Investigation into the circumstances surrounding the death of a man at HM Young Offender Institution Stoke Heath on 22 January 2005

Report by the Prisons and Probation Ombudsman for England and Wales

November 2005

This is the report of an investigation into the death of a man at HM Young Offender Institution (YOI) Stoke Heath on 22 January 2005. He was serving a six year sentence for offences of robbery. The purpose of my investigation was to establish the circumstances and events surrounding the young man's death, including the quality of care provided by the Prison Service.

The investigation was led by one of my colleagues. I am grateful for all the assistance that the investigation team received from the Governor of Stoke Heath and his staff, including the establishment's Liaison Officer.

A key objective of all my investigations is to make sure that the bereaved family has the opportunity to raise any concerns and contribute to my inquiries. In this case, the investigation team was able to meet with the young man's father and partner in separate meetings and also with his brother. I am most grateful to them for agreeing to hold these meetings at what must have been a very difficult and distressing time.

I offer sincere condolences to the young man's family and friends in their sad loss. The young man was only 18 years of age when he died and had just become a father.

STEPHEN SHAW CBE
PRISONSAND PROBATION OMBUDSMAN **NOVEMBER 2005**

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SUMMARY

The young man was remanded into custody at HMYOI Brinsford on 3 September 2004, for offences of robbery, and was later sentenced to six years in prison on 8 October. He was sent to Stoke Heath.

On arrival at Stoke Heath, the young man was placed on an F2052SH 'Self Harm At Risk Form', as concern had been expressed about his vulnerability and risk of self harm by a member of Crown Court staff. During the First Reception Health Screen, he was reported to have been tearful and upset at the length of his sentence. The young man was initially located in the healthcare unit as an in-patient for observation. He moved from there to E Wing on 9 October, where access to support and the Samaritans phone help line was explained to him.

The F2052SH was closed on 13 October. The young man was reported to be feeling better and to have settled onto the wing. He moved to F wing on 22 October where he got into trouble for refusing to work and for fights with other prisoners. The young man was placed on closed visits after being passed a rosary during a visit and being overheard during a telephone call asking his partner, to bring a lighter in for him.

A second F2052SH was opened on 26 October after the young man said that he felt like hanging himself as a result of being placed on closed visits. He was especially upset as he thought he would not be able to hold his baby, which his partner was expecting. On 29 November, the young man was again involved in a fight with other prisoners.

During a telephone call with his partner on 1 November, the young man made threats towards her and threatened to kill himself. He blamed her for the fact that he was on closed visits. The young man again threatened to kill himself on 3 December because his television was not working. On 6 December, and again on 7 December, he told staff that he was being bullied by other prisoners. The young man was transferred to B wing on 11 December for his own safety following an investigation of the bullying allegation. The F2052SH was closed on 15 December.

A third F2052SH was opened on 22 December at the young man's request as his partner had ended their relationship. This was closed on 29 December as the relationship had resumed.

On 20 January 2005, The young man received a visit from his partner, her father and the new baby. The young man and his partner had been talking about getting married and the Chaplain had been counselling them about this. This visit was the first time the young man had seen the child. During the visit he apparently got upset because his name was not recorded on the birth certificate. However, the visit ended amicably, with the young man agreeing to have photographs taken with his partner and the baby.

On 21 January, the young man had a telephone conversation with his partner during which he argued with her over the issue of the birth certificate. He asked to be taken back to his cell. He was tearful and made superficial cuts to his wrists. The young man was placed on an F2052SH and seen by a nurse who decided that he should remain on B Wing and see a medical officer the next day. At 1.20 am on 22 January, an Officer Support Grade (OSG) the night patrol officer, checked on the young man and found him hanging in his cell.

This report makes a total of ten recommendations.

CONDUCT OF THE INVESTIGATION

The lead investigator for the Prisons and Probation Ombudsman was assisted in the investigation by a Senior Investigator and an Assistant Ombudsman.

During the course of initial inquiries, the investigation team were shown around Stoke Heath and visited the cell where the young man died. They reviewed all the relevant documentation and established a chronology of events. Notices were issued to staff and prisoners telling them of the investigation and offering them the opportunity of contributing. There were no responses to these notices.

One of my Family Liaison Officers contacted the young man's family and offered them the opportunity to meet with her and the investigator to discuss the purpose of the investigation and to raise any concerns or questions that they would like explored and addressed. They met with the young man's father on 17 March 2005 and with his partner in a separate meeting, also on 17 March. A meeting with the young man's brother took place on 10 May. The concerns raised are examined further in this report.

The investigation team met the Governor of Stoke Heath, a representative of the local Prison Officers' Association (POA), and a representative of the Independent Monitoring Board (IMB) to tell them about the investigation process. Six members of staff were interviewed during the course of the investigation. They were all offered the opportunity of being accompanied by a work colleague or Trade Union official.

The investigation team also met with the safer custody manager, the training manager, and a representative from the Anti Social Behaviour Unit.

The investigation team contacted Her Majesty's Coroner to tell him of the nature and scope of the investigation. The Coroner provided a copy of the Post Mortem Report of 28 January 2005. This recorded the cause of death as 'hanging'. The report also noted six superficial cuts running horizontally across the front of the young man's left wrist which appeared to be of very recent origin.

The investigation team had telephone conversations with an Acting Detective Inspector and a PC responsible for investigating the incident on behalf of the Police. The police were advised of the scope of the Ombudsman's investigation and provided copies of police statements taken as part of their investigation. They were offered the co-operation of the Ombudsman's investigation and to share any information which might be relevant to their inquiry. Transcripts of the interviews undertaken by the investigation team were sent to the police.

Shropshire County Primary Care Trust organised a clinical review of the healthcare provided to the young man while at Stoke Heath.

BACKGROUND INFORMATION

The young man

The young man was born on 29 August 1986, and was 18 years old when he died. He was remanded into custody at HMYOI Brinsford on 3 September 2004, charged with offences of robbery occurring between 28 August 2004 and 1 September 2004. He was convicted and sentenced to six years imprisonment on 8 October and sent to HMYOI Stoke Heath.

The young man had previously been in the care of social services. He had been charged with various offences between 2002 and November 2003 and sentences had included an Action Plan Order, a Supervision Order, Community Rehabilitation Orders and financial penalties. Youth Offending Service records indicated that over this period the young man who died had engaged positively with the conditions of his supervision. He had been the subject of two separate 18 months Community Rehabilitation Orders imposed by Youth Court on 6 August 2003 and 22 September 2003. His last offences, before 28 August 2004, were committed between 14 November 2003 and 22 November 2003 for which he was given a financial penalty by Magistrates Court on 2 July 2004. West Mercia Area Child Protection Committee (ACPC) are conducting a serious case review of the circumstances surrounding the young man's death, as he had been a looked after child. My investigation team has agreed to forward a copy of the draft report to them to assist in their review.

The sentence on 8 October 2004 was the young man's first custodial sentence and he was clearly shocked by its length. Before this, he had been employed as a double glazing salesman, and was living with his partner in a rented flat. His partner was expecting the young man's baby in January 2005. When he arrived at Stoke Heath he was upset and shocked at the sentence, but said that he had no thoughts of self-harm or suicide as he had his partner and the baby to think about.

The young man and his partner built up a good relationship with one of the Chaplains at Stoke Heath, and the young man told the Chaplain hat he wanted to marry his partner. The Chaplain was looking into this and she arranged counselling sessions with the couple individually and together. They discussed their expectations, how difficult it would be to get married in prison, and how to sustain the relationship after the birth of the baby. The young man remained determined to go ahead with the wedding.

The baby was born on 13 January 2005. The young man had a visit, with the child and his partner's father, on 20 January 2005. The details of the visit are described by the Chaplain. She said that the young man was not happy about his partner's father attending, but was persuaded by the Chaplain that the young woman needed moral support as this was her first prison visit with the baby. During the visit, the young man became angry about the child's birth certificate as his name was not included as the father. His partner had

brought forms for the young man to sign that needed to be witnessed by a solicitor, and the Chaplain said she would help to facilitate this. Eventually, the young man agreed to have photographs taken with him, his partner and the baby. The Chaplain described his partner's visits with the young man as always following the same pattern: the young man becoming angry with his partner, starting to cry, and then calming down and apologising for his behaviour. She said that the young man joined a parenting course and participated fully.

The young man clearly considered the Chaplain to be supportive to both him and his partner. One of the notes that he left after his death confirmed that.

The young man's father told the investigation team that he had several concerns that he wanted the investigation to address. First, he had concerns over the length of his son's sentence which he considered was too long. He also believed that the young man was bullied while at Stoke Heath and suggested that the investigation team might talk to the young man's brother who had also been at Stoke Heath. He asked the investigation team to clarify whether the young man was taken to hospital appointments and what these were for. He also questioned why the young man did not have a cellmate if Stoke Heath were concerned about his risk of self-harm, and whether the young man's cell was searched for evidence that he was going to take his own life. He was also concerned about the staffing levels on B Wing and in Stoke Heath generally, and questioned whether they were adequate. Finally, he raised concerns about the funeral arrangements for his son. Although the young man's brother was allowed by HMYOI Werrington to attend the funeral, he said this was handled insensitively by the escorting prison. The brother was escorted by five prison officers. He was not allowed to read an eulogy he had written for the young man or to carry the coffin and was not allowed to sit next to his mother during the service.

The young man's partner did not have any specific concerns. She described in general terms her relationship with the young man and her visits to him. Her last visit had been the one on 20 January 2005, when she had brought the baby to see him. She described the visit as a difficult one, particularly in relation to the young man raising the issue of his name not being on the birth certificate as the child's father. The young woman said that she was adamant that the baby was going to have the same surname as her to avoid any potential difficulties with using the young man's surname, as he was in prison. She confirmed that she had been actively working on having the young man's name put on the birth certificate and in this respect she brought the relevant legal documents with her on 20 January for him to complete. She said that the visit had ended amicably with the young man agreeing to have photographs taken with her and the baby.

The young man's brother was in Stoke Heath between 15 October 2004 and 29 November 2004, at the same time as the young man. He was transferred to Werrington YOI on 29 November where he remained until 25 April 2005. He was then transferred to Thorn Cross YOI, where he is currently located. The investigation team met him and he showed them letters from the young

man saying that he had been assaulted in the shower and had been involved in fights at Stoke Heath. A letter dated 16 December 2004 said that two prisoners attacked the young man in the shower and his eye was injured. In another letter, the young man said that a prisoner hit him with a spade. The brother said that when he was at Stoke Heath, he was not on the same Wing as the young man but he had two Wing visits to see his brother. The young man told him that if he did not get parole he would kill himself and that he was going to end his relationship with his partner. The brother said that he told the young man not to be stupid and not to finish with his partner. The brother did not disclose this information to prison staff. He said that he also spoke to the young man briefly on another occasion when they were both in the segregation unit at the same time.

The brother said that he had been escorted to the young man's funeral by five prison officers from Werrington and there were a further five prison officers from Stoke Heath at the funeral. He said that he sat in the front row of the chapel with the prison officers who had escorted him and was handcuffed throughout. Werrington had promised him that the handcuffs would be covered but they were not. He wanted to carry the coffin and read a piece he had written, but he was not allowed to do either. The Chaplain from Werrington read the eulogy he had written. The brother said that he applied for compassionate release for the day, as he wanted to attend the funeral and wake without being handcuffed. He said that this request was refused by the Governor of Werrington. He was upset and felt cheated about not being able to take part in the funeral in the way that he had wanted. He could not understand why he had been escorted by five prison officers, when his prison record was good and he was on enhanced privileges.

The brother confirmed that he had been asked by staff at Werrington if he needed somebody to talk to after he was told about the young man's death, and again after the funeral, and that staff at Thorn Cross were aware of what had happened. When he was in Werrington, he was allowed extra visits and telephone calls with his family after the young man's death. His father visited him there.

HMYOI Stoke Heath

Stoke Heath was built in 1964 as a category C adult prison. Two years later it was converted, and has since been used to hold young offenders between the ages of 15 and 21. The accommodation is divided into separate areas for juveniles between the ages of 15 and 17 and young adults between the ages of 18 and 21. The accommodation for young adults consists of four main residential units, B, E, F and G Wings. E Wing consists of double cells, while B, F and G Wings comprise single cells only. On 22 January 2005, Karl was located on B wing, which is designated as a 'healthy living' unit and held 72 prisoners at that time. B Wing is unique as most young people on that unit ask to be accommodated there. They sign a voluntary drugs testing (VDT) compact and have access to a good range of courses and support, including stress management, help with smoking cessation, and drug and alcohol courses. There is a well-equipped fitness suite which can be used during association periods.

The Healthcare Unit is a new two storey centre and was opened in July 2004. It has eight in-patient rooms all of safer cell construction and with CCTV. The use of a TV is agreed on an individual basis and is risk assessed. Patients are not allowed to smoke there.

The local strategies for the care of prisoners at risk of self-harm at Stoke Heath are in accord with national policy. The local policy for the prevention of suicide is published within the prison and is available to both staff and prisoners. The governor in charge of Safer Custody holds monthly meetings with all departmental area representatives. Since December 2004, these meetings have been called Safeguards meetings and address both anti-social behaviour and suicide prevention which were previously addressed in separate meetings. The governor explained that there is a new Suicide Prevention Policy (dated January 2005). The Suicide Manager, confirmed that this document has not been implemented yet. The policy has been delayed, as in February 2004, Stoke Heath was identified as one of four establishments in the West Midlands to pilot and roll out the new Prison Service ACCT Document (Assessment Care in Custody and Teamwork), the new suicide prevention arrangements. This has had significant training implications to provide training for case managers, assessors and staff of all disciplines in the foundation module before going live on 16 May 2005. In the meantime, the new Suicide Prevention Policy document is being adapted to incorporate the spirit of the new Prison Service instructions for suicide and self harm prevention. Stoke Heath is therefore still using the old version (dated July 2003). That policy makes it clear that prisoners on a F2052SH (a form used for prisoners at risk of suicide or self harm) on normal location should be checked at times specified in the Intervention Plan, but at least three times

per shift. If more frequent observation is required, a prisoner would need to be admitted to the Healthcare Unit. Not all staff interviewed were clear about the required level of observation.

The roles of staff in respect of F2052SH procedures are detailed in that policy and are described in an annex to this report. The policy makes it clear that it is wrong to assume that self-injury is carried out to manipulate others. It states: 'there is a very common view that self-injury is used by prisoners to manipulate 'the system' or individuals in it. Like many other things self-injury can sometimes be used to manipulate others. However, by far the most important reason that people injure themselves is to deal with unresolved distress or emotional needs. People injure themselves for the effect it has on them not on other people. It is only seldom and never exclusively carried out solely to manipulate others or to gain attention.' There are several references made by staff to Karl 'manipulating' the system and these are highlighted within this report.

The governor said that staff receive training in suicide prevention as part of their induction and thereafter should be given refresher training every year. There is a monthly programme for the refresher training. She said, however, that as far as she is aware this training has not been taking place. She explained that staff are currently being scheduled to be trained on a new system for suicide prevention (ACCT).

The training manager for Stoke Heath, provided a list of Suicide Prevention courses delivered in April 2005. This showed that ACCT Manager training, a two day course, had been scheduled for 31 March and 1 April, 11 and 12 April and 14 and 15 April. A half day Suicide Prevention refresher course had been scheduled for 7 April and 21 April.

THE YOUNG MAN'S TIME AT STOKE HEATH

The young man was charged with offences of street robbery and escorted from the Police Station to Magistrates Court on 3 September 2004. The Prisoner Escort Record (PER) which accompanied him from the Police Station made no mention of any self harm or suicidal intentions. The young man was convicted but not sentenced. He was remanded into custody at HMYOI Brinsford on 3 September 2004 and was to return to Magistrates' Court on 13 September. The pre-sentence report indicated that a custodial sentence would be a new and daunting experience for him. The young man was aware of how seriously courts view street robberies and was preparing himself for a possible lengthy sentence. He was also concerned about how his partner was going to cope. No self-harm or suicidal intentions were noted during the first reception health screen assessment at Brinsford.

8 October - first F2052SH opened

The young man appeared at Shrewsbury Crown Court on 8 October and was given a six year sentence. A member of staff in Shrewsbury Crown Court raised a self harm warning form for the young man as he was considered to be a suicide risk due to the shock of his sentence. The young man was transferred from Shrewsbury Crown Court to Stoke Heath. The member of staff from Shrewsbury Crown Court phoned Stoke Heath to advise them that a self harm warning form had been raised for the young man.

When the young man arrived at Stoke Heath he told reception staff that the shock of his sentence had made him say that he would harm himself but that he was fine. An F2052SH was immediately opened by Officer Harper, a member of reception staff at Stoke Heath. A First Reception Health Screen was undertaken by a nurse. The young man was described as tearful and upset, and shocked at his sentence. He said he had a partner and a baby on the way, but had no thoughts of self-harm or suicide as he had too much to lose. The assessment revealed that the young man had received psychiatric treatment when at school and was prescribed antidepressants at nine years old. The young man said that he had self-harmed at 13 years old. He was located in Healthcare to be observed every 30 minutes, and scheduled to be seen by a doctor the next morning. The young man was frustrated as he was not able to smoke and did not have a TV in the Healthcare Unit.

The young man saw a doctor the following day, 9 October. He was angry about his sentence but was keen to leave healthcare and to be located on one of the Wings. The young man said that he had no thoughts of self-harm. He was discharged from healthcare to E Wing. The young man remained on an F2052SH and a support plan was implemented, which was for him to receive appropriate Wing induction, speak to Wing staff and Senior Officers if he had any problems, and to receive continued support from healthcare. When the

young man arrived on E Wing, he was still concerned with the length of his sentence, but did not voice any other worries or concerns. The available support was explained to him, that is Wing staff support, healthcare support, Samaritans and prison Listeners. (Listeners are prisoners specially trained by the Samaritans to assist other prisoners by listening to their problems.)

On 11 October, when the young man's F2052SH was reviewed, he said that he did not feel suicidal and had no idea of self-harm. He said his focus at the time was appealing against his sentence, and he was aware of how to do this. The young man was taking legal advice. The investigation team did not find any evidence that he had appealed against his sentence.

On 13 October, the F2052SH was closed. The case review confirmed that the young man had initially been shocked at his sentence but had become much more settled.

On 8 November, the young man was spoken to regarding his attitude to work in the Assembly Department. He said he hated the job and wanted a job change and would smash things up if this did not happen. An anti social behaviour alert form was raised. On 11 November, he again refused to work in the Assembly Department. The young man was placed on report and the adjudication hearing was heard on 12 November. He pleaded guilty to refusing to work, and his earnings were stopped for five days.

On 14 November, the young man was issued a further warning regarding his poor attitude towards work. On 16 November, he punched his cell wall and he saw a doctor on 17 November for a hand injury. No consideration was given to reopening the F2052SH and the incident was not treated as a deliberate self harm incident.

The young man was involved in a fight on 19 November and sustained bruising and slight swelling to his right side, and swelling to left elbow. He pleaded guilty at the subsequent adjudication hearing and received punishments suspended for a month.

The young man was again placed on Governor's report on 23 November for receiving a rosary from his partner during a visit. There were concerns over what else might be passed during a visit and apparent evidence that he was asking his partner to bring in a lighter. The young man became abusive to officers when leaving the search room. During the following adjudication hearing he admitted receiving the rosary but said that he had not realised this was against the rules. He pleaded guilty to the charge and was punished by loss of earnings and canteen facilities for 10 days and loss of association and TV for 14 days. He was very upset after the adjudication and very tearful. The young man was placed on non-contact visits on 25 November.

The young man first mentioned that he was being bullied on 26 November. He told an officer in reception, that he was being bullied by other trainees to have drugs sent in. He would not give names of those who were bullying him.

A governor recommended that an anti-bullying investigation should be carried out.

26 November - second F2052SH opened

The young man told the officer in reception that he would hang himself, as he was on non contact visits and the officer placed him on an F2052SH. The young man also made a formal complaint about being placed on non-contact visits. This decision was reviewed on 30 November, in light of his personal circumstances and he was allowed to have open visits as a matter of compassion.

The young man was seen in healthcare after coming from the Wing in tears. He was kept in healthcare overnight and returned to the Wing on 27 November. The young man was then interviewed by a Senior Officer (SO) regarding the bullying issues but he would not name names. The SO explained that no further action could be taken. The young man did not appear overly concerned about that.

On 28 November, the young man's personal officers spoke to him about the bullying issues. The young man talked about his difficult childhood and was disturbed and crying, saying he could not take any more and wanted his TV back. The officers were to look at the possibility of counselling for him. There is no evidence that this happened.

Following a F2052SH case review on 29 November, the young man was given his TV back as a matter of compassion, as he had forfeited his TV for 14 days on adjudication on 23 November.

On 29 November, The young man had another fight at work. He returned to the Wing in a tearful state and said that he had been assaulted for no reason. The young man received an eye injury but it did not require any medical treatment. He was told by a Governor that he was going to be allowed to have an open visit with his partner and his baby.

On 30 November, a Wing manager interviewed the young man. He said that he was being bullied by other prisoners and was under pressure to give cigarettes and a lighter to other prisoners. He was reluctant to give names. An officer from the young manufacturing Unit submitted a report with further information. The young man's personal officers were to work with him to try to get more information.

On 1 December, The young man attended the adjudication concerning the fight he had on 29 November. He pleaded not guilty and the charge was dismissed. During a monitored telephone call, the young man became abusive and threatening to his partner. The phone call also revealed that he told his partner he would kill himself. The visit with his partner that day was monitored. The young man was still on a F2052SH. He was formally told that he would be allowed an open visit with his partner and the baby.

The young man said that he had been 'beaten up' that morning at work by two prisoners from F Wing. The Governor recommended that his personal officer should interview him about these issues. The young man's TV was broken and he demanded that it be fixed. The young man was offered a move to healthcare but he did not want to go as he said he would not have a TV and would not be allowed to smoke there. The young man said that he wanted to move to B Wing and he spoke to an officer on B Wing who made an entry in the young man's core record to say that he would see about a move.

On 2 December, the young man showed an officer a letter written by another prisoner who threatened to harm him. He said that he had been assaulted by a prisoner, whom he named, when he was hit with a spade at work. The young man said that he would name five other bullies if he was moved to B or E wing. There was a recommendation from a security manager that the young man's Wing manager be informed, that the Security Unit interview him about the bullying, and that consideration be given to moving him to another Wing. Also on 2 December there is a note in the young man's F2052SH which says 'very manipulative individual who is using the 2052SH to try to get his own way'.

On 3 December, the Wing Manager noted that the young man was manipulating the F2052SH system, threatening to cut himself because his TV was not working. She recommended that consideration be given to a Wing move and a job change for him. It was subsequently agreed that the young man would have a job change from 6 December, and a two-week plan for good behaviour would be implemented before a Wing move was looked at.

The young man had a F2052SH review on 6 December. He still refused to identify the bullies. The young man said that the bullies were from his Wing but did not give him any trouble on the Wing. An officer wrote in his summary of the review, 'He is using the bully issue to manipulate a work and Wing move. As the one thing he did say was that the lads are off this Wing. But they give him no grief on the Wing. I find this hard to credit.' The young man later named one prisoner who he said was bullying him.

The young man tried to stay off work but was not put on report. A Case conference was convened. The young man said he would get kicked if he stayed and he had previously had two fights at work. The young man's Wing was informed and he was removed from machine training. The young man was told he would have to return to work, and the situation would be monitored. Instructors were made aware of the situation.

The young man was sent to work on 7 December. He later returned to the Wing complaining that he had been threatened by other prisoners that he would get 'beaten up'. He was moved to a quieter workshop, but that did not seem to suit him. He later gave the names of four prisoners who he said were bullying him and a bully alert form was raised.

On 8 December during the F2052SH review it was decided that the young man was not strong enough to be taken off the F2052SH. It was considered

that the bullying issues at work needed to be sorted out and that he needed to settle in one area for a while. The young man attended an adjudication for refusing to work the previous day. He pleaded guilty, but the charge was not proceeded with. It was recommended that Security Unit and F Wing conduct an investigation into the allegations of bullying. An officer wrote an observation in the Security Report that the young man was warned to come up with names or he would be put on Governor's report.

On 9 December, the young man attended an adjudication hearing for fighting on 29 November. This charge was also dismissed.

On 10 December, the young man alleged that he was assaulted in the shower but he would not name the person involved. He sustained a bruise to his eye. There is an entry on the F2052SH by a Senior Officer on B Wing, which says, 'He is manipulating all those who are trying to help him.'

On 11 December, the young man was moved from F Wing to B Wing for his own safety, on the instruction of a Senior Officer. The Security Unit was to conduct its own investigation in a sensitive manner.

The young man was taken to hospital on 13 December for treatment to his eye. The F2052SH was reviewed and closed on 15 December. There is no record of this review on the form.

22 December - third F2052SH opened

The young man was much more settled on B Wing, and there were no further issues until 22 December when he was distressed after a phone call with his partner. The young man said that she was going to end the relationship. He wanted to be placed on an F2052SH, although he said that he did not have any thoughts about self-harm. A razor was removed from his cell and he was placed on an F2052SH. The young man was sent to healthcare for assessment. He patched things up with his partner and said that he felt much better, and had no intention of self-harm. A doctor assessed him and considered it was safe for him to leave healthcare. The young man was therefore was sent back to the Wing.

On 23 December, in an outgoing letter to his partner, the young man said he would hang himself if she ended the relationship. A Senior Officer spoke to the young man about the letter and the young man said the letter had not been meant in that context.

On 27 December the young man spoke briefly to his partner on the telephone and he spoke to a Chaplain about the marriage arrangements.

The F2052SH was closed on 29 December. The young man had patched things up with his partner and had enrolled on a parenting course. The young man seemed positive about the future.

On 6 January 2005, the young man attended a further hospital appointment for his eye injury and was advised to continue using eye drops**.**

The young man's baby was born on 13 January. On 14 January the young man attended an adjudication on a charge of idleness. The charge was not proceeded with. On 20 January the young man had a visit from his partner and his child, as previously described.

EVENTS OF 21 AND 22 JANUARY

On 21 January at around 7pm, the young man was upset after a phone call with his partner and asked to go back to his cell. An officer took him back to his cell. At around 7.45pm, the same officer was locking prisoners up after association. He got to the young man's cell and was concerned about him as he was crying, had overturned his chair in his cell and thrown some letters on the floor. The officer spoke to the young man in his cell. As he was talking to him, he noticed superficial cuts to his wrist. He talked to the young man for approximately 15 minutes, and once again the young man told him that he did not want to go to healthcare as he would not have a TV and would not be allowed to smoke there. The officer spoke to his colleague, another officer, who agreed that the young man should be put on a F2052SH. The colleague told the first officer that, if he was unsure, he should refer to the Senior Officer. The first officer referred to the Senior Officer who agreed that the young man needed to be put on a F2052SH. The first officer explained to the young man that he was going to put him on a F2052SH as he was concerned for his wellbeing. The young man was put on a F2052SH at 8:05pm.

This was the first F2052SH that the first officer had completed in a real situation. The Senior Officer left him to complete the F2052SH. He had already stayed a long time past the end of his shift. He was satisfied that the first officer was properly trained in completing an F2052SH. The first officer called for healthcare support. The young man was left alone in his cell for approximately 20 minutes, while the first officercompleted the paperwork and waited for a member of healthcare staff to arrive. Night staff came on duty shortly after.

At night B Wing is staffed by an Officer Support Grade (OSG) who is supported by a Night Orderly Officer and Assistant Night Orderly Officer who cover the whole prison. Their respective roles are detailed in the prison's Operational Instructions.

The night staff on 21 January- a Senior Officer who was the Night Orderly Officer, the Assistant Night Orderly Officer and the Night Patrol Officer - came on duty around 8.30 pm. The Assistant Night Orderly Officer and the Night Patrol Officer were present when a nurse arrived to see the young man at 8.45 pm. The nurse noted that the young man no longer had thoughts of self-harm. He told her that he did not want to be admitted to Healthcare as it would make him worse because he would not be able to smoke or watch TV. She noted that the young man maintained good eye contact and communication throughout her meeting with him. She decided that the young man should stay on B Wing, that the level of supervision should be 'as per F2052SH', and he should see the medical officer the next day. Healthcare support would be available in the meantime if required. A healthcare support plan would have been put in place after he had seen a doctor. The assistant Night Orderly Officer was content with the nurse's decision not to locate the young man in Healthcare. No interim support plan was put in place. Page two of the F2052SH requires completion by a Residential Unit Manager. This

was not done by either of the senior Officers, who were aware that the F2052SH had been opened. As a result there was no consideration given as to what needed to be done to help the young man on normal location, and no level of observations was agreed.

An officer wrote in the Wing Observation Book, 'cuts to wrist, he has been seen by healthcare and assures the nurse that he will not hurt himself further. 2052SH opened at 20.05. Night patrol informed.' The night staff, were all aware of this information. The Night Patrol Officer checked the young man at 9.10 pm and 12:05 am and this was noted in the F2052SH. The first entry states that at 9.10 pm the young man was 'sitting on his bed and appeared subdued in manner but said that he was ok when asked.' At 12.05 am on 22 January 2005, the Night Patrol Officer noted that the young man 'was sat watching TV. He asked for some toilet paper.' The Night Patrol Officer says that he checked the young man again at 12.20am and 12.40am. This was not recorded on the F2052SH. Since the young man's death, Stoke Heath has implemented a system of staff ringing the cell bell twice to indicate they have spoken to a prisoner and this registers via the cell bell call system.

At 1.20 am, the Night Patrol Officer again checked the young man and saw that he was hanging. He raised the alarm and said that within a few seconds he was joined by the Assistant Night Orderly Officer and two officers. The Night Patrol Officer went to collect an emergency suicide pack and switched on the landing lights.

An officer unlocked the cell door. According to Operational Instructions, OSG's on night patrol duties are issued with a cell key in a sealed pack and should only use them in cases of grave emergency, for example a cell fire or apparent suicide. During night patrol, cell doors should only be unlocked when two officers are present, unless in an emergency situation when life is threatened. OSG's must raise the alarm on the prison radio and ensure that a response has been received stating that assistance will be sent immediately before entering the cell.

On opening the cell door the young man was found hanging by a ligature. The three officers supported the young man's body, removed the ligature from his neck and placed him upon the bed. They started to conduct cardio pulmonary resuscitation (CPR).

The Night Orderly Officer was in the communications room with a colleague when the emergency 'code blue' incident message was broadcast over the prison radio system. In the Suicide Management policy document, code blue means a prisoner is having difficulty breathing, code red represents an incident involving blood spillage, and code brown represents an incident with a definite possibility of loss of life. The two officers immediately went to healthcare to collect a Staff Nurse who collected the 'code blue bag' from a cupboard. This bag contains resuscitation equipment. The Night Orderly Officer escorted the Staff Nurse to B wing. Nursing staff do not have the keys required to gain access to all parts of the prison during the night patrol, hence the need for the escort. The other officer remained in the Healthcare centre to

locate an oxygen cylinder and face mask which he then took to the young man's cell. The Staff Nurse did not know the whereabouts of the emergency oxygen cylinder.

Upon arrival at the young man's cell, the Staff Nurse checked the young man's pulse and breathing which were absent. She checked his airway and she then continued mouth-to-mouth resuscitation assisted by an officer who performed cardiac massage. The Staff Nurse then used an automatic defibrillator. The Staff Nurse's attempts at resuscitation are not recorded in the young man's medical record. The investigation team understand that all nurses from Healthcare are appropriately trained in the use of the defibrillator and basic life saving skills and that they receive annual refresher training and updates. One officer is reported to have told the Staff Nurse that the young man was lifeless with no pupil reaction upon his arrival at the scene. The investigation team found that prison officers do not routinely receive lifesaving skills training.

Paramedics arrived at the scene at 1.30am and resuscitation was attempted for a further 20-30 minutes. The emergency ambulance arrived at 1.40 am and a Doctor confirmed death at 2.55 am.

EVENTS AFTER THE YOUNG MAN'S DEATH

Stoke Heath's governing Governor explained that the prison care team were on site after the young man's death to help any staff who needed support. Prisoners on the young man's landing were unlocked and were told about what had happened, by a governor. They were all taken to the chapel. One of these prisoners was identified as being particularly upset and was placed on an F2052SH. The rest of the Wing were gathered together and told by the wing governor. Other Young Adult Wings were told the basic facts of what had happened by senior staff. The Senior Officers in the Juvenile Wings were given an information note of what to tell the juvenile prisoners if they were asked. A prisoner on a juvenile wing was identified as being related to the young man and he was seen individually and told by staff. A governor also ensured that the young man's brother was supported by staff at Werrington and he was given permission for extra telephone calls to his family and extra visits.

The prison liaised with the Police Family Liaison Officer in terms of contact with the family and his partner. The chaplain and a governor visited the young man's father, mother and partner on 21 January, on separate visits. The Chaplain also accompanied the young man's family to identify the body.

The Chaplain led prayers in the prison chapel for staff and prisoners who wanted to pay their respects. She also assisted the family with the funeral arrangements, along with the prison family liaison officer. She was asked by the young man's family to conduct the funeral service.
Cards of sympathy were sent to the family by prisoners from B wing.

CLINICAL REVIEW

In accordance with procedures agreed with the NHS, the investigation team advised Shropshire Primary Care Trust (PCT) of the young man's death. The PCT then arranged to undertake a clinical review of the healthcare provided to him while at Stoke Heath. A multi-disciplinary panel undertook the review. This consisted of a Commissioner for Prison Healthcare, a Nurse Consultant with responsibility for Self Harm and Suicide Prevention, a Director of Quality and Nursing, and a doctor who is aPrimary Care Medical Advisor. Their report is attached. It makes a number of recommendations which are in line with my own conclusions and views. The report also highlights a number of issues in respect of healthcare staff completing paperwork. In particular, the review says that the position or role of healthcare staff making entries in the Inmate Medical Record (IMR) was not always recorded, and a small number of entries in the medical record only noted that the young man had been seen by healthcare staff and did not record why he had seen or any outcome of the consultations.

CONSIDERATION AND CONCLUSIONS

The young man had a troubled time at Stoke Heath. He had concerns about the length of his sentence and was worried about his partner. He also said that he was being bullied and there were concerns about his behaviour. He was the subject of four separate F2052SH self- harm at risk forms during his time at Stoke Heath.

The incident on 21 January was the first time the young man had self-harmed. Given the number of F2052SH forms that had been opened in a short period of time, it might have been appropriate to refer the young man for a mental health assessment. However, this is not a requirement according to the current Suicide Prevention Policy.

Recommendation:

The NOMS Safer Custody Group should consider whether it should offer new advice to Establishment suggesting that, in cases where a number of self harm incidents occur or at risk forms are raised within a short period of time, a mental health assessment should be carried out.

Had the young man been admitted to the Healthcare Unit on 21 January, when he was seen by a nurse, his death might have been prevented as a result of increased levels of supervision and observation. However I am satisfied that the decision made by the nurse to leave the young man on B Wing was reasonable and justified given his presentation to her.

The Suicide Prevention Policy makes clear that, when an F2052SH is opened by an officer, it should subsequently be endorsed by a Senior Officer and an interim support plan implemented. This did not happen with the F2052SH opened by the officer on 21 January. Although I do not criticise the decision that the young man should be cared for on the Wing, I am concerned that there was no plan about how this was to be done.

There are several references within the paperwork indicating that staff were of the opinion that the young man was manipulating the F2052SH system. These remarks are unfortunate and inappropriate

I believe the wrong emergency code was used when the young man was found. An emergency code blue was called when a code brown was the correct one to use. However, I note that the codes are not very clearly defined in the Suicide Prevention Management policy document and I do not believe the outcome was affected.

When the F2052SH was opened on 21 January 2005, the young man was left on his own in his cell for 20 minutes in a distressed state. Care should have been taken to ensure that there was somebody with the young man during this time.

Recommendation:
Stoke Heath's new Suicide Prevention Policy should be implemented without delay and should cover the above issues, providing clear guidance to staff.

Some staff were unsure of about the required frequency of checks that should be made during night patrol on prisoners subject to a F2052SH or ACCT.

Recommendation:

The Governor should remind staff that when a self harm at risk form is opened it should clearly state the level and frequency of observations that should be made.

Recommendation:

A training needs analysis should be carried out to cover training in suicide awareness, risk assessment and prevention, taking into account the new ACCT procedures.

The Night Patrol Officer did not enter the young man's cell immediately on discovering that he was hanging. According to Operational Instructions, OSG's on night patrol duties should only enter a cell on their own, using the key in the sealed packs, in cases of grave emergency. During night patrol cell doors should only be unlocked when two officers are present, unless in an emergency situation. OSG's must raise the alarm on the radio and ensure that a response has been received stating that assistance will be sent. In this case the delay in entering the cell after the alarm had been raised was minimal and was unlikely to have made any difference to the outcome. However, staff should be reminded that they can enter a cell alone in an emergency situation, being mindful of their own safety and the individual circumstances of the situation.

I am also aware that Prison Officers at Stoke Heath do not routinely receive life saving skills training.

Recommendation:

Governor should remind staff that that they can enter a cell alone in an emergency situation, being mindful of their own safety.

Recommendation:

Consideration should be given to providing prison officers with basic life saving skills training and annual updates.

During his time at Stoke Heath, the young man alleged that he was being bullied by other prisoners on a number of occasions. I am entirely satisfied that these issues were correctly dealt with and appropriate action was taken, resulting in the young man being moved to another Wing (B Wing) for his own safety. The young man settled well on B Wing. I do, however, have concern that an entry on 1 December which suggested that the young man might benefit from counselling does not appear to have been followed up. This is an issue the Governor will wish to consider to ensure that such recommendations are properly followed through.

I am also concerned that, in one instance, there was a threat to place the young man on Governor's report if he did not name those responsible for the allegations of bullying against him.

Recommendation:

The Governor should remind staff that it is not appropriate to say that a prisoner will be put on report for not giving the names of bullies.

The young man was also subject to a number of adjudication hearings while at Stoke Heath. I am satisfied that these adjudications were all conducted fairly.

CLINCAL REVIEW

The clinical review made a number of recommendations which I endorse. In particular:

On responding to the emergency on 22 January, the Staff Nurse did not know where the emergency oxygen cylinder was located.

Recommendation:

All new staff joining the healthcare unit, whether on a temporary or permanent basis should be shown where the equipment is kept as part of their induction. The member of staff responsible for responding to emergency calls should check the location, presence and working order of all emergency equipment at the beginning of each shift.

Paperwork relating to the young man which was completed by healthcare staff did not always record the position or role of the member of staff making the entry.

Recommendation:

Each member of healthcare staff making a note in the healthcare record should state their position along with their name.

A small number of entries on the electronic healthcare record system relating to the young man and following consultations only noted that he had been seen and did not record why he had been seen by healthcare staff.

Recommendation:

Entries on the electronic system should always include full details of the consultation, so that the reasons for, and the outcomes of, medical consultations and interventions are clear, thus enabling appropriate continuity of care.

RECOMMENDATIONS:

POLICY:

The NOMS Safer Custody Group should consider whether all prison officers should be provided with basic life saving skills training and annual updates.

The NOMS Safer Custody Group should consider whether it should offer new advise to establishments suggesting that, in cases where a number of self harm incidents occur or at risk forms are raised within a short period of time a mental health assessment by a mental health practitioner should be carried out.

OPERATIONAL:

Stoke Heath's new Suicide Prevention Policy should be implemented without delay and should cover the following issues, providing clear guidance to staff:

- **When a self harm at risk form is opened by an officer it should subsequently be endorsed by a Senior Officer and an interim support plan should be implemented.**
- **References by prison staff which indicate they were of the opinion that prisoners are manipulating the self harm system are clearly inappropriate**
- **Emergency codes to be used should be should be clearly defined in the Suicide Prevention Management policy document.**
- **That it is not appropriate to leave a prisoner on their own for a prolonged period when they are in a distressed state.**

The Governor should remind staff that when a self harm at risk form is opened it should clearly state the level and frequency of observations that should be made.

A training needs analysis should be carried out to cover training in suicide awareness, risk assessment and prevention, taking into account

the new ACCT procedures.

The Governor should remind staff that that they can enter a cell alone in an emergency situation, being mindful of their own safety.

The Governor should remind staff that it is not appropriate to say that a prisoner will be put on report for not giving the names of bullies.

HEALTHCARE:

All new staff joining the healthcare unit, whether on a temporary or permanent basis, should be shown where the equipment is kept as part of their induction. The member of staff responsible for responding to emergency calls should check the location, presence and working order of all emergency equipment at the beginning of each shift.

Each member of healthcare staff making a note in the healthcare record should state their position along with their name.

Entries on the electronic system should always include full details of the consultation so that the reasons for, and the outcomes of, medical consultations and interventions are clear, thus enabling appropriate continuity of care.

OBSERVATION:

The investigation team met the dead man's brother at Thorn Cross YOI and he complained of his treatment by Werrington YOI when he was escorted to his brother's funeral. He has been advised that this is not within the remit of my investigation, but he has been told how to make a formal complaint to Werrington YOI if he so wishes.

OBSERVATION OF GOOD PRACTICE:

I consider Stoke Heath's contact with the young man's family to have been very sensitively handled and I commend those involved. It must have been a comfort for the family at a very difficult time. The interventions of the Chaplain are particularly commended.

COMMENTS FROM THE PRISON SERVICE:

The Prison Service has pointed out that the five members of staff from Stoke Heath who attended the young man's funeral were invited to do so and accepted the opportunity to attend the funeral and pay their respects.

The Prison Service has also pointed out that the fact that the young man's brother was escorted and handcuffed was a matter for the Governor of Werrington and resulted in a properly conducted risk assessment. Once it was decided to escort the brother in handcuffs, the situation was discussed by Governors of both prisons. They agreed that it would not be practicable for the brother I to assist in carrying the coffin while in handcuffs. They say that they also agreed that it would be insensitive to require the brother to stand in front of the congregation at the church, to read an eulogy, while handcuffed, and that it was agreed with the young man's family that the eulogy would be read by the Chaplain from Werrington and a copy was placed on the young man's coffin.

The Prison Service has also pointed out that the correct emergency code was used when the young man was found. Code blue is in fact the code to use in this situation and there is appropriate resuscitation equipment to be brought to the scene when a code blue emergency is called.