

**Investigation into the death in custody of
a prisoner
at HMP Manchester in November 2004**

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

February 2006

This is the report of an investigation into the death of a man at HMP Manchester on 11 November 2004. He was found hanging in his cell at lunchtime that day.

I wish to offer my sincere condolences to the family and friends of the man for their sad loss. I know the staff and prisoners at Manchester who knew him share those sentiments.

The investigation was undertaken by my Deputy Ombudsman. As a qualified clinician, she has been able to consider the clinical aspects of the man's care as well as other aspects of his time in custody. I would like to thank the Governor of Manchester and his staff for their participation in this investigation.

I make one recommendation regarding the overall standards of record keeping and have identified three areas of good practice. Additionally, the report includes some housekeeping matters that I draw to the attention of the relevant authorities.

I regret the delay in bringing this report to fruition. The man's death occurred before 1 December 2004 when interim arrangements for the investigation of deaths in custody, agreed between my office and the Prison Service, were still in place.

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Prisons and Probation Ombudsman

February 2006

Summary

The man was received into custody at HMP Manchester on 31 August 2004. He was on remand having been charged with murder. This was the first time he had been in prison. Due to concerns expressed by court staff, the man was identified as at risk from self harm and appropriate documentation (a F2052SH) was raised.

The man found it difficult to settle into prison life, particularly being around young men often serving short sentences. It was therefore arranged for him to transfer to the relative stability of the Lifer Unit. He appeared to settle quickly onto the unit and "kept himself to himself".

At the end of September, the man was assessed as no longer being at risk of self harm and his F2052SH was closed after a case review. On 19 October, the man was seen by a Consultant Forensic Psychiatrist, in order for him to prepare a report for court. The psychiatrist was concerned about the risk the man posed to himself and, after discussions with prison staff, a further F2052SH was opened. This was closed nine days later when the man was considered to be in "good spirits".

On 11 November, the man was found by an Officer suspended by a ligature from the toilet door of his cell. Staff acted promptly to try and resuscitate him, but they were unsuccessful and he was pronounced dead at 12.36pm.

I conclude that the man was cared for by staff and managers in an appropriate manner. In particular, staff went to considerable lengths to ensure the man was re-located to the Lifer Unit where he felt comfortable. The man had said that he would not kill himself because of his love for his children. He gave no warning that he might end his life as it seems he did on 11 November 2004.

Investigation Methodology

The investigation was opened by my Deputy Ombudsman. She met with the Governor, deputy governor and the head of safer custody at Manchester. She was later given a comprehensive and helpful briefing on the events leading up to and after the man's death.

Ombudsman's notices were then issued to staff and prisoners, identifying the scope of the investigation and inviting anyone whom wished to see the investigators to make themselves known. Staff and prisoners in key positions or locations were identified and were invited to speak to my Deputy Ombudsman. All responded willingly and fully. The local branch of the Prison Officers' Association and the Independent Monitoring Board were briefed. They were helpful and offered constructive comment and advice.

Local police were contacted and they provided all the information at their disposal.

Background

HMP Manchester

HMP Manchester is a high security local prison. It is situated just outside Manchester city centre and is part of the high security directorate within the Prison Service. The prison is generally regarded within the Prison Service as a progressive and well managed establishment.

Manchester operates under a Service Level Agreement (it is therefore managed under similar lines and protocols to private prisons and subject to the same performance monitoring procedures). The prison's certified normal accommodation is 961 and its operational capacity (maximum crowded capacity) is 1,261

The last standards and security audit rated the establishment at 87% for Standards and 95% in Security. When considering the specific performance issues that are key to the care of prisoners, the audit scores were 95% for suicide prevention, 58% for safer establishments (anti-bullying), 88% for health services to prisoners, and 94% for prisoner induction. With the exception of anti-bullying, these scores are all in the good range.

The last inspection of Manchester by HM Chief Inspector of Prisons was in 2001. The inspection report concluded that "there was much good about the cultures and priorities of Manchester prison. It was certainly not a prison giving major cause for concern; indeed the flexibility and positive approach of staff and managers, and their achievements against considerable pressures are a lesson to many other local prisons."

Events leading up to the death

The man was received into custody at HMP Manchester on 31 August 2004 following his appearance in court. The man had never been in prison before and his only previously recorded brush with the law was in 1989 when he received a conditional discharge.

On his reception to Manchester, he was seen by reception staff who completed his cell sharing risk assessment. The man was considered to be a low risk and therefore suitable for multi-cell location. An entry on the risk assessment indicates he would prefer to share a cell with someone his own age. The document also clearly notes he was on an open suicide/at risk form (F2052SH).

The F2052SH had been raised by staff on reception as a result of information received from court staff. The man was interviewed by the initiating member of staff who found him to be low in mood and saying he wished it was he who was dead and not his victim. After the man had been seen by the unit manager and healthcare staff, it was agreed that he would be managed on a normal residential unit in a shared cell.

As part of the reception process, the man was also seen and interviewed by healthcare staff. During the interview, the man did not inform staff of any significant physical health concerns. However, it was noted that he had a small cut to his left hand that had apparently been sustained during the disturbance that had led to his remand in custody. The man stated that he did not use drugs and only drank alcohol on a social basis. The reception nurse noted that the man appeared “withdrawn.” He was asked a number of questions about his mental health and denied any previous contact with mental health services or attempts to self-harm. Following the completion of the assessment, the man was appropriately referred to the doctor.

The man was seen by the doctor later the same day. Whilst the doctor noted that he was not actively suicidal, he offered support and documented that he should be observed. However, he did not make a note of the nature of the observations – their type and frequency.

The man was then located on G wing. He was provided with the local Induction Programme booklet. The initial risk assessment was completed, but was not signed by the completing member of staff. The following day, the man completed the local prison compact. This document clearly lays out the expected behaviour of both staff and prisoners, along with the regimes and facilities prisoners can expect.

On 2 September, the man was seen by the Mental Health In-reach Team. The assessment concluded by recommending that he should be seen by the doctor for consideration of anti-depressants. An appointment was subsequently arranged for the secondary screening process. However, the man was unable to attend this appointment as a result of operational difficulties encountered by the prison. It does not appear that a further appointment was made for this secondary health assessment to take place.

Also on 2 September, the man had an F2052SH case review. The summary of the review warns staff, “not to be fooled by his present state which is he’s on cloud nine.” Staff were trying to arrange a prison job for the man and arranged a phone-call for him to ring his children. The review summary and support plan are comprehensive and clearly identify the man’s current emotional state and management needs. A further review was scheduled for 15 September.

On 4 September, an unscheduled case review was undertaken following the deaths of two other prisoners in Manchester. In such situations, I consider the process of undertaking full multi-disciplinary case reviews rather than a paper review to be good practice.

Over the next ten days, the entries in the F2052SH give little indication as to how the man was feeling. There are a handful of entries that are well written and demonstrate positive interaction with staff.

On 15 September, the scheduled multi-disciplinary case review was held. This concluded that, whilst the man was starting to settle and find his feet, the document should remain open. It was noted that the man was finding it hard living amongst younger prisoners serving short sentences. It was therefore agreed that he should transfer to the more settled environment of the Lifer Unit.

The same day, the man was moved from the induction unit to the Lifer Unit on C Wing. The Lifer Unit has accommodation for 124 prisoners. These are mostly those serving life sentences, although there are some prisoners serving other long sentences and some remand prisoners who are likely to be given life sentences if found guilty. The man was apparently anxious when he first went onto the wing. However, he appeared to settle quickly and “kept himself to himself.” The F2052SH indicates he spent long periods of time in his cell on his bed watching television.

On 24 September, an entry in the wing observation book notes that other prisoners were trying to intimidate the man and spreading malicious rumours about him. A security information report was completed and submitted to the security department in a timely manner. The man was also seen by staff regarding these issues. He was advised to contact staff if there were any problems. He felt confident that his cellmate would look after him if there was any trouble.

On 29 September, a further scheduled case review of the F2052SH was held. The man said he had good family support and would not self-harm as he loved his daughters too much. The case review concluded that the F2052SH should be closed.

The man appears to have settled on the Lifer Unit, although there are no entries in his wing history sheet over the coming days. An entry in his wing history sheet dated 8 October notes that he had apparently settled down and had no particular problems. However, on 14 October, the man was moved from ‘C’ wing inner to ‘C’ wing outer ahead of the waiting list, as staff felt he was vulnerable and the move would be better for him. My investigator found the atmosphere on ‘C’ wing outer to be very positive with staff referring to prisoners by their first name. Prisoners in turn felt

comfortable and able to approach staff if they had problems or needed information and support.

On 19 October, the man was seen by a Consultant Forensic Psychiatrist, in order for him to prepare a report for court. The psychiatrist was concerned following this interview that the man was at an increased risk of self-harm, and, after discussing this with staff, a further F2052SH was raised. The psychiatrist also referred the man to the Mental Health In-Reach Team again. The Team saw the man the following day and documented they could find no evidence of mental illness or suicidal ideation. The reviewer did recommend “standard F2052SH observations”, but once again did not identify what these were.

The 72 hour case review was held on 21 October and, whilst the general consensus was the document could be closed, it was felt appropriate to keep it open for another seven days and then review the case again. The F2052SH remained open for a further seven days, but was closed on 28 October when, following a case review, the man was found to be in “good spirits.”

There are no further entries in the man’s wing history sheet or his medical record.

On discovery of the death

On 11 November, at about 12:15pm, an officer was asked by a prisoner to open his cell door. When asked where his cell key was, the prisoner said that his cell mate had it, but he did not know where he was. The officer therefore unlocked the cell door and saw the man suspended from the toilet door with a ligature made from a torn bed-sheet around his neck. The officer left the cell to press the alarm bell to summon assistance.

The officer immediately returned to the cell and lifted the man to relieve the tension caused by the ligature. The prisoner came into the cell to help the officer and began removing the ligature. Another officer arrived and took over from the prisoner who then left the cell.

The officers lowered the man to the floor and checked for signs of life. They could not find any. Healthcare staff had by this time arrived and began cardio-pulmonary resuscitation. By 12:30pm, the paramedics were at the cell. Resuscitation attempts were continued until 12:36pm when the duty General Practitioner, pronounced death following a collective decision to stop the resuscitation.

Events after the death

Following the discovery of the man, the prison's contingency plan for a death in custody was activated. The Greater Manchester Police were contacted and informed of his death. They attended the prison and carried out their own investigation.

The man's daughter was on the way to visit her father when he was discovered. The chaplain and duty Governor therefore went to the visitors' centre to meet her and break the sad news. This must have been a very difficult thing to do, and I commend their actions.

The man's daughter visited the prison again on 12 November and met with the deputy governor and members of the chaplaincy team.

The governing Governor wrote to the family on 16 November expressing his condolences on behalf of all at Manchester.

The care team was made available to all staff to offer post incident support. A notice to prisoners was issued informing them of the death and offering them the support of Listeners and the Samaritans.

All those prisoners on an F2052SH were interviewed and their cases appropriately reviewed.

Issues considered during the investigation

Suicide and self-harm procedures

The man was appropriately managed on the F2052SH document. The case reviews were comprehensive and identified clear management plans. However, the quality of the daily entries was very variable and did not always provide evidence of positive staff/prisoner interactions. Furthermore, the absence of good quality entries meant there was little evidence available for informed decision making during the care planning process.

The use of the review record inserted inside the front cover of the F2052SH document is considered good practice. Similarly, I welcome the local guide for managers on 'What to look for when checking F2052SH forms'

Records and record keeping

Overall, the standards of record keeping were far from satisfactory. There are only four entries in the man's wing history sheet indicating how he was coping with prison life. The entries in the F2052SHs are variable. The entry in the medical record by the forensic psychiatrist is brief and gives little insight into the man's actual mental state.

Although I understand the pressures on prison staff, especially in a busy and complex local prison, record keeping is an integral part of the care process and a tool of professional practice. It should not be thought of as an optional extra to be fitted in if circumstances allow. The terminology used in some records does not enable the multi-disciplinary team to manage the prisoner effectively. For example, the medical record states "observe" but does not go on to explain the reasons for the observations. Another entry states "standard F2052SH obs", but again there is no explanation of what observations these are

Healthcare

On 19 October, the man was seen by a consultant forensic psychiatrist for a report for the court. The psychiatrist identified the man as at risk of suicide and quite correctly opened an F2052SH. He also referred him to the Mental Health In-reach Team. However, there is no evidence of the report for court in the medical record. Furthermore, the entry is very brief and gives no insight into the man's mental state or the reason for his referral to the In-reach Team.

Wing location

It is evident that appropriate and timely efforts were made to locate the man on a residential unit with a more settled environment and with prisoners nearer his own age. My investigator found that staff on the Lifer Unit create a calming and friendly environment in which staff and prisoners have respect for each other. Staff refer to prisoners by their first name and prisoners feel able to approach staff for help, support and information.

Findings and Conclusions

Very little was known about the man. There are limited entries in his medical record and wing history sheet giving little insight into how he was coping with prison life. What entries there are indicate that the man was clearly troubled by his offence and remorseful for his actions.

The Governor should remind all staff of the importance of timely and appropriate contemporaneous records to enable the multi-disciplinary team to provide seamless care for the prisoner using all available information and knowledge about an individual.

On the day the man apparently ended his own life, he was expecting a visit from his daughter. Throughout his short time in custody his family had been very supportive - visiting and writing regularly. The man also had regular phone contact with his family and friends.

The man was cared for by staff and managers in an appropriate manner. Employment was sought for him to enable him to keep occupied during the day and a place in education was secured at his request. When the man expressed unease about his location on the induction wing due to his age and potential life sentence, arrangements were made to re-locate him. The man was therefore moved to the more settled environment of the Lifer Unit.

I find that staff went to considerable lengths to ensure the man was in an environment where he felt comfortable. The man stated he would not kill himself because he loved his children too much. Yet sadly and without apparent warning, it seems he chose to end his life on 11 November 2004.

Recommendations

- The Governor should remind all staff of the importance of timely and appropriate contemporaneous records to enable the multi-disciplinary team to provide seamless care for the prisoner using all available information and knowledge about an individual.

Good practice

- The use of the local case review record is considered a good aide memoir for managers and staff.
- The management guide, 'What to look for when checking F2052SH forms' provides duty managers with the salient points for management checks and ensures consistency.
- The local induction booklet is well written and user friendly. It provides prisoners with a significant amount of useful information about expected conduct of staff and prisoners along with the regimes.