparation for work. The only entries about the man in the L4 staff observation book are those relating to his death the following day.
11. He was moved to cell L4-25 during the morning of 14 October. The double cell already had one occupant, a fellow prisoner. The prisoner left the cell during the afternoon and in this time the man was seen by a landing officer. This was the last time he was seen alive.
12. At about 3:50pm, the prisoner returned from his visit, and the cell door was unlocked by another landing officer. On opening the cell door, the officer discovered that the man was hanging from the bars at the cell window.
13. He was taken to hospital at 4:30pm and was pronounced dead at 4:50pm.
14. It has been almost impossible to construct a picture of the man's time in Leicester prison, because few of the staff interviewed recalled anything significant about him and his wing history sheet has only a few brief entries. The only remarks about him in any of the four staff observation books relate to the discovery of his death. I have not, therefore, been able to find out anything about any activity the man might have engaged in, or any help or advice he may have been given by staff other than that relating to health issues. It is not known whether the man received any visits, but the prison did supply a transcript of one telephone call with an unidentified person which took place shortly after he was first remanded.

15. By reporting sick for the first time, telling his cell mate that he had an allergy, telling the landing officer that he had had stomach ache and a healthcare officer that he had had a nose bleed, the man seems to have been trying to draw attention to himself on 15 October. Unfortunately, it would seem he did not make his distress clear enough in order to receive the help he needed.
16. The man left a note which said, "When I die call my mum on this number."
17. I have uncovered no reason why the man should suddenly have had such a significant dip in mood on 15 October to make him want to hang himself.
18. This report makes three recommendations

Conduct of the Investigation

19. This investigation was conducted under the terms of transitional arrangements agreed between my office and the Prison Service that applied between 1 April and 30 November 2004. In line with those arrangements, I appointed a Prison Service Staff Officer, to conduct the inquiry on my behalf. She was supported by a colleague from the Ombudsman's office.
20. The investigators met the Governor of Leicester prison and representatives from staff associations.
21. They issued a notice to prisoners and staff, inviting anyone who might have information relating to the man's death to make themselves known to the inquiry.
22. They interviewed prison staff and the two prisoners who had shared cells with the man. Transcripts of the interviews are attached as annexes of this report. They were also given statements supplied by prison staff in the immediate aftermath of the man's death.
23. A review of HMP Leicester's Suicide Prevention policy and practice was carried out by the Area Suicide Prevention Advisor.
24. The inquiry team received all due co-operation and assistance from prison staff and prisoners.

HMP Leicester

28. HMP Leicester is a local prison for adult men, built in 1825. With a capacity of 385 prisoners, it is one of the smallest local prisons in the country. The most recent report by Her Majesty's Chief Inspector of Prisons was in 2003. In 2004, the Independent Monitoring Board were pleased to report that the installation of in cell electricity was due to be completed in August 2005.
29. A report by the Area Suicide Prevention Advisor, is attached as an annex to this report. He found that the strategy, policy and practice of suicide prevention at Leicester is basically sound. The majority of staff interviewed during his inquiry had had recent, up to date, training. However, the advisor makes one telling comment:

“It appears that on the main residential unit of landing 3 and 4 that staff had only limited time to support prisoners beyond the bare minimum. Prisoners talked of staff being too busy to listen to them and that most of their requests had to be made by written application.”

Key Findings

The man's location and movements in HMP Leicester

30. On his arrival at Leicester prison, the man went through the standard reception process for prisoners. He was interviewed and photographed, allocated a prison number and seen by a member of the Healthcare team, a nurse, for a First Reception Health Screen. So far as I can judge, the reception process was conducted appropriately and was sufficient for the purpose of gathering initial information. In fact, the most significant conversation the man had with staff during his time in custody appears to have been during the reception process when he was interviewed by the nurse. My investigator found the approach by staff to new prisoners to be reassuring and respectful. However, as in a number of older local prisons, physical surroundings in the Reception area have a number of shortcomings.
31. After reception, the man was taken to the prison's First Night Centre where he remained for two nights. He would have gone through a short induction process; this would have involved being interviewed about his immediate needs and issued with a reception pack containing tobacco and a £3 "credit" to enable him to make a telephone call. He was also interviewed by staff from the Chaplaincy, Probation and Resettlement departments but no information is available about the content of these interviews. At the time of the man's reception into Leicester, it appears that there was no policy requiring staff to make extra efforts to establish his needs as a foreign national.
32. Two days after reception, the man was moved to L3 landing. This is the landing to which new prisoners who do not require detoxification from drugs are allocated. The man should have been allocated a Personal Officer on L3, who would have been responsible for ensuring that his needs were met. There is more about the inadequacies of the Personal Officer scheme later in this report.
33. The man went out to court for further remand on 29 September and then returned to L3.
34. On 14 October, the man moved to L4 landing. Although there is no evidence to corroborate this, staff have said that they assumed he was moved there because he was about to be allocated work. He was placed in cell L4-25 with a prisoner. It was in this cell that he died on 15 October.
35. The prisoner recalls that the man's English was quite good, and that he said he had come to England a couple of years earlier with his father. The man told the prisoner that he had been arrested after sending his passport away when applying for a driving licence. He said that the man did not go down to collect the tea meal on the evening of 14

October, which meant that he had no tea and did not collect his breakfast pack for the following morning. He would have been issued with a flask to collect hot water from the hot water boiler on the landing recess so that he could make himself a drink

36. The prisoner says that, during the night of 14 /15 October, the man got out of bed several times and walked over to the window. The prisoner said that he gave the man a cigarette on a couple of occasions. During the morning of 15 October, the prisoner says that the man pressed the cell bell on a couple of occasions telling staff that he had an allergy and needed to see a doctor. The prisoner says that staff warned him that, if he continued to press the cell bell, he would be punished.
37. Staff did book the man “special sick” at 10:00am, through the special sick book on the Centre. A healthcare officer (HCO) saw the man at his cell door soon afterwards. He said that the man complained that his nose had been bleeding, although it was not doing so at the time. Further enquiry revealed that the man had had a cold and had been blowing his nose vigorously. He agreed with the HCO that this was probably the cause of the bleeding. He also told the HCO that he had suffered with a stomach ulcer in the past. The HCO recalled a good conversation and said that the man was showing no signs of stress or of intending to harm himself, or attempting suicide. The HCO gave the man advice about his nose, but did not give any medication or refer him to the doctor.
38. The prisoner recalled that the man collected and ate his lunch and “seemed okay”. He said that the man gave no indication that he was contemplating harming himself. The prisoner left the cell at approximately 1:45pm, because he had a visit with his solicitor that afternoon.
39. The next and last person to see the man alive was a landing officer. The officer answered the L4-25 cell call bell at about 2:30pm. In interview, she said that she was not aware that he had rung the bell on previous occasions and she did not say that he had been warned about using his bell. She said that she opened the cell rather than speak to the man through the door, because she was having difficulty understanding his heavily accented English. The officer said that the man asked if there was due to be kit change that afternoon. The officer replied that she would check, but that if his landing was not due for a kit change he would be in his cell all afternoon. The officer recalled that the man told her that he had had stomach ache that morning, and had been seen by someone. She says that, when she left the man, he smiled at her and climbed under the duvet on his bed.

Events of 15 October

40. An officer opened the man's cell door at 3:50pm to let the prisoner back into cell L4-25. The officer saw that the man was hanging from the window bars. The ligature was made of a bed sheet.
41. The officer immediately called for assistance from other staff. He was followed into the cell by a second officer, who assisted the first officer in cutting the man down from the window. They placed the man on one of the beds in the cell and were joined by a third officer, who assisted in cutting the rest of the ligature from the man's neck. The radio was not used to summon assistance and the staff who assisted were alerted by the first officer's shout. He checked for vital signs and, being unable to find a pulse, decided that the man should be placed on the floor so that staff could begin to attempt to resuscitate The man. The staff immediately began to attempt to resuscitate the man through artificial respiration and cardio pulmonary resuscitation (CPR).
42. The landing officer was present as well as the other officers. She did not have a radio and so telephoned the healthcare centre for assistance. At about 3:55pm, a HCO entered the cell. He asked for an ambulance to be called and tried to use the prison defibrillator to see if he could detect signs of life. The battery on the defibrillator was flat and so the HCO and the first officer continued manual CPR and artificial respiration.
43. Paramedics arrived at the scene at about 4:00pm. They continued to work on the man and their defibrillator showed that there were some signs of life. They made the decision to move the man to hospital. He was strapped into a chair and taken to the ambulance which left the prison at 4:30pm. Sadly, the man was pronounced dead at the hospital at 4:50pm.
44. The immediate response by the staff who found the man was speedy, professional and entirely compassionate. The ambulance was at the prison within three minutes of being called and paramedics were at the scene within ten minutes of him being discovered.
45. All staff and prisoners at Leicester were informed of the man's death as soon as practicable after the prison received the news. Staff involved were de-briefed and offered the services of the prison's Post Incident Care Team. No member of staff interviewed expressed dissatisfaction with the way they were treated after the man's death was discovered.
46. The man's cell mate was immediately located with another prisoner for company, and later with a friend in the prison. He told my investigator he was satisfied with the way he was treated by staff.

47. All prisoners subject to F2052SH procedures (for those considered to be at risk of self harm or suicide) were immediately reviewed and reassured.
48. All relevant agencies were informed of the man's death and the Governor attempted to contact the man's mother through the Kenyan Embassy.

Issues Considered in the Investigation

The Personal Officer Scheme

49. At the time of the man's death, Leicester's Personal Officer Scheme was under review. The Personal Officer Scheme is meant to ensure that prisoners have an identified member of staff to whom they can turn for help or advice. The member of staff should see the prisoner regularly, deal with any needs or problems, and record the prisoner's progress in their wing history sheet. In addition, any other member of staff may record their observations about a prisoner in the history sheet or the wing observation book.
50. The system current during the man's time at Leicester was the following:
- Two officers on a landing would be allocated a bank of cells for personal officer duties. The officers would be responsible for prisoners housed in those cells. (Because Leicester is a local prison where the turnover of prisoners is frequent and rapid, prisoners are often not in the same cell for very long.)
 - Officers were allocated personal officer time as and when staffing levels allowed. If there was a shortage of staff through sickness or operational requirements elsewhere in the prison, there would be no time to be allocated for such duties.
51. The man's history sheet shows only four entries on September 22 and 23, and no further entries before his death on 15 October. None of the entries was made by landing staff, and my investigators could not find any member of staff who considered themselves to be the man's personal officer. It was clear to the investigation team that landing staff knew nothing at all about the man.

Immigration Issues

52. The man was arrested and charged with possession of a false instrument (his passport). It appears that discrepancies had come to light when he sent the passport away, as proof of identity, when applying for a United Kingdom driving licence.
53. The man stated to the authorities that he was a Swaziland national, but the contact number he left for his mother was in Kenya and it is believed that he was in fact Kenyan. He told his cellmate that he had entered the United Kingdom two years previously with his father, but did not say where his father was at the time of his arrest. He stated that his next of kin was "No one in this country."
54. The Immigration Service had issued a form IS91 against the man, which required him to be held as a detainee. He would probably have

been aware that he would be subject to removal from the United Kingdom. His status was that of detainee and he told his cellmate that his case was due for review on 27 October, which was the date he was due back in court.

Medical and Healthcare management

55. The man's prison medical record and First Reception Health Screen state that he had no medical or healthcare problems, was not a drug user and was not considered to be at risk of self harm or suicide. His prescription chart does show that he was prescribed Ibuprofen on 22 September, but there is no indication of the reason for this.
56. It may be significant that, on the day he died, the man asked to see a doctor and gave his cell mate and two members of staff three different reasons for feeling unwell. However, there is nothing to indicate that he was showing signs of distress. He appears to have been given appropriate advice by the HCO for the symptoms he presented at the time.

Conclusions

57. It is impossible to tell what might have been the trigger for the man to hang himself. He appeared to have no medical or mental health problems, was not a drug user and did not seem to have any problems with staff or other prisoners. There were no significant events due to take place (his next court appearance was almost two weeks away). He had changed cells the day before he died, but did not have a close relationship with his previous cell mate. In addition, a lack of any significant information about the man's time in prison makes it impossible to do more than guess at his motivation.
58. The Personal Officer scheme at Leicester at the time was poor. Staff appeared not to know anything about the man, despite the fact that he had been in custody for more than three weeks.
59. After finding the man, staff acted promptly and professionally and made every effort to resuscitate him. It is worthy of note that paramedics were with the man within ten minutes of the ambulance being called.
60. Leicester's contingency plans were good and were followed appropriately. Staff and prisoners were appropriately supported in the aftermath of the man's death.

Recommendations

1. The Governor of Leicester should review the Personal Officer scheme to ensure that staff are given enough time, on a regular basis, to ensure meaningful contact with prisoners and that all observations are recorded.
2. There should be regular testing of emergency medical equipment held at the prison to ensure that it is in working order.
3. Staff involved in attempting to save the man's life should be formally recognised for their swift, professional and compassionate response.