Investigation into the circumstances surrounding the death of a man at HMP Camp Hill in February 2009

Report by the Prisons and Probation Ombudsman for England and Wales

February 2010

The man who died was found at about 7.20am in his cell at HMP Camp Hill having hung himself during the night of 6 and 7 February 2008. Staff and paramedics attempted to resuscitate him but were unsuccessful. He was 23 years old. I offer my sincere sympathy and condolences to the man's family and friends for their loss.

The investigation was carried out on my behalf by my colleagues Mr F and Ms A. A clinical review of the man's healthcare was undertaken by a doctor on behalf of the local Primary Care Trust. I am grateful for his review. I would also like to thank Governor I of Camp Hill at the time of the man's death and his staff for their co-operation and assistance. Particular thanks go to Ms R for her help throughout the investigation.

The man who died was sentenced to 30 months in prison for graffiti and criminal damage offences committed approximately 18 months previously. Since the offences he had started work and begun paying off a court fine. Given the over-crowding in our prisons, and the possibility of some form of community punishment, I find it disappointing that the courts found it necessary to send him to prison. Although it is not in my remit to investigate the actions of the courts, I will make the Secretary of State aware of my findings.

The man coped well at HMP Wandsworth but was unhappy about moving to the Isle of Wight. While the transfer was in accordance with current practice, I do understand the frustration of prisoners who are moved long and difficult distances from their friends and family. The man did not, it seems, immediately become depressed or suicidal but his telephone calls reveal his frustration.

The Court of Appeal reduced his sentence on 3 February 2009, but not by enough for him to walk free from the court that day. Although he initially refused to return to Camp Hill, on his arrival he appeared in reasonable spirits and did not show any concerns to friends or staff. He spoke to his girlfriend many times on the afternoon of 6 February and their conversations ranged widely in terms of mood. The calls reveal a man struggling to deal with his isolation.

The man had a lot to live for and could have been released as early as the end of March. We cannot know for certain whether he intended to end his life, or whether it was a cry for attention which went wrong. In either case, there was nothing to predict that he might consider such a course of action and I do not think that this tragic death could have reasonably been foreseen.

The man's family raised several concerns and I hope that this report answers their questions. I make six recommendations in this report and endorse the three recommendations from the clinical reviewer.

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

Jane Webb
Deputy Ombudsman **February 2010**

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SUMMARY

The man who died was sentenced to 30 months in prison for criminal damage in October 2008. He was sent to HMP Wandsworth where he seemed to settle into prison life. He moved to Camp Hill in early 2009 in accordance with prison policy as he was a category C prisoner. It appears that he found the location of the prison on the Isle of Wight difficult as he felt isolated from his friends and family. Despite this he did not raise any concerns with staff and was not considered to be at any risk of harming himself.

The man appealed against his sentence. He went to the Court of Appeal on 3 February and his sentence was reduced by 10 months. Apparently he had some hope it would be reduced sufficiently for him to leave custody that day. Shortly after his return to Camp Hill he moved to a cell opposite a childhood friend. His friend said that he seemed heartened by their proximity and described him as appearing fine.

The man spoke to his girlfriend several times on the afternoon of 6 February. One of these conversations included an apparent end to their relationship. However, conversations continued throughout the afternoon and, although sometimes difficult, the final telephone call appeared to show that they retained their commitment to each other.

The Night Patrol Officer asked the man to turn his music down at approximately midnight that night. He remembered him agreeing without complaint, and not raising any other concerns. He was found the following morning by the officer undertaking the morning roll check at 7.20am. Despite the arrival of the emergency services, the man was declared dead at 7.35am.

I make six recommendations in this case regarding the duties of the Night Patrol Officer, the use of the Prisoner Escort Record (PER) by escort staff, and contact with the next of kin. I also endorse the three recommendations of the clinical reviewer.

THE INVESTIGATION PROCESS

1. One of my colleagues, Mr P, opened the investigation on Thursday 12 February. The investigator met senior prison managers and took possession of copies of the documentation relating to the man who is the subject of this report. Mr F was also provided with transcripts of some of the man's telephone calls. Notices of the investigation had already been sent to the prison. No-one came forward in response to the notices.

2. Mr F and a colleague, Ms A, visited Camp Hill from 29 to 30 April to interview staff and prisoners. Mr F had written to the local Primary Care Trust requesting a review of the man's clinical care while he was in custody. A review panel was appointed and Mr F attended a meeting on the Isle of Wight on 20 May. The clinical reviewer was provided with a copy of the medical documentation in order to complete his report.

3. Mr F asked for a copy of the night instructions on a number of occasions. To date, he has been unavailable to review them.

4. One of the Ombudsman's Family Liaison Officers Ms P contacted the man's partner, as his listed next of kin, and his parents. She informed them about my investigation and offered them the opportunity to raise any concerns or questions that they would like addressed. Another Family Liaison Officer, Mrs S, and Mr F subsequently met the man's parents on 25 March 2009. His family raised a number of issues:

   - Why was he transferred from Wandsworth to Camp Hill?
   - They requested further information about the regime at Camp Hill and the suitability of it for a non-violent offender such as the man who died.
   - Why was an outstanding hospital appointment never followed up during the three weeks he spent at Camp Hill?
   - Why was he placed in a cell by himself given his distress at going back to Camp Hill?
   - Why did the family have no contact from the man for three days following his return to Camp Hill?
   - Why did staff not consider him to be more vulnerable after his return?
   - Why was he allowed to have a leather belt?
   - Whether staff used a Stanley knife, rather than a purpose made anti-ligature knife, to cut the ligature?
   - The family were unhappy with the way the news of the man's death was broken to them.

5. The man's family have been kept informed of the progress of the investigation throughout its process and later raised some additional issues through their legal representative, including:

   - The man's use of cannabis in prison and the possible impact on his state of mind.

- His actions during his transfer back to Camp Hill following his appearance at the court of appeal.
- They wished for the man's friend to be interviewed.
- The response by staff when the man was found.

6. In response to the man's family's concerns, on 9 July Mr F interviewed the escort staff who transferred him to and from the Court of Appeal.

7. I have done my best to address the family's concerns in the issues section of my report. I hope the findings of my investigation help his family better understand the events leading to his death.

HMP CAMP HILL

8. HMP Camp Hill was built in the early years of the 20th century. It is a category C prison accepting prisoners from London and the South-East and holds 595 prisoners. On 1 April 2009, Camp Hill merged with Albany and Parkhurst to become HMP Isle of Wight.

9. The prison comprises nine residential units ranging from Victorian style galleried units to single corridor buildings. Some of the units have specific functions. St Andrew's is the First Night Centre and St David's is the Induction Unit. St Patrick's holds vulnerable prisoners. St Stephen's holds prisoners who have reached the enhanced level of privileges. There is also a segregation unit that can hold up to 19 prisoners.

10. Health services at Camp Hill and the other two prisons on the Isle of Wight are commissioned by the Isle of Wight NHS Primary Care Trust. The prison's healthcare is clustered with HMP Albany and is provided by HMP Parkhurst. Parkhurst provides healthcare to the 1,500 or so prisoners on the island and has a 12 bed in-patient facility (mainly providing psychiatric treatment). Prisoners' medical needs are catered for by way of out-patient clinics and core day primary nursing cover. There is no nursing or healthcare cover at Camp Hill during the night.

11. There is association in the evenings for approximately an hour. At the time the man was at Camp Hill, exercise was offered to the prisoners every morning. It would last for half an hour in the week, and up to an hour at the weekend.

Cell Sharing Risk Assessment

12. The cell sharing risk assessment process is the basis for decision making when a prisoner's location is being decided. It was introduced to improve the Prison Service's ability to risk assess and to track potentially violent or racist prisoners who should not share cells with other prisoners. The Prison Service describes the purpose of it as:

- draw together and pool information about risk from operational and health care staff
- make best use of documentary evidence
- support staff judgements about allocation to cells
- where cell sharing is unavoidable for a high risk prisoner , provide for senior managers to decide and record additional operational precautionary measures
- provide a readily accessible record about risk of harm to others as a prisoner moves between wings/prisons
- record decisions about managing and reviewing risk to enable early identification of racist, homophobic or violent prisoners to ensure that other prison service procedures to protect potential victims are followed.

Incentives and earned privileges scheme (IEP)

13. The IEP system is a means of monitoring prisoners' behaviour and rewarding good behaviour and punishing poor behaviour. Prison Service PSO 4000 describes it as follows:

> "The IEP scheme complements the discipline system by rewarding good behaviour. In addition to any local aims, it is intended to encourage prisoners and YOs [young offenders] to behave responsibly, to participate in constructive activity, and to progress through the system. This will foster a more disciplined and controlled, and therefore safer environment for prisoners and staff. It should also contribute to the reduction of re-offending by encouraging prisoners to lead law-abiding, productive and healthy lives."

14. Within the local system prisoners are able to move up a level (basic, standard or enhanced) and earn various privileges. Poor behaviour can result in moving down a level or losing privileges. Privileges include association time and extra visits.

Categorisation

15. The Prison Service explains categorisation as:

> "Categorisation is the procedure used to determine the appropriate level of security required by each individual prisoner. The prime consideration when categorising a prisoner is *risk* – risk of escape or abscond and risk to the public were the prisoner to do so. Allocation of a prisoner follows categorisation and is a separate process designed to determine the most appropriate prison for individual prisoners within the prescribed category having regard for
>
> - the needs of security
> - the needs of the prisoner and
> - the need to make the best possible use of available spaces in the estate".

16. Camp Hill accepts category C prisoners from a number of prisons including Wandsworth. The man's sentence was too long for him to remain at Wandsworth because it is a prison serving the courts in London and mainly holds prisoners who are yet to be sentenced. He was transferred once a vacancy became available at a Category C training prison. In this instance, the vacancy was at Camp Hill. My investigator was told by Governor T that it was not unusual for someone in the man's position to be transferred to Camp Hill.

CARATs

17. CARATs (Counselling, Assessment, Referral, Advice and Throughcare) work with prisoners with drug problems.

Pegging

18. Pegging involves an hourly patrol around the wings. The Night Patrol Officer is required to touch an electronic scanner at certain points in the wing which records the time of the pegging. There are four pegging points in St James and St Thomas wings meaning that the Night Patrol Officer is required to touch the scanner at eight points each hour. Operational Support Grade R explained to the investigator that there are generally two pegging points at the end of each landing. However he also explained that at the time of the man's death four of the pegging points on the wings had been painted over. A Prison Officers Association (POA) representative explained to the investigator that the pegging point is inserted into the wall and then covered so it cannot be tampered with. A black dot of paint is then placed over it so the Night Patrol Officer can identify where it is. However, the POA suggested that prisoners had accidentally painted over some of the black dots when decorating.

19. Therefore, Operation Support Grade R had to peg at only two points on each landing on the night of the man's death. It should be noted that pegging does not require the Night Patrol Officer to look in any cells or check on any prisoners. The routine ensures that the Night Patrol Officer regularly patrols the wings.

Handover

20. When the night staff hand over responsibility to the oncoming day staff, the outgoing staff should remain on duty until the day staff have completed their first roll check. (A roll check is a physical check to see if the prisoners are in their cells.)

Independent Monitoring Board

21. Each prison has an Independent Monitoring Board (IMB) made up of members of the community. The Board's role is to ensure that the prison is properly run and that prisoners are treated decently. Each Board produces an annual report for the Secretary of State. The most recent report from the Camp Hill IMB covers the period 1 August 2007 to 31 July 2008.

22. The Board commented on the improvements the prison has made in productive activity for prisoners. Reference was made to the introduction in 2007 of the Learn Direct centre which helps prisoners with online literacy and numeracy support. It did note staff shortages affecting some activities for prisoners. The report commented favourably on the reception procedures, and declared that Camp Hill worked hard to ensure the safety of prisoners.

The IMB ended their report by highlighting the limited facilities in place for prison visits.

HM Chief Inspector of Prisons

23. HM Chief Inspector of Prisons conducted an unannounced full follow-up inspection of HMP Camp Hill from 9 – 13 February 2009. In her report she wrote that the previous inspection in August 2006 had revealed a prison lacking in direction and not fulfilling its role as a training prison. However, the report did note that under better management:

> "…there has been progress in all areas – but despite this the prison was still not performing sufficiently well in any of our four key areas: safety, respect, purposeful activity or resettlement. Six of our eight recommendations from the last inspection had not been achieved, and the other two achieved only partially."

24. Prisoner-staff relationships were described as relaxed, and the report noted that most prisoners felt they could ask staff for help. The report's verdict on activity and time out of the cell for prisoners was mixed. The range and quality of activities was reported to have improved but there was still not enough for all prisoners. While 75 per cent could undertake some activity that still left a considerable number of prisoners who spent up to 23 hours a day in their cells if association was cancelled. Despite these concerns, the report highlighted an increased core activity day for those in work or education, a wide-ranging education curriculum and some vocational training. However, the report concluded that, overall, the establishment was not performing sufficiently well against the prison test for purposeful activity.

25. It is of concern to read in the report that the Chief Inspector considered that suicide and self-harm prevention was poorly implemented despite recommendations following deaths in custody. Although the report stated "…Camp Hill was not an unsafe prison…" it recommended that "the procedures around safer custody should be strengthened and prioritised as a matter of urgency".

Previous deaths at Camp Hill

26. Camp Hill experienced two self-inflicted deaths in 2007, and another has occurred since the man who is the subject of this report's death. I have considered whether there are any similarities between this death and the others. When the first death occurred, the staff were unsure about whether to go into the cell, and regrettably I have found similar uncertainty after the man's death. The following recommendation was made:

The Governor should review all Camp Hill's night instructions that relate to discovering a death or suspected death in custody. Particular attention should be focussed on when a cell may be unlocked and the staffing level that is required to do so.

27. The prison accepted this recommendation and ensured that the night instructions and contingency plan complied with it.

28. There were no direct similarities between the second death and the death of the man who is the subject of this report. The most recent death does not have any direct similarities with the man’s death.

KEY FINDINGS

The man who died

29. The man who died left school aged 16 without any formal qualifications. He came into contact with the legal system on a number of occasions for relatively minor offences, and spent some time in custody. He had become interested in graffiti while at school and continued this behaviour afterwards. His family described how graffiti was his passion. However, following these offences, he obtained a job and felt that he had grown up. He resumed paying off a court fine and took up golf.

30. The man who died had many friends and a supportive family. They described how he doted on his brothers and sisters. He was in a stable relationship with his girlfriend, and told his probation officer that he regarded this as the primary reason for settling down to a more moderate lifestyle.

31. The man's family said that over 400 people attended his funeral. He received tributes from all over the world and events, such as a balloon launch, were held in his memory.

HMP Wandsworth (10 October 2008 to 16 January 2009)

32. The man who died was sentenced to 30 months in prison on 10 October 2008 for criminal damage caused by spraying graffiti on trains. He appeared to settle into prison life. The staff who completed the cell sharing risk assessment made no record of any concerns about self-harm and he was assessed as being at low risk of harm to others.

33. Prison officers found the man smoking cannabis in his cell on 10 October. They confiscated the drugs and reminded him of the illegal nature of his behaviour. Nevertheless, he applied for enhanced status on the IEP (Incentives and Earned Privileges) system on 23 October. It does not appear that the IEP review occurred before his transfer to Camp Hill.

34. The wing reports at the time of his IEP application revealed that he was mixing well with other prisoners and appeared motivated to attend courses. However, he received IEP warnings in late October and late November for being on the wrong wing and for not removing a curtain from his window.

35. The man's wing file in late November and December contained various entries regarding him having trouble sleeping and subsequent difficulties in getting up for his course. (He was attending a multi-skills course which was a stage towards a City and Guild qualification.)

36. On 31 December, a security information report (SIR) was completed after the man wrote a letter to a friend suggesting that he had access to drugs. A governor noted on the security information report that his mail was to be monitored. On 8 January 2009, he received a further IEP warning for refusing to go to work.

37. The investigator was told that the man that died had been referred to an Ear, Nose and Throat specialist and was seemingly placed on a medical hold for this. (This is an administrative category that aims to prevent a transfer to another in prison so that the appointment can take place. However, only prisoners with life-threatening conditions are not allowed to be moved.) He also had an appointment to see the dentist at Wandsworth on 2 February.

HMP Camp Hill (16 January to 7 February 2009)

38. Despite the medical hold, the man was transferred to HMP Camp Hill on 16 January after his security categorisation as 'C'. ('C' is the lowest categorisation that prisoners can be initially categorised as.)

39. The man progressed through the normal reception procedures on arrival which included a health screening and cell sharing risk assessment. During his health screen he told the nurse that he had no thoughts of harming himself. It was recorded on his medical record that he was angry about being on the Isle of Wight. My investigator spoke to the nurse and, although she could not remember him, she said that this was not an unusual reaction amongst prisoners sent to the prison. There is no indication that he mentioned his outstanding medical appointments during the initial screening.

40. The man was deemed to be at low risk of harm to others. He said that he was content to share a cell initially, but would prefer a single cell when he moved out of the induction wing.

2 – 6 February

41. The man left Camp Hill on 2 February to begin his journey to London to hear the Court of Appeal's decision on his sentence. His journey coincided with heavy snowfall and he stayed overnight at HMP Winchester, rather than at HMP Brixton as originally planned. My investigator interviewed the Reliance escort staff who took him to and from the Court of Appeal. Officer H was part of the team that collected him from Winchester. Prison staff at Winchester relayed no concerns about the man to the escort team. Officer H said that, although he was quiet, he did not behave in a way that concerned her. Nothing of significance was reported to have occurred on the journey to the Court of Appeal.

42. The man was hand-cuffed and taken into the Court of Appeal on 3 February by the escort staff. (My investigator was told that it is standard practice to double-cuff each prisoner. This is when the prisoner's hands are hand-cuffed and also hand-cuffed to an escort officer.) Officer S recalled that he seemed fine when he was taken into the reception area. He appeared at the Court where his sentence was quashed and replaced with one of 20 months.

43. Officer S and Officer H went to the court cells to collect the man. However, when he was told that he would be returning to Camp Hill, he refused to leave his cell. Officer H recalled that Serco staff were also outside his cell. (Serco

is another escort services company that works in the Court of Appeal.) She told my investigator that one of the Serco members of staff told the man that "you can either go on the van yourself or you have to get put on the van". She said that he was not crying or shouting and when he saw the number of officers outside the cell he left the cell voluntarily. Officer S said that during their walk to the vehicle, the man said that his family lived in London which was why he did not want to return to Camp Hill. During the first part of the journey London to Camp Hill Officer S sat in the back with him and said that he did not appear at all distressed.

44. The first part of the journey ended at Fareham Police Station where the man was transferred to a different vehicle. Officer H said that he appeared fine whey they got to the police station at 6.00pm and he got into the second vehicle without a hesitation. Officer J was the driver for the second vehicle. He described the man as seeming a bit down, although he was not surly or uncooperative. The officer explained that prisoners coming from the Court of Appeal are often low in mood:

> " … they have been to the Court of Appeal and they are expecting to have their sentences quashed or time taken off their sentence and if that doesn't happen I don't expect the chap to be happy when I pick him up and bring him back, it is not unusual."

45. Officer N was also on the second vehicle. She told my investigator that a member of staff from the first vehicle told her about the man's initial refusal to return to Camp Hill. She said that it was not described as an issue to be concerned about:

> "They said he has been fine, he didn't want to come initially from the impression I got. He didn't want to go back to Camp Hill but he has been on the van and he has been no trouble and obviously he came from that van to our van no trouble whatsoever."

46. Officer N talked to the man during their journey and told my investigator that there was nothing in their conversations that concerned her. Officer J bought him some chips before they took the ferry to the Isle of Wight. He did not remember him saying anything of concern when he was handed back to the custody of Camp Hill at about 8.00pm. Officer N confirmed this, describing him as walking off the escort vehicle quite happily. He was not assessed by staff upon his return to the prison.

47. The man who died was located in St James' wing and was put in a cell opposite his friend. He was in a double cell and was the only occupant. On 4 February, he asked for his new release dates and for the Home Detention Curfew (HDC) process to begin. (HDC allows prisoners to live outside prison providing they do not breach the rules of their curfew, and is designed to help prisoners prepare for life after release.)

48. The man made several telephone calls to his girlfriend and spoke to her eight times on 6 February. They initially spoke about his appeal, but began to

argue. During a subsequent telephone conversation he told her that their relationship was over and he was going to tear up all her photos and letters. He was angry that she was planning to go on holiday while he was in prison. Another prisoner, Mr L, confirmed that he saw him tearing up letters and photos and putting them in the rubbish bin on the wing. However, he did not report this to officers until after the man's death.

49. The man telephoned his mother at 3.45pm to tell her that he had split up with his girlfriend and was unhappy at being at Camp Hill. He told her he might punch a prison officer to try to get out of the prison and she advised him not to.

50. At 4.00pm, shortly after speaking to his mother, he rang his girlfriend back and they continued their discussion. They spoke again at 4.50pm and the conversation ended with them saying that they loved each other. At teatime Officer M heard him having a loud telephone call. The officer estimated to my investigator that this call was at approximately 5.30pm. Officer M could not make out the content of the conversation and did not view it as unusual or of concern. It is probable that Officer M is referring to the call the man made to his girlfriend.

51. At 6.20pm the man asked Officer G to ask the occupant of a nearby cell to turn his music down and thanked the officer for doing so. Officer G remembered that he saw him on his bed at 7.20pm and that he was apparently fine.

7 February

52. Operational Support Grade R was the Night Patrol Officer on St James' and St Thomas' wings on the night of 6 and 7 February. One of his responsibilities was to undertake the pegging duty. At about midnight operational support grade R asked the man to turn his music down. Operational support grade R remembered that he complied and did not raise any concerns with him.

53. The man's friend told my investigator that, shortly after the music was turned down, he thought he heard him call to him. He went to his door and called back but got no reply. He thought that the man called to him again but once again was unable to establish any contact. The distance between cells which are opposite to one another on St James's wing is approximately 1.5 metres. The man's friend told my investigator that these events made him feel uneasy, although he could not really explain why, and he did not report any concerns.

54. Another important task for the Night Patrol Officer is the completion of the roll check and reporting the number of prisoners on those wings to the control room before 6.00am. Operational support grade R wrote in his police statement that he carried out his roll check and checked the man's cell at approximately 5.00am. He told my investigator that he was unable to recall what he saw in the cell but knew that it must have appeared fine, as otherwise he would have immediately raised the alarm.

55. Officer C came on duty on St James' wing at approximately 7.05am. She told operational support grade R that he could leave and she began her own roll check. She reached the man's cell at about 7.20am and looked through the observation panel in the door. She saw him in a seated position on the floor next to the bed. He had a ligature around his neck which was tied to the bar on the bunk bed. Officer C told my investigator that she was deeply shocked by what she saw. She radioed for assistance and ran down to the wing office which entailed going along the corridor to the stairs, to the ground floor, and to the office. The officer said that she felt vulnerable going into the cell on her own. She was the only person on the wing and had all the keys in her possession. It was still dark and she told my investigator that she felt in a state of shock. The telephone was ringing when she got to the wing office. Night Orderly Officer Principal Officer T (PO T) was on the telephone and she told him what had happened. From the office she got the attention of operational support grade W who had just left St Stephen's wing. The records show that Officer C called for assistance at 7.22am and the ambulance was requested by the control room a minute later at 7.23am.

56. Operation support grade W arrived and went upstairs with Officer C. They opened the man's cell at 7.25am, about five minutes after the officer saw him hanging. Operation support grade W cut the man's ligature with his anti-ligature knife. Officer C became aware that the prisoner opposite, the man's friend, was severely distressed by what he could see through the gap between his door and the wall. While operational support grade W checked for signs of life, Officer C tried to comfort and calm the man's friend.

57. PO T and Officer O arrived a minute later and the PO checked for signs of life. He told my investigator that, from the man's physical appearance, he believed that he was already dead and so cardio pulmonary resuscitation (CPR) was not attempted.

58. PO T then opened the man's friend's cell and took him downstairs to remove him from the scene and provide him support. The ambulance arrived at the prison at 7.28am and the paramedics reached the cell at approximately 7.35am. The paramedics noted that hypostasis and rigor mortis had already set in and pronounced the man dead at 7.35am. (Hypostasis is the gathering of blood in the areas of the skin closest to the ground.)

59. The staff care team arrived quickly to support the staff who discovered the man who died. A prisoner, Mr L, told my investigator that prisoners were told about his death when a note was placed under their cell doors.

60. Deputy Governor T was contacted at home and told of the man's death as he was the duty governor at that time. He came to the prison and, having visited the cell, went to the Command Suite where he coordinated the prison's contingency plans and prepared to contact the man's next of kin.

61. The only next of kin named in the man's records was a telephone number for his girlfriend but no address was listed. Governor T and other senior

managers discussed with the police the best method of contacting her considering the distance involved. Various methods were considered including sending the local police, contacting a local prison and telephoning. Having spoken to the Governor of Camp Hill, Governor I, by telephone Governor T decided to telephone the man's girlfriend.

62. Governor T telephoned the man's girlfriend at 9.35am to break the news. She was distressed but was able to provide a telephone number for his parents. Governor T telephoned his mother at 9.52am and broke the news to her. He then telephoned his father at 9.58am. Governor T told my investigator that he asked each person if they had someone with them before breaking the news to them. At 10.12am the man's father's partner telephoned the prison to thank Governor T and ask for further information. Following the publication of the draft report, the man's family disagreed with this account and asked my investigator to note that they had, in fact, told Governor T that they were alone at the time but the news was broken regardless.

63. At 11.15am Governor O was telephoned at her home and appointed Family Liaison Officer. She arrived at the prison at approximately 12.00pm. Governor O telephoned the man's girlfriend and father to introduce herself to them.

64. The Metropolitan Police called Governor O in the early afternoon to discuss whether a police FLO should visit the family. As Governor O had been told by the Duty Governor that the family did not want the police to visit them, she cancelled this visit.

65. I understand that the man's possessions were handed back to the family, and the prison contributed to the costs of the funeral.

ISSUES

Clinical care in prison custody

66. Although the man did not have any serious medical concerns, he did come into contact with prison medical staff on a number of occasions. The clinical reviewer from the local PCT, summarised them as follows:

> "During his stay at HMP Wandsworth, the man had a number of health concerns of a minor nature for which a number of specialist appointments were made. These were disrupted by his move to HMP Camp Hill..."

67. In response to the draft report, the man's mother said that she thought he had also been on hold for a leg injury and because of a multi-skills course but the investigator has not seen evidence of this. It is clearly not ideal that someone is transferred from a prison while awaiting medical appointments. However, the doctor from the local PCT writes in his clinical review that:

> " … there is a new PSO [Prison Service Order 3050] out and because of current population pressures, unless life threatening, prisoners can be transferred and then, maybe transferred back nearer the date to arranged outpatient appointments. This is not a practical solution, especially from the Island."

68. It was also noted by the doctor from the local PCT that, although the man was transferred while awaiting medical appointments, he did not mention most of them to staff at Camp Hill. During his first reception health screen at Camp Hill he did say to the nurse that he needed to see a dentist. It was confirmed by the clinical review panel that an appointment with a doctor was arranged but had not taken place when he died. Nurse S described this length of time as the usual period to wait to see a doctor. The clinical reviewer, with the agreement of the panel, made the recommendation:

    The Head of Healthcare should ensure that outstanding appointments are reviewed and addressed as far as is possible within the constraints of the prison

69. Despite these concerns the opinion of the clinical reviewer was that:

> "Overall, in my view, the man received appropriate attention for a number of conditions of which he complained to medical staff and the response times were appropriate. I have therefore concluded that he did receive care equivalent to that he would have received in the community."

Use of cannabis

70. Officers found the man smoking cannabis shortly after he arrived at Wandsworth. In December 2008, he wrote to a friend suggesting that he had

access to cannabis. There are no references to drugs in his prison record while at Camp Hill, and the Ombudsman's investigator discovered nothing to suggest otherwise. He refused the CARATs service at Camp Hill and undertook neither mandatory nor voluntary drug tests.

71. The toxicology report revealed that: "There was no indication of involvement of prescription, nor commonly abused drugs including Ethanol [alcohol] in this death." The clinical reviewer was asked by Mr F, on behalf of the man's family, to consider any impact cannabis may have had on his death. He wrote:

> "Misuse of cannabis can cause mental health problems, particularly when used for long periods of time. However, there is no evidence that the man used cannabis at Camp Hill or while there that he was suffering with mental health problems related to cannabis use."

Transfer to Camp Hill

72. The man's family wanted to know why he had been sent to Camp Hill. They considered it a long way from his home and felt that he should have been able to stay in a prison in the London area. In addition, they told the investigator that Camp Hill had the reputation of a 'punishment prison' with a restricted regime.

73. My investigator asked Governor T why the man had arrived there. It was explained that he began his time in custody in a local prison (Wandsworth). This type of prison serves the courts in their area and primarily holds prisoners for short periods of time. The man's original sentence of 30 months was too long for him to serve in a local prison. Once he was classified as a category C prisoner, the next stage would be for him to be transferred to a category C prison. This type of transfer is managed by the Population Management Unit (PMU) at Prison Service Headquarters and is dependent on the spaces available at the prisons. The man's family were concerned that he was categorised incorrectly. However, he was categorised as category C which is the lowest categorisation a prisoner can initially be classed as. I do not find anything untoward or unusual about this decision.

74. Prisoners from a number of establishments including Wandsworth are allocated to Camp Hill. It appears that a space became available and the man was automatically transferred there. The PMU involved in such transfers is not aware of the particular circumstances of the prisoners involved. It moves the prisoner according to their categorisation and the spaces available.

75. It may be that being transferred to Camp Hill is regarded as a punishment by some prisoners. Governor T told my investigator that approximately 50 per cent of Camp Hill prisoners come from the London area and, although it is not a great distance in miles, the journey is complicated by crossing the Solent. In addition, being on an island can mean that prisoners feel more isolated. It is not accurate to regard transfer to Camp Hill as a punishment as it is part of the usual method of organising the prison population. That said, it is clearly

desirable that prisoners are kept as close to their homes as possible. Unfortunately, in our over-crowded prisons, this is simply not always possible.

The daily regime at Camp Hill

76. Some prisoners may well dislike being at Camp Hill for reasons as described. However, the two prisoners interviewed spoke highly of the prison and did not raise any serious concerns. In addition, one officer mentioned some prisoners describing Camp Hill as a 'bird burner' meaning that the sentence passes quickly.

77. The recent HM Chief Inspector of Prisons report (referred to at the start of this report) indicated that while purposeful activity has improved at Camp Hill, further work needs to be undertaken. It was explained to my investigator that the man who died had not been at Camp Hill long enough to begin work or education.

The man's actions at the Court of Appeal

78. The man initially refused to leave his cell at the Court of Appeal as he did not want to return to Camp Hill. However, it was explained that if he did not voluntarily leave the cell, staff would be obliged to remove him forcibly. He then left the cell of his own accord and returned to Camp Hill. My investigator was told that staff are authorised, where necessary, to use "control and restraint" techniques which involve the use of reasonable force. This was not necessary in this case.

79. The escort staff involved in the man's return to Camp Hill told my investigator that it was quite common to transport prisoners unhappy with travelling to Camp Hill. Camp Hill was said to be often an unpopular destination due to its location on the Isle of Wight. The escort staff said that some prisoners are vehement in their protests, others are violent and some are visibly distressed. The accounts of the man who died are consistent in describing someone unhappy with their situation, but in a rational manner. None of the staff involved were concerned by his behaviour, and were shocked when they found out he had died.

80. I was pleased to hear that the escort staff on the second part of the journey were made aware of the man's behaviour at the Court of Appeal. However, it does not appear that prison staff were told of this upon his return to Camp Hill. I appreciate that his actions were on the lesser side of the spectrum of behaviour that the escort staff frequently witness, but little effort would have been taken to record it on the Prisoner Escort Record (PER). Although I accept that he did not present as being at risk of harming himself, it would have been preferable for the prison staff to be aware of his reluctance to return to Camp Hill.

Escort staff should ensure that information about a prisoner's refusal to return to the escort vehicle is included on the PER.

The man's state of mind after his appeal

81. The man returned from the Court of Appeal at approximately 8.00pm on 3 February 2009. He had won his appeal and his sentence had been reduced by ten months. Despite this, he may well have been disappointed as it appears that he hoped to have walked free from the Court of Appeal. No formal reception screening was undertaken when he returned from the Court of Appeal to check on his mental and emotional well-being and there were no healthcare staff in the prison at that time.

82. The clinical reviewer summarised:

> "The man was not seen by healthcare staff at HMP Camp Hill following his appeal on 3 February. The clinical review meeting made two recommendations in respect to this. Whether an encounter with a member of the healthcare staff on 4 February would have made any difference it is, however, impossible to say."

83. The issue was raised during the meeting for the clinical review, and it was agreed that this situation should not continue. It was explained that healthcare staff were often not aware if people had left the prison if they returned out of hours. The doctor from the local PCT wrote:

> "If a prisoner goes out of the prison for any purpose that could significantly affect them as an individual, a health review, needs to be undertaken. Initially, the admitting orderly officer needs to take responsibility. Whilst not clinically trained they need to speak to the prisoner, make a judgement using their interpersonal skills, looking for signs and symptoms and take further medical advice, would provide a safety net through the night. A system needs to be put into place where someone has ownership and will handover to Healthcare."

84. He recommended that:

All prisoners that return to the prison should be reviewed by reception staff and healthcare should be informed within 24 hours. The Night Orderly Officer should undertake this role during the night by filling out an assessment form as part of their core duties.

Healthcare should undertake an intermediate reception on a returned prisoner within 24 hours.

85. I am pleased to learn that the prison has accepted these recommendations and has already implemented systems to ensure that they are fulfilled.

The man's location alone in a double cell

86. The man's family asked why he was in a cell by himself, especially as he had been disappointed by the result of the appeal. As I have noted above, the prison did not undertake any formal action to check whether he was in any way distressed so it does not appear that this was a factor in assigning him a single cell. In addition, when he first arrived at Camp Hill he had asked for a single cell when one became available, and this may have been a situation where the prison attempted to meet the wishes of the prisoner.

Whether the man who died was distressed at Camp Hill

87. With any apparently self-inflicted death it is important to consider whether there were any warning signs that the person was at risk of harming themselves which were missed. When the man who died arrived at Camp Hill he went through the usual reception processes. The nurse who undertook his health screen noted that he was angry about being at Camp Hill. She told my investigator that this was not unusual and did not prompt her to undertake any further action. During the three weeks at Camp Hill, he did not present any signs of being at risk of harming himself. He did not harm himself and did not appear distressed to any of the officers the investigator spoke to.

88. The investigator spoke to the man's friend who lived in the opposite cell on St James' wing. The man's friend said that he was in good spirits and did not mention being particularly unhappy. He thought that the man might have mentioned some tension with his girlfriend but the man's friend did not think that there was anything unusual about this in a prison setting. The man's friend was extremely shocked by what happened as he said that he had no idea that he might do such a thing.

89. The telephone calls that the man made on 6 February reveal his unhappiness at the thought of his girlfriend going on holiday. It appears that the isolation he felt at Camp Hill was magnified by the idea of her going abroad. Although harsh words were spoken and he appeared to end the relationship, the timing of subsequent calls suggests that this was not a definite decision. He spoke to her several times after the threat to end the relationship. Prison staff would not have been aware of the content of the calls, and would not have monitored them.

90. The final telephone call between the two is relatively conciliatory and they declare their love for each other. These conversations were undoubtedly difficult for the man but they do not clearly explain his later actions.

91. The man's behaviour at Camp Hill elicited no concern from prison staff. The nurse who spoke to him on his arrival did not consider his unhappiness at being at Camp Hill unusual. I agree that this is not a clear indicator of self-harm or suicidal ideation. Officer M also considered the loud telephone call he heard as relatively normal in a prison setting and did not feel the need to follow it up. It might have been good practice to speak to the man to check on his welfare following the conversation but I am reluctant to criticise staff. The

man does not appear to have given any sign that he might consider harming himself – either to staff or to his friend and his actions were a shock to all who knew him.

Response when the man was discovered hanging

92. During interview, operational support grade R assured my investigator that his final roll check undertaken at approximately 5.00am had revealed nothing of concern having looked in each cell. During interview with my investigators, operational support grade R was asked whether he did fully carry out the 5.00am roll check. He replied that he did, but could not provide any detailed recollection of seeing the man who died. However, he stated that he could not have seen anything untoward otherwise he would have raised the alarm.

93. The man was found at approximately 7.20am and there was evidence of hypostasis and rigor mortis. Rigor mortis is the stiffening of the body after death because of a loss of Adenosine Triphosphate (ATP) from the body's muscles. (ATP is the substance that allows energy to flow to the muscles and help them work, and without this the muscles become stiff and inflexible.) Rigor mortis begins throughout the body at the same time but the body's smaller muscles - such as those in the face, neck, arms and shoulders - are affected first. I understand that rigor mortis normally appears within the body around two hours after death, with the facial and upper neck and shoulder muscles first to show its effects. However, it should be noted that the speed of rigor mortis is affected by a number of factors including the size of the person and the temperature of the room.

94. The local Ambulance Service Patient Report Form was completed by paramedic D. It indicates that the paramedics were called at 7.23am and arrived at the man's cell at approximately 7.35am. On the form was written:

> "<u>Conditions unequivocally associated with death</u>
> A) The patient's condition - Hypostasis, Rigor Mortis - Jaw - was incompatible with life.
> B) On my arrival, the patient was in a collapsed state with no signs of life AND, no breathing, no pulse, pupils fixed and dilated, ECG showing Asystole.
> C) There was no evidence of CPR performed in the previous 15 minutes and there were no indications of drowning, hypothermia, poisoning or overdose."

95. The investigator wrote to the Home Office Pathologist to ask if he could provide an estimation of the time of death. The investigator received a reply from the pathologist after the draft report had been issued. The pathologist considered the circumstances in which the man was found and wrote:

> "The descriptions provided by the ambulance service paramedic who attended him at 07.32hr on 7th February 2009 are thus entirely compatible with the man having been alive at 05.00hr that day."

96. The man’s family asked about the knife used to cut the ligature. The investigator has been assured that the knife used was an anti-ligature knife, and was not a Stanley knife.

97. The Night Patrol Officer, operational support grade R, left the prison before Officer C completed her roll check. This meant that when Officer C found the man who died she was entirely alone on St James’ wing and felt uncomfortable entering the cell on her own. It seems probable that the time delay in entering the cell did not impact on the man’s chance of survival. However, this would clearly not be so in every case. The investigator has been unable to review the night instructions but I would encourage the Governor to ensure that they are clear on the responsibilities of staff when confronted with a prisoner in distress.

98. In addition, she may well have felt able to go into the cell had operational support grade R been with her. I am disappointed that staff left prior to the oncoming staff having completed their roll check. I understand that this was not uncommon but it is not acceptable.

The Governor should remind all Night Patrol Officers of their responsibility to remain at their posts until the morning roll check is complete.

Informing the man’s girlfriend and family of his death

99. The only next of kin contact details held by the prison was a telephone number for the man’s girlfriend. Next of kin details are noted when a prisoner arrives at a prison, and I think it important that staff attempt to gather full information. The lack of an address for his family was one of the factors involved in the decision to break the news by telephone.

The Governor should remind reception staff to record the full address and telephone number of the next of kin for all new receptions into prison. If it is not possible to attain accurate details on reception, efforts should be made to obtain and record them as soon as possible thereafter.

100. Governor T told my investigator that he felt very uncomfortable breaking news of the death of a prisoner over the telephone. The man’s family have informed my investigator that they were deeply distressed by the way the news was broken to them. He explained that there were several reasons why he did undertook this course of action.

101. Discussions were held about the possibility of sending a member of staff from Camp Hill to break the news in person. The distance involved meant that it would have taken several hours. Governor T was aware of the possibility of the man’s family and girlfriend finding out from another prisoner before the member of staff arrived in person. Governor T also considered asking the police in his family’s area to break the news. My investigator was told that the local police informed Governor T that it would take at least four to five hours

for them to undertake this role. This too was deemed an unacceptably long delay.

102. The governor also ruled out the idea of using prison staff from a prison in the London area. It was a Saturday and staffing levels would have been low. It was felt that this would have caused an unacceptable delay in breaking the news. Although I accept that it would have taken longer than a telephone call, I would hope that one of the London prisons would be prepared to assist Camp Hill in a task such as this.

103. PSO 2710 says that the news should be broken in person wherever possible. It acknowledges that this is not always possible and lists further options (such as using a FLO from another prison or the police). It notes that breaking the news by telephone should only be done as a last resort. Despite this, I do understand the choice Governor T had to make as there were competing demands to balance. There was obviously a need to tell the man's loved ones as soon as possible, but it had to be done in the most compassionate and sensitive manner possible. I am satisfied that the decision was reasonable at that time, although procedures could have been put in place to minimise the risk of it happening. I would strongly encourage the Governor to develop procedures to ensure that such a situation is not repeated. In addition, it does not appear that a face to face meeting with the man's family took place after the breaking of the news.

The Governor should ensure that Camp Hills's local contingency plan for a death in custody includes specific procedures for attempting to break the news in person.

The Governor should ensure that Camp Hill's local contingency plan for a death in custody makes provision that, where face to face notification of the next of kin is not possible, and the prison have used alternative means, this should be followed up as soon as possible with a visit by an appropriately appointed Family Liaison Officer from the establishment.

Other concerns of the man's family

104. The family also asked about the location of the photos that were found torn up in the bin on St James' wing. The man's family also asked about the letters found in his cell after his death. I understand that these documents were taken by the police as evidence for the Coroner's inquest and have not been seen by the investigator.

105. The man did not telephone his family between his return from the Court of Appeal on 3 February and 6 February and his family asked if there was a reason. I understand that there was a delay transferring telephone credit onto his account. He raised this with Officer M on 6 February who ensured that this was amended.

106. The man's family also asked about him having his belt in his possession. This type of item is only taken from prisoners in extreme circumstances when they

are deemed to be at severe risk of harming themselves. There was no evidence that he was at risk and so he was allowed to keep his belt. However, even if staff had considered him to be at risk of harming himself he may still have been allowed a belt. PSO 2700 states:

> “However, removing personal belongings from a person who is feeling hopeless and depressed … can increase feelings of distress and therefore increase the risk of suicide, self-harm or a higher risk method of self-harm. Where possible, prisoners at risk should be allowed to retain their belongings unless it is clearly unsafe to do so.”

107. The man’s family asked for further clarification regarding the belt as the statement made by the man’s friend appeared to suggest that the man had had his belt removed by the prison. I can confirm that the man’s friend meant that it was him whose belt had been removed by the prison. I apologise if the account of the conversation with the man’s friend was unclear. The investigator asked the prison for further information about the belt that was found in his cell. They were unable to explain when or how he had acquired it. A prisoner’s property is their own responsibility and they may exchange property with other prisoners. The nature of property in prisons means that it can be very hard to establish how prisoners acquire items.

108. The man’s family felt that they were misled by the prison with regard to the funeral costs. They said that they were led to believe the prison would cover the costs of the funeral when, in the event, the prison only contributed towards the overall total. Although the money was not important, his family said that this confusion added to their distress. The issue of the prison’s contribution to the funeral costs is one that is featured time and again in the reports this office publishes. At such a sensitive time, it is important for the prison to be extremely clear on their processes to prevent any misunderstanding. I would remind the Governor of this.

Conclusion

109. Prisoners sent to establishments far from their families often find it hard to deal with their perceived isolation. The man who is the subject of this report clearly fitted into this category, and his unhappiness was increased by events in his personal life. Despite these feelings he appeared, in many other respects, to be dealing well with his time in custody. The decision to end his life was an abrupt one with no real warning signs. I have made recommendations for future conduct at Camp Hill but do not think that this tragic death could reasonably have been predicted. I sincerely sympathise with his family and friends.

RECOMMENDATIONS

1. Escort staff should ensure that information about a prisoner's refusal to return to the escort vehicle is included on the PER.

   The National Offender Management Service accepted this recommendation and said:

   > "This occurrence happened during transportation by an escort services company and not NOMS staff, we do recognise it as good practice and such occurrences would be recorded."

2. The Governor should remind all Night Patrol Officers of their responsibility to remain at their posts until the morning roll check is complete.

   The National Offender Management Service accepted this recommendation and said:

   > "An instruction was promulgated locally by the head of Operations within 48 hours of the incident which stipulates that patrolling staff are to remain within the unit until the oncoming staff have conducted a roll check. Indeed the instruction also required all night staff to remain in the establishment until all rolls are collated."

3. The Governor should ensure that reception staff are encouraged to gather full next of kin details when a prisoner arrives at the prison.

   The National Offender Management Service accepted this recommendation and said:

   > "Instructions were issued to Reception staff within 48 hours of the incident. These instructions are also given to Induction & 1st night staff."

4. The Governor should ensure that Camp Hills's local contingency plan for a death in custody includes specific procedures for attempting to break the news in person.

   The National Offender Management Service accepted this recommendation and said:

   > "The Contingency Plans have been amended as requested. HM Prison Isle of Wight now has a lead Governor grade on Death in Custody who deploys the Family Liaison Officer to deliver the message to the family."

5. The Governor should ensure that Camp Hill's local contingency plan for a death in custody makes provision that, where face to face notification of the next of kin is not possible, and the prison have used alternative means, this should be followed up as soon as possible with a visit by an appropriately appointed Family Liaison Officer from the establishment.

The National Offender Management Service accepted this recommendation and said:

> "The Contingency Plans have been amended as requested. HM Prison Isle of Wight now has a lead Governor grade on Death in Custody who deploys the Family Liaison Officer to deliver the message to the family. The system now employed ensures the deployment of trained Family Liaison Officers and has, due to long distance visits, used the FLO of nearby establishments. When this occurs, our FLO is still deployed to help the family and to give further information."

6. The Governor should remind reception staff to record the full address and telephone number of the next of kin for all new receptions into prison. If it is not possible to attain accurate details on reception, efforts should be made to obtain and record them as soon as possible thereafter.

   The National Offender Management Service accepted this recommendation and said:

   > "See 3 (above) instructions given to Induction & 1st Night managers to ensure compliance."

Recommendations made by the clinical reviewer:

7. The Head of Healthcare should ensure that outstanding appointments are reviewed and addressed as far as is possible within the constraints of the prison

   The National Offender Management Service accepted this recommendation and said:

   > "All outstanding medical appointments a patient may have are reviewed and GP appointment where appropriate made as soon as possible. All reasonable attempts are made to acquire patients IMR/medical records, ensuring outstanding appointments are addressed with the constraints of prison regime."

8. All prisoners that return to the prison should be reviewed by reception staff and healthcare should be informed within 24 hours. The Night Orderly Officer should undertake this role during the night by filling out an assessment form as part of their core duties.

   The National Offender Management Service accepted this recommendation and said:

   > "This is already undertaken though it is recognised a formalisation of the process should happen. This has been taken forward by the establishment and is current practice and has been since the death of the man who is the subject of this report."

9. Healthcare should undertake an intermediate reception on a returned prisoner within 24 hours.

   The National Offender Management Service accepted this recommendation and said:

   > “All returning prisoners (out of the prison for +24 hours) have an intermediate reception undertaken as soon as healthcare are informed.”