

**INVESTIGATION INTO THE DEATH OF A PRISONER
AT HMP LIVERPOOL ON 13 DECEMBER 2004**

REPORT BY THE PRISONS AND PROBATION OMBUDSMAN FOR ENGLAND

AND WALES

November 2005

The prisoner, a man, died at HMP Liverpool on 13 December 2004. This is the report of an investigation into his death. Sadly, the death of the man was one of three apparently self-inflicted deaths to have occurred at Liverpool prison during 2004.

I offer my sincere sympathy and condolences to the man's family and friends for their loss. I know that the staff and prisoners at Liverpool who knew him share those sentiments.

Since 1 April 2004, I have had the responsibility of investigating the deaths of all prisoners, the residents of Approved Premises (probation hostels) and those held in immigration detention. The terms of reference for this particular investigation can be found in an annex to the report. I am indebted to two investigators from my office for undertaking the investigation. One of my office's family liaison officers has maintained contact with the man's family.

I also wish to thank the Governor of Liverpool and her staff for their help and co-operation during this investigation. I am grateful to North Liverpool Primary Care Trust for arranging a clinical review of the man's care.

The man had served his country with distinction in the armed forces, but was increasingly troubled by flashbacks. Arising out of this investigation, I have made a number of recommendations but have also identified good practice at Liverpool that is worthy of commendation.

Stephen Shaw CBE
Prisons and Probation Ombudsman

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Summary

1. The man was a 31-year-old man from the Liverpool area. He died on 13 December 2004 at HMP Liverpool. The investigation team reviewed the man's prison record and interviewed prisoners and staff.
2. Information from the man's father and his prison records show that he had previously attempted to take his own life.
3. The man was convicted at Bristol Crown Court on 20 November 1998 for an offence of indecent assault. He was sentenced to five years imprisonment. The sentence required him to register on the sex offenders' register for an indefinite period and he was registered on 9 May 2001 whilst at HMP Full Sutton. He was subsequently released on 31 January 2002. A condition of his licence and the register was that he registered his address with the police and that no persons under the age of 18 should live at those premises.
4. As part of his licence conditions, he lived with his father and had to inform the police of all future changes of address. The man became an in-patient at Clatterbridge Psychiatric Hospital, Wirral, between 2 March and 8 July 2004, where he took two drugs overdoses and attempted to hang himself. On leaving hospital he failed to return to live with his father. The man was arrested on 12 August 2004, as a person on the sex offenders' register who failed to notify his change of address between 8 July and 12 August 2004.
5. He appeared at Wirral Magistrates Court on 13 August and was remanded in custody to HMP Liverpool. Before leaving the court, the man was identified as being a suicide or self harm risk. He arrived at Liverpool at 4:25pm and was placed on G wing. He was not placed on F2052SH self-harm monitoring. He remained on G wing until he went to Liverpool Crown Court on Friday 10 September and was sentenced to two months imprisonment. However, due to the time he had already served on remand, he was released immediately.
6. On Monday 11 October 2004, the man attended Birkenhead police station and registered his change of address from his father's home to his mother's. As a result of police enquires, it became clear that he was not residing at his mother's address. The police circulated the man's details, as he was again not complying with the requirements of the sex offenders' register. The police traced the man on 3 November at a hospital where he was having a psychiatric assessment. He readily admitted breaching the order and arrangements were made for the staff to contact the police upon his discharge. The man was admitted later that day to Clatterbridge Hospital as a voluntary psychiatric patient.
7. The police were informed of the man's impending discharge from Clatterbridge hospital on 16 November. On attending the hospital, they were informed that

earlier in the day he had harmed himself by cutting his wrists. A hospital doctor assessed the man as being suitable for discharge. He was arrested and conveyed to Wirral police station. He fully admitted breaching the sex offenders' register, was charged and remanded in custody to appear at Wirral Magistrates' Court the following day.

8. Wirral Magistrates remanded the man to Liverpool prison. He was identified as a vulnerable person and placed on K wing, which is the wing designated for vulnerable prisoners, and placed in cell K5-9. A self-harm monitoring form, F2052SH, was raised as he was identified at Reception as likely to be at risk of suicide or self harm.
9. The man made four telephone calls from the prison during the evening of 26 November, three to his partner and the last when his mother's answer phone took the call. The calls to his partner indicated that they had been in a relationship, but that she did not want to acknowledge or continue with the relationship for fear of having her children taken into care. The man mentioned that he was not taking his prescribed medication.
10. On the afternoon of Monday 30 November, the man's cell was unlocked and he was found hanging from a ligature which was attached to the plumbing pipes at the rear of his cell. He had also cut his left wrist. Due to the prompt action of staff, he was resuscitated and taken to outside hospital for further treatment. He had left a note indicating he had intended to take his life.
11. The man returned to the prison during the evening of the same day and placed on a one-to-one watch in the healthcare centre. He was discharged back to K wing after a case review three days later on 3 December, and located in cell K4-02.
12. The man remained on K wing, on self-harm supervision, as a result of staff concerns regarding his mental health. He was the subject of a psychiatric assessment on Friday 10 December by a psychiatrist, but his findings were not communicated to K wing staff. It was decided that he should remain on the wing.
13. The man was found hanging in his cell at 2:45pm on Tuesday 13 December, from a ligature made from his bed sheet. It was tied around his neck and right wrist, and attached to a window catch. A member of staff initially burnt through the man's ligature with a cigarette lighter and another cut it off. Cardiac pulmonary resuscitation (CPR) was commenced, and an ambulance summoned. After staff and paramedics attempted to resuscitate him for a considerable time, the locum prison medical officer pronounced that he had died at 3:20pm.
14. The man's cell mate in K4-02 was interviewed and said that, prior to his death,

he had been going through the man's belongings when he was out of the cell and had found a note indicating that he was going to take his life. He regrets that he did not bring the note to the attention of staff.

15. The Governor and chaplain visited the man's parents as soon as practicable during the evening and broke the sad news of his death. The Governor and Chaplain subsequently attended the funeral.

Conduct of the Investigation

16. The investigation was opened at the prison on 16 December 2004 by two of my investigators. The Governor and her staff produced the man's core file and a number of other documents for examination. The records had been secured after his death and stored in the Governor's office.
17. Notices were issued to staff and prisoners informing them of my investigation.
18. Representatives of the Prison Officers' Association (POA) and the Independent Monitoring Board (IMB) also met the investigators to be informed of the investigation and gave their full co-operation. Contact was made with Merseyside police.
19. Documents relating to the man's time in custody were examined, including an additional entry to the Inmate Medical Record completed by an outside medical practitioner which was inserted at a later date. My investigators contacted the Coroner's Officer at Liverpool, to brief him on the nature and scope of my investigation and request a copy of the post mortem report. At the time of writing has not been received.
20. The North Liverpool Primary Care Trust was contacted and has commissioned a clinical review of Mark's care whilst in prison custody. At the time of writing the review is still awaited.
21. My two investigators and the Liverpool chaplain met the man's parents on 6 January 2005 where their concerns were raised and discussed. Another meeting between the investigator and my Family Liaison Officer took place on 25 January.

The Man

22. The man was 31 years old at the time of his death. He was born on 26 October 1973 in Birkenhead. He was divorced and had a daughter and a step-daughter. His parents live independently of each other. As a schoolboy, the man had been hailed a hero and commended by the Army Cadets after rescuing a drowning child from a lake. He joined the Army Cadets whilst at school, and fulfilled his childhood ambition by joining the army at 15. Between May 1990 and June 1997, he served in the Royal Armoured Corps. In addition to service in the United Kingdom and Germany, he also had postings to Bosnia and to Northern Ireland. According to his parents he loved the army and service life. He was mentioned in dispatches as being the youngest serving British soldier in Bosnia. He left the army to get married in June 1997. His discharge certificate of service showed that his conduct was graded as exemplary. Prior to his discharge he had been promoted to corporal. He has a younger brother who is in the army, and a sister who lives with her family.
23. The man's mother described him as a private person who kept his feelings to himself. She never learnt the true extent of what he had seen in Bosnia, and said that he only opened up to her when he had been drinking alcohol and told her some of what he had seen and done.
24. On leaving the army, the man was very unsettled and had six jobs in quick succession that generally lasted about two weeks. His last job was as an MOT Inspector. Prior to his conviction in 1998, he was of good character. His two subsequent terms of imprisonment were as a result of him breaching his sex offenders' order by failing to notify the police of his change of address.
25. Prior to being remanded in custody in 2004, the man had formed a relationship with a local woman. She had two small children from a previous relationship and it was believed that he was living with them.

HMP Liverpool

26. Liverpool was constructed in 1855 to replace a much older and more cramped establishment in the centre of Liverpool. It covers some 22 acres. Most of the original hospital and cellular accommodation remains, though it has been extended over the years. There are eight wings, all of which are in use, having been refurbished and equipped with integral sanitation. The prison holds both sentenced and remand prisoners and serves the whole of the Merseyside area.

27. At the time of his death, the man was located on K wing which houses vulnerable remand and convicted prisoners. K wing is on five floors with floor one being below ground level. All cells have in-cell television. Prison cell K4-02 is a double occupancy cell with bunk beds, in-cell sanitation with modesty panel, a desk, chair and wardrobe.

Events prior to The Man's death

28. The man was originally convicted of indecent assault at Bristol Crown Court on 20 November 1998. He was sentenced to five years imprisonment. He served his sentence at the following prisons:

Bristol	9 October 1998
Guys Marsh	22 January 1999
Bristol	8 April 1999
Full Sutton	5 August 1999
Released from Full Sutton on 31 January 2002	

29. The prison records identified the following attempts and references to self harm:

HMP Bristol

On 1 October 1997, whilst remanded in custody awaiting trial, the man was found in a cell with a shoelace tied to a radiator and his neck. He was fully conscious and responded to instructions. He was removed to a strip cell.

HMP Guys Marsh

On 26 February 1999, he cut his left wrist.

HMP Full Sutton

On 3 March 1999, a community psychiatric nurse wrote on his medical record, "I am concerned he may attempt suicide again".

HMP Full Sutton

On 20 March 1999, the man made two unauthorised calls to his then wife, stating that he was going to commit suicide. Officers were alerted and found a piece of twine shaped like a noose, which could take a man's, body weight.

Appeal Court

On 11 October 1999, he slashed his left wrist with a razor blade whilst appearing at court to appeal against his sentence and conviction. He believed the proceedings were not favourable, and slashed his wrists.

30. The nature of the man's conviction required him to be registered on the sex offenders' register for an indefinite period. He was placed on the register on 9 May 2001 whilst at HMP Full Sutton. A condition of the register was for him to live at a fixed registered address where no persons living under the age of 18 resided. The man registered his father's address in Liverpool and went to live with him.

31. On 8 July 2004, Merseyside Police were notified that the man had been an

in-patient on a psychiatric wing at Clatterbridge Hospital. On discharge, he did not return to his father's address. He gave himself up to the police on 12 August for breaching the conditions of the register. He was arrested and remanded in custody to appear at Wirral Magistrates' Court on 13 August 2004. He pleaded guilty and was remanded in custody pending sentence. He was located on G wing after going through Liverpool reception process.

32. The man appeared at Liverpool Crown Court on 10 September and was sentenced to two months imprisonment. He was released immediately owing to the time served on remand.
33. On Monday 11 October, the man attended Birkenhead police station and registered his change of address from his father's address to his mother's. However, as a result of police enquiries, it became evident that he had not actually lived with his mother.
34. The police found the man at Clatterbridge Hospital on 3 November where he was undergoing a psychiatric assessment. He was subsequently admitted as a voluntary psychiatric patient until 16 November.
35. On Tuesday 16 November, the man was arrested, after being discharged as a voluntary psychiatric patient. Earlier in the day he had slashed his wrists, but was deemed fit enough to be discharged. He was arrested and conveyed to Wirral Police Station, where he was charged and remanded in custody to appear at Wirral Magistrates' Court on 17 November.
36. A suicide self harm warning form was completed whilst he was in police custody by Police Sergeant Moore who wrote:

"Had cut his wrists with a razor blade prior to arrest. Attempted to hang himself on 08/04. "
37. The man arrived at Liverpool on 17 November and a F2052SH (self-harm at risk form) was opened. It noted that he suffered post traumatic stress and that he had attempted to hang himself on 8 April. At 7:30pm he was placed on K wing in cell K5-9. A Senior Officer in reception interviewed him and informed him of the help he could receive whilst in prison including the wing Listeners' scheme (a support service provided by prisoner volunteers trained by the Samaritans).
38. On 19 November, the man attended a review of his F2052SH. It was decided to continue to monitor him through talking with him and observing him on the wing before making any further decisions.
39. On 26 November, he appeared by video link to Wirral Magistrates' Court and was remanded in custody again until 17 December. Records of telephone

conversations that evening show that the man said he was not taking his prescribed medication. The calls to the man's partner indicated that their relationship was at an end as she was fearful of having her children taken into care.

40. There was nothing further significant noted on his prison records until approximately 4:10pm on Tuesday 30 November. The man's cell was unlocked by a prison officer on the man's wing to allow his cell mate to go in. The cellmate found the man alone and unconscious in their cell, having attempted to hang himself from low level pipes at the rear of their cell. He had slashed his left wrist. The officer asked the man's cellmate to shout for help and then entered the cell. He loosened the ligature and was assisted by other staff. Owing to the timely intervention of the staff, he was revived and taken by paramedics to outside hospital for further treatment. He had left a note indicating his state of mind.
41. The man returned to the prison at 9:00pm the same day and was placed on a one-to-one watch in the healthcare centre. On Friday 3 December, after a psychiatric assessment, he returned to K wing where he was allocated a different cell, K4 02, sharing with another prisoner.
42. On 3 December, another review of the man's F2052SH was carried out. He told the review team that he was still having flashbacks and finding it hard to switch those feelings off. He said that he had no active thoughts of self harm and was feeling positive for the future. He was looking forward to seeing the British Legion Welfare Officer who was due to visit him to discuss sheltered accommodation. He was told that if he experienced any further thoughts of self harm he should go to the wing centre surgery or contact the health care centre. The F2052SH monitoring continued.
43. On Monday 6 December, the man opened up the wound on his left wrist and a Healthcare Officer re-stapled the wound. The next day, a further review took place and it was decided that he should continue to be monitored under the F2052SH arrangements.
44. The Royal British Legion County Field Officer (ex-services welfare officer) met the man at the prison the same day. He was able to offer the man the prospect of sheltered accommodation, following a period in an ex-serviceman's retreat in Wales. When interviewed for this investigation, the welfare officer said that he thought the man was positive and had something to look forward to upon his release from prison.
45. The suicide prevention officer at Liverpool, a senior officer, met the man on K wing on 7 December as a result of his act of serious self harm on 30 November. He said that the man did not present to him as someone who was unable to cope. The man had told him that he was an ex-serviceman who had tours of

active service in Bahrain and Northern Ireland and suffered from post traumatic stress. He had said that he had served three years for offences against his daughter. He said he had admitted the offences to protect his ex-wife and that the Criminal Cases Review Commission was looking into his case. He also explained that the Royal British Legion was going to provide support. The Senior Officer thought that the man was progressing towards some self control.

46. At the 2052SH review, the man was asked a series of questions and replied as follows:

Question: What were the factors which immediately led up to the incident?

Answer: My condition just overtakes me at times. I get this overwhelming urge and just do it, I have been receiving medication but that has been changed in the last week and the new one doesn't seem to be working".

Question: What if anything do you think could be done by the Prison that is not being done?

Answer: No. Nothing.

Question: What if anything is there that can be done to help you right now?

Answer: Nothing I've got a job in the laundry, I'm getting on with people everything is okay. I'm back at court soon and I've been told I can be sentenced up to six months imprisonment.

47. On 8 December, it was decided that the man should not work in the laundry. He had been assessed as at high risk of self-harm and there were poisonous chemicals in the laundry.

48. The following day, a review of his self-harm status (F2052SH) was carried out and he was informed the reviewers that he was a low risk of self-harm and signed a collaborative plan. He was happy to gain employment and said that he would inform staff and listeners if he was at a low ebb. He would keep his mind active during the quiet moments. The man would continue with wing supervision and monitoring and was informed of listeners and other help systems.

49. On Thursday 9 December, a Senior Officer, who was one of the reviewers, was extremely concerned as to the man's state of mind and considered that he should be moved to the healthcare centre. Such were this Senior Officer's concerns that he took the unusual step of reporting his concerns to the Deputy Governor, who instigated an assessment of the man's needs. A Registered Medical Nurse saw the man later that day in the healthcare centre. A Health Care Collaborative Holistic Assessment was carried out and the following was

noted:

Staff perception of the problem

Serious risk to himself - recently hung himself and suffers from flashbacks that precipitate acts of self-harm

Staff suggested solution

Staff believe he needs intensive psychiatric input and a referral to a single point

Patient's Perception of problem

Deep depressive episodes that make him think about killing himself

Patient's Suggested Solution

Continue with prescribed medications. Referral to psychiatrist. To maintain contact with the British Legion

HCC Staff's perception of problem

Continues to pose a high risk of self-harm/suicide and appears to be reluctant to engage to explore your problems

HCC Staff's suggested solution

To explore issues plus design a diversional plan to cope with flashbacks

Collaborative Plan

Referral to single point for an urgent psychiatric assessment. Work helps and redirects him from suicidal thoughts and subjectivity and objectivity helps. The man has agreed to try and read whilst in his identified vulnerable period whilst trying to sleep in order to direct himself from his flashbacks. Healthcare staff will continue to monitor as required

Patient to Complete

I have got no thoughts of self-harm and enjoy the rest of my life, as I should do as normal.

The man's overall risk assessment was scored as low.

50. On Friday 10 December, the man was assessed by a psychiatrist from the Scott Clinic, who was in the prison at the time. The psychiatrist recorded in the inmate medical record (IMR) that the man was adamant that he did not want to be transferred to the healthcare centre, and noted that his suicide risk would only escalate if he were forced to move to there. As a result the man remained on the wing.
51. The next day, a nurse recorded that the man's stated he had no current problems and said he was well. He considered that he was orientated well in

time, place and person. He did not express any self harm or suicidal thoughts and he showed some insight, saying that he has a personality disorder. It was Nurse's opinion that he appeared to be coping on the wing.

52. The man's daily supervision and support record shows that he was observed four times in his cell the following day.

53. On Monday 13 December, an officer began duty on K wing at 8 am. He checked the man twice during the morning and found him in what he described as his usual quiet mood. He was sitting alone in his cell, with the door bolt shot open to prevent closure. At 1:00pm his cellmate went to court and so the man was located in an adjoining cell with three other prisoners. They were interviewed for the investigation and they described the man as chain smoking and quiet whilst he was with them. After lunch, the cell was unlocked by another wing Officer and the three other prisoners went to work. As the man was not going to work, he was relocated in his own cell and the officer again shot the door bolt open to prevent the man locking himself in. The officer asked the man how he was and he replied fine. He asked him if he was going to watch TV and he replied, "I don't watch TV much."

Discovery of The Man's Death

54. At 2:45pm, the wing officer was performing a routine check on the man. He looked through the cell window and saw the man standing at the back wall facing him. He saw that the bolt was still shot but when he tried to open the door it would not move and it appeared that the door had been barricaded. The Officer said that he instinctively knew that something was wrong. He began to run for assistance when he met and spoke to a drugs worker, on the stairs. He asked her to contact Control and call for medical assistance. The drug worker realised the urgency of the situation and immediately went for assistance.
55. The Officer then spoke with a wing Officer and both immediately went to the cell. Initially, they could not get into the cell as furniture had been placed behind the open door. They pushed the door open and forced their way in. Once inside the cell, the Officer could see that the man was hanging from the window catch with a ligature which appeared to be a cotton sheet eight to nine inches in length. His arms were by his side and his knees were slightly bent, but his feet were touching the floor and it appeared to both officers that he was standing up.
56. This Officer used his own cigarette lighter to burn through the ligature, and the man slipped down to his knees. The Officer believed the man to be dead. He noticed that the man had tied a strip of cotton sheet - the same as the ligature - around his right wrist. The first Officer on the scene summoned assistance through a passing drugs worker.
57. The deputy primary care manager was walking along K 2 landing at the time. He said that at 2:45pm a drugs worker asked him to go with her to a cell on an upper level. On reaching cell K4-2, he saw two Officers in a state of shock standing on the landing. He went into the cell and he saw the man slumped against the far wall.
58. The deputy primary care manager states that the man had a ligature attached around his neck that he believed was tied to the horizontal pipes which run along the far wall. The deputy primary care manager used his cut-down scissors to cut the ligature near to the back of the man's neck, and lowered him on his back on the floor. He checked for signs of life and radioed for assistance. (I think it most likely that the Officer had already burnt through the ligature so that the man slumped to the ground, and that the deputy primary care manager actually cut the ligature where it had tightened on the back of the man's neck.)
59. The deputy primary care manager began cardiac pulmonary resuscitation (CPR), and requested an ambulance via his radio. The primary care manager joined the deputy primary care manager in the cell together with a healthcare nurse.
60. The primary care manager took over chest compressions from her deputy

whilst he concentrated on mouth to mouth resuscitation using a facemask. The primary care manager set up the defibrillator and attached the defibrillator pads to the man's chest.

61. An officer commenced a log of events at 3:00pm outside the cell. At 3:05pm, two paramedics entered the cell. One of the paramedics inserted an airway and reconnected an ambu bag, whilst the deputy and primary care managers continued with CPR. The paramedics' ECG monitor monitored the man's condition. The prison doctor was called at 3:15pm when he pronounced that the man had died.
62. At 3:25pm, all staff vacated the cell. The police were notified and carried out a full forensic examination of the cell and took statements from staff and prisoners.
63. The Governor and the chaplain left the prison as soon as practicable to personally notify the man's parents.
64. A note written by the man prior to his death was found in the cell. The note indicated that he had intended to take his life and his cellmate has identified it as the one written by the man days earlier.

Family Liaison

65. The man's family has been pleased with the contact they have had with the prison following his death. As noted, the Governor and the chaplain together delivered the sad news of the man's death and also attended the funeral. The man's mother has written to the prison thanking the staff for trying to save her son's life.

Clinical Review

66. A clinical review of the man's healthcare needs was requested and the reviewer was asked to consider the following issues:

(i) A prisoner stated that the man used to "palm" his medication and dispose of it either by giving it away or putting it in the toilet. Did the current system for administering medication on K wing allow prisoners to "palm" medication?

(ii) The man made a serious suicide attempt on 30 November 2004 and was taken to outside hospital. He returned the same day to be placed in the healthcare centre where he spent three days before returning to K wing. Is it usual for someone who has made such a serious attempt on his life to be returned back to his normal wing location after three days?

(iii) It is clear that K wing staff had serious concerns about the man's location on 10 December, to the extent that the Deputy Governor was consulted. The Psychiatrist of the Scott Clinic examined the man and considered transfer to outside hospital but the man remained on K wing. Did the Psychiatrist examine the man by appointment, or was it because of concerns from K wing staff? How was the decision made for the man to remain on K wing?

(iv) Is it usual for a doctor to write up a page from an inmate's medical record when out of the prison? Does this practice run the risk of documents being mislaid, and not fed into the core inmate's medical record? Is the urgency with which the Psychiatrist attempted to contact the doctor on 10 and 13 December an indication of how concerned he was about the man?

(v) What arrangements are there to inform wing staff after a psychiatrist has seen a prisoner?

Conclusion

68. The man had harmed himself on previous occasions during his terms of imprisonment. The staff at Liverpool had quite clearly and correctly identified him as being at risk of further self-harm. After he attempted to hang himself on 30 November 2004, wing staff acted promptly and correctly in resuscitating him and ensuring that he received treatment at outside hospital. He was returned to the prison the same day and placed in the healthcare centre where he remained until 3 December when he was returned to K wing. He was present during subsequent reviews of his self-harm status and presented as low risk of self-harm. The Nurse saw him on 9 December 2004 in the healthcare centre and assessed him as low risk of self-harm.
69. The Psychiatrist assessed the man on 10 December on K wing but wing staff were not informed of the details of the meeting. He made an entry to the man's medical record which was provided to the investigation team after the beginning of the investigation. This said that he considered that the man was at greater risk of self-harm in the healthcare centre. A written care management plan was not produced, and neither was the interview recorded on the self harm form 2052SH.
70. One of the first officers on scene ran from the cell for assistance. Both officers were subsequently found outside the cell in some considerable shock. There was no delay before other staff attended and emergency aid was given.

Recommendations

Operational

1. Consideration should be given to issuing anti-ligature knives to all Liverpool wing officers as standard issue. This would assist the preservation of life in similar incidents.
2. The Governor should consider whether it is feasible for all officers to have up to date first aid qualifications.

Recommendation 2 is not accepted by the prison service.

Healthcare

As the clinical review has yet to be received the following recommendations relate to the findings of my investigation rather than those of the clinical review team. Any further recommendations identified by the clinical review will be included in a supplementary report.

3. There should be better communication between healthcare and wing staff, including provision of an appropriate management plan to enable continuity of care.
4. It was apparent from the recordings of the man's telephone calls and an interview with his cellmate that he had not been taking his medication as prescribed. I recommend that the procedures for dispensing medication be reviewed to ensure compliance with prescribed treatment.

Recommendation 4 is not accepted by the prison service.

5. When a doctor assesses a prisoner as at risk of harming themselves, an F2052SH (or now ACCT) form should be opened and completed in full, including a decision about the most appropriate location, a management plan and the appropriate levels of observation.

Good Practice

Locating the man with other prisoners at 1:00pm on 13 December 2004 was a sensible safety measure.

The Governor should commend those responsible on 30 November 2004 for the successful attempt to resuscitate the man, and also the subsequent endeavours of staff to keep him alive on 13 December. Some staff were involved on both occasions.

It was also good practice for the Governor and Chaplain to visit the man's parents in person to inform them of his death.

The reception Senior Officer should be commended for his dedication and persistence in highlighting his concerns about the man.

