

**Investigation into the circumstances surrounding the
death of a man, a prisoner released from HMP Sudbury on
temporary licence
in March 2010 who died the same day**

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

August 2010

The man was in his early forties when he died on 13 March 2010. He had been approved for day release to undertake community work as part of his resettlement plans and was released from HMP Sudbury on temporary licence on 13 March. It was the fourth time that he had been released and he was found later that morning hanging from a tree in a public park. For the purpose of this report, I have concentrated in the main from the time when he arrived at Sudbury in August 2009, although I have included background information from when he first went into prison.

As part of the normal process for receiving prisoners the man was asked by officers and healthcare staff whether he had any suicidal thoughts. None were noted and I am satisfied that throughout his imprisonment there was never any suggestion that he was at risk of suicide or harming himself.

The investigator and Family Liaison Officer join me in offering our sincere condolences to his family and friends for their sad loss.

I wish to thank the Governor of Sudbury for making the necessary facilities and information available to the investigator. I also thank the prison Liaison Officer for his assistance.

In the course of the investigation, I asked for a clinical review to be carried out into the medical care and treatment of the man received in custody. The clinical review was led by a doctor and he had an assistant. I am grateful for their assistance and report.

Jane Webb
Acting Prisons and Probation Ombudsman

August 2010

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SUMMARY

In April 2008, the man appeared at a Crown Court having been charged, along with his son, with causing grievous bodily harm. They were found guilty and remanded into prison custody pending sentence and taken to HMP Nottingham.

The man had been imprisoned on three previous occasions. His prison record suggests that he settled in well after being sentenced, although on one occasion it was suspected that drugs had been sent to him. This was later found not to be the case and he was recategorised as a category D prisoner and transferred to Sudbury.

Whilst at Sudbury, and as part of the normal routine for preparing prisoners to return to the community he was given temporary day release to be with his family. Although prison authorities and probation staff were unaware the man's relationship with his wife was in difficulties. Those difficulties eventually led to his wife wanting to end the relationship.

On 13 March 2010, the man was released for the fourth time on temporary licence. He was expected to return to the prison that evening. However, after he returned to his home, it would seem that his wife confirmed she wanted a divorce.

From what has been learned from the police, the man left the family home and went to a local pet shop where he purchased a dog lead. After leaving the shop he telephoned his wife to say he was going to a local park and intended to end his life. His wife telephoned police and they commenced a search of the park and, as part of that search, scrambled the police helicopter.

In the meantime, a member of the public walking her dog found the man hanging from a branch, high up in a tree. She telephoned the emergency services and they attended. Due to the height, it was some time before the man was taken down. Because the police had prevented the paramedic from climbing the tree or approaching the body, by the time he was taken down, it was too late for paramedics to attempt to resuscitate him. I understand the man had used the dog lead to hang himself.

The clinical reviewer mentions a medical procedure at HMP Nottingham (which had no bearing on the man's death) I have forwarded a copy of his report to the prison Head of Healthcare for consideration. Finally, although I make no formal recommendation, I invite the National Offender Management Service (Prison Service) to remind prison healthcare what the Chief Inspector of Prisons said in her most recent document "Expectations" about continuity of care.

In her introduction she said "Expectations is the basis for robust, independent and evidence-based assessment of conditions in prisons and the treatment of prisoners. Its content and approach have proved helpful to others who are monitoring and examining prisons, here and in other jurisdictions. It is, and should remain, a core part of the methodology of effective prisons inspection in England and Wales."

The Chief Inspector of Prisons said “Prisoners should be cared for by a health service that assesses and meets their health needs while in prison and which promotes continuity of health and social care on release. The standard of health service provided is equivalent to that which prisoners could expect to receive in the community.”

THE INVESTIGATION PROCESS

1. When the Ombudsman's office was notified on 13 March 2010 of the man's death, the investigation was allocated to a Senior Investigator. He contacted the prison and arranged to open the investigation on 17 March.
2. On 17 March, the investigator met a Detective Constable (DC) at the prison. The DC is the prison intelligence officer and he gave the investigator further information about what had occurred. He added that the Coroner had held a post mortem and the cause of death was hanging.
3. The following day the investigator met the Deputy Governor, prison Liaison Officer, two prison Family Liaison Officers, Clinical Nurse Manager, and two members of the prison's Independent Monitoring. The purpose of the meeting was to explain the Ombudsman's role in investigating deaths in custody and to identify those people who the investigator wanted to speak to.
4. Over the two days the investigator was at the prison, he carried out a number of informal interviews with prison staff and prisoners. One of the prisoners was the man's son.
5. In the meantime Derbyshire County Primary Care Trust (DCPCT) appointed a doctor to carry out a clinical review. The doctor is a general practitioner and partner of a practice in Buxton, Derbyshire. He was supported by the Head of Clinical Quality (commissioning) for DCPCT. He is an experienced registered nurse within the National Health Service.
6. On 15 April, one of my Family Liaison Officers (FLO) contacted the man's wife. He told her about the Ombudsman's investigation and invited her to contribute to the investigation. His wife told the FLO she had no concerns about the care provided to her husband while he was at Sudbury, but did ask to see the results of my investigation.

HMP SUDBURY

7. The prison is situated in the East Midlands area. It is a category D open prison holding medium to long term adult male prisoners, including a number of men serving life sentences. Originally the site was used as an RAF airfield, but was converted to a prison in the late 1940s. Since then the prison has undergone extensive refurbishment and modernisation. Accommodation is provided for a maximum of 571 prisoners.

Her Majesty's Chief Inspector of Prisons

8. Her Majesty's Chief Inspector of Prisons reports on all prison establishments. The majority of inspections are announced and allow the prison being reported on to prepare for inspection.
9. In the introduction to her latest report on Sudbury, following an announced follow up inspection carried out in 2007, the Chief Inspector of Prisons said the prison was basically safe. She went on to say it was a good prison despite population pressures which meant it had been receiving short sentence prisoners. She said work was required to improve healthcare, ensure there were sufficient activities and training for all prisoners and to ensure resettlement was a core function of the prison.

Independent Monitoring Board

10. Each prison has an Independent Monitoring Board (IMB) made up of members of the public and their role is to monitor the prison and to report any concerns that they have regarding the prison, or how prisoners are treated. In the first instance, the Board report any concerns they may have to the Governor, or, if considered necessary, reports directly to Parliament. Board members are able to visit any area of the prison at any time and have direct access to any prisoner who they wish to see, or who requests to see them. The Board holds regular meetings in the prison, with the Governor attending for part of the meeting. The Chairperson of the Board produces an annual report to the Secretary of State for Justice.
11. In its latest report, the Board said they considered the relationship between staff and prisoners to be good. They added that standards had been maintained and in many instances improved. The Board also pointed out that the prison had won a number of awards for performance and community work.

KEY FINDINGS

12. Imprisonment was not a new experience for the man. Prior to receiving his latest prison sentence, he had been imprisoned on three different occasions, beginning in December 1988 when he was sentenced to three years in a young offender centre. In October 1996, he received his second term of imprisonment and he was also imprisoned in 2000.
13. On 23 April 2008, the man appeared at Nottingham Crown Court having been jointly charged, with his son, with grievous bodily harm. They were found guilty and remanded to HMP Nottingham pending sentencing. (It is worth noting that the man and his son have been at the same prisons throughout their sentences, but for ease, unless I specifically say so, the remainder of this report refers to the man.)
14. All prisoners arriving at an establishment undergo an initial health screening. In his clinical review the clinical reviewer said the routine healthcare check carried out by a nurse during the reception procedure asked relevant health questions and had specifically covered issues relating to deliberate self harm or suicidal ideas. There were no concerns identified. However, he noted that the screening document had not been fully completed by the person responsible for filling out the document, with gaps in the section dealing with mental state.
15. The clinical reviewer added that his enquiries had shown that the reception healthcare information did not match the information contained in the man's primary care medical record. In that record, it had been noted by the man's own doctor that there had been a previous history of amphetamine drug use by the man. There was no indication on the health screening form that the man reported any problems with drugs. The clinical reviewer commented that the man's medical records from his own general practitioner had not been requested by prison healthcare and therefore it was not possible for prison healthcare to confirm the medical history.
16. The man's blood sugar was also tested at this time. A level of 7.1 was recorded, which is above the upper end of normal, 6. The clinical reviewer said that in a primary care setting the figure would have prompted a fasting blood glucose test, which is a diagnostic test for diabetes.
17. On 15 May, the man was sentenced at Nottingham Crown Court to six years and six months imprisonment. Following his appearance at the court, he was taken back to Nottingham, where he was assessed as being suitable for allocation to a category C prison.
18. The following week, on 23 May, the man was transferred to HMP Stocken, a category C prison located in the County of Rutland. Prison records show that he settled in well and in November was being considered for transfer to a category D open prison at a later date. (Open prisons have the lowest level of security measures with no perimeter fence or wall to prevent prisoners leaving.)

19. On 11 November, some seven months after the initial blood sugar test was conducted at Nottingham, a fasting test was carried out. The clinical reviewer said in his clinical review that the test was part of enquiries relating to cardiovascular risk. The doctor said the results were normal at 3.7.
20. The test had been carried out after the man was seen by one of the prison doctors. This consultation focussed on smoking and how to reduce the risk of heart disease. Additionally the doctor examined a skin lesion under one of his eyes, which was thought to be xanthelasma which is a potential sign of high cholesterol. The clinical reviewer said blood tests were promptly taken and reviewed.
21. On 18 November, the man was seen by a doctor and his medical notes show that there was a discussion about cardiovascular risk. It would appear that his father had suffered heart disease and so the man was prescribed statin treatment, which is used to lower cholesterol.
22. In February 2009, the process for considering the man for category D status which had started the previous year was stopped after a suspected security breach by a member of his family. An attempt had been made to bring drugs into the prison, which were apparently concealed in a picture. It would appear from the notes that a routine security check had taken place on the incoming post and that traces of drugs had been detected.
23. Further entries in the man's prison record show that, despite this, he settled down and there were no further concerns about him. In April he was again considered for category D status and on 1 August his security category was reduced.
24. Ten days later the man was taken to Sudbury. During the routine reception procedure no risks of suicide or self harm were identified.
25. From then on the man appears to have settled into open conditions well. However, there was one occasion when, in January 2010, an officer went into his room and believed he could smell cannabis smoke. A routine drug test was carried out on him, which showed that he had not used cannabis. No further action was taken.
26. There is little in the man's healthcare record other than minor ailments. The man sought help and advice in early January about stopping smoking. The clinical reviewer regarded this as positive behaviour and something which would not have led to concerns about the man's safety.
27. On 8 February, the man began working in the staff restaurant which is outside the prison and is commonly referred to as the "officers' mess". The investigator met the manager and she told him that she had known the man since he arrived at the prison. The manager said initially he worked in the prison kitchen which is where she first met him. She described him as a quiet man, who would often be seen staring through the windows into the air. She said it was similar to day dreaming.

28. The manager said soon after the man began working in the officers' mess, she had to speak to him about his appearance. She said he had not had a shave and that he looked untidy. The manager told the investigator that he apologised and said he had a few problems. She said he did not say what the problems were and nor did she ask. The manager said the man would regularly ask to be allowed to return to the prison during the morning and was anxious to see if there had been any mail for him, and he would also ask to use the telephone. Asked if she had ever been concerned about the behaviour the manager said that she was not.
29. The following month, on 9 March, a resettlement meeting took place to consider a paid community work placement for the man. This would mean he would be allowed out of the prison each day to work in the local community as part of the preparation for his release. The meeting, chaired by one of the prison Family Liaison Officers, identified the man as suitable and he was scheduled to join the scheme on 12 July.
30. The liaison officer said the man had been at the meeting. He was in a very good mood and had not given any cause for concern. The man told the meeting that his resettlement plans were to return to his wife, as he wanted to help support his family.
31. The next day, the man discussed his relationship problems with another prisoner employed in the officers mess, although he did not go into detail. The prisoner described the problem as "a bad patch". He told the investigator that the man had asked him to write a poem, which he wanted to copy and post to his wife that day, to ensure it would arrive at home for Saturday which is when he would next be there. Although he did not keep a copy of the poem, he said it related to "breaking up". The prisoner said he was certain that the man had posted the poem that evening.
32. The investigator asked the prisoner if he had any concerns about the man's safety. He said that he did not. He said he suspected the man might well have been drinking, but did not have any evidence to support his view.

13 March

33. On 13 March, the man was released from Sudbury on temporary licence known as "Resettlement Day Release". He left the prison at 8.00am and returned to his home address in the Nottingham area, which is about one hour away from the prison. As the licence was a day release licence, it was expected that he would return to the prison later that day.
34. As part of this investigation the investigator spoke to the prison's Head of Offender Management. He is responsible for the prison policy for releasing prisoners on licence. He said the man had been released on licence on three other occasions and had always returned to the prison on time. The Head of Offender Management said he was not aware of any problems with the man's relationship. Had he known of any difficulties, he would have carried out a new risk assessment before deciding whether he could be released or not.

He added that an additional safeguard is feedback from the field offender manager. The Head of Offender Management said had the field offender manager been concerned about the relationship, the manager would have contacted him to make him aware and would have to approve any further release. He said there had been no such contact or concern raised.

35. I understand from the Detective Constable (DC) that when the man arrived home, his wife told him that she wanted a divorce. During a conversation with our FLO, the man's wife told him that her husband knew they were going to separate and could not understand why this upset him so much.
36. The DC said the police incident log shows that at 10.46am, the man's wife telephoned Nottinghamshire Police to tell them that her husband had left the house in a depressed frame of mind and she feared for his safety. At 11.10am, she telephoned the police again to say he had telephoned her using a mobile telephone to say that he had purchased a dog lead. He told her that he was heading for Bestwood Park, where he said he intended to hang himself from a tree. He also told her that he was going to visit his mother who, I understand, had died and is buried in a cemetery some way from the park. In the meantime, the police sent officers to the park and also scrambled the police helicopter in an effort to find him.
37. At 11.49am, a member of the public was walking her dog in the park when she saw the man hanging from a branch high up in a tree. She contacted the police. Two minutes later and in response to the telephone call, police officers who had been searching nearby arrived. Unfortunately they were unable to reach the man who was suspended high up in the tree and so they asked for the fire brigade to attend. (I understand that the man had used the dog lead and choke chain to hang himself.) Paramedics also arrived, but they too were unable to do anything for him until he could be taken down from the tree. (It is estimated by the paramedics that he was suspended about 20 feet above the ground.)
38. In his clinical review the clinical reviewer said the ambulance log obtained as part of his enquiries show that the emergency ambulance call was allocated to the Paramedic at 11.56am. The log shows he arrived into the area at 12.02am, but had to walk part of the way, arriving about one minute later.
39. When the paramedic arrived at the scene, a police officer prevented him from going any further. In his evidence to the clinical reviewer the paramedic said that, when he arrived, he could see the man suspended from the tree. He said he looked to try and find a way to climb the tree with the intention of cutting the man down and assess his clinical condition. The paramedic said the officer would not let him proceed and thought it might have been for his own safety, or because the officer believed there was nothing which could be done for the man. He went on to say that, from what he could see, he tended to agree that there was nothing which could have been to save the man. The paramedic said that, although he did not make a written record, he told the officer that without examination the man he could not pronounce that he was dead.

40. Police records show that at 1.50pm, undertakers arrived and removed the man's body to the mortuary at Queens Medical Centre, Nottingham. At 7.59pm a doctor examined the man's body and certified his death.

Events following the man's death

41. After being told about his death, a Senior Officer (SO) arranged to meet his son to break the news to him. Unfortunately the son was not in the establishment as he was representing the prison at a football match in the community. As he too was temporarily released from the prison for the day, he was also allowed to take with him his mobile telephone. (Ordinarily prisoners are not allowed to have a mobile telephone in their possession, unless working in the community.)
42. During the son's return to the prison, he received a telephone call from his partner. Although she did not tell him what had happened, he realised that something was wrong. When he arrived at the prison, he was met by the SO and taken to a private room where the news of his father's death was broken to him.
43. The SO told the investigator that he had arranged for the son to be allowed to use the prison telephone to call his family. Additionally he arranged for prisoners and staff to support him.
44. The investigator spoke to the man's son. He told the investigator that he had been with his father throughout the sentence and on no occasion had his father ever discussed ending his life. The son said that over the previous few weeks before his death his father had been unhappy and they had spent a lot of time together in his cell. He said that, although his father was unhappy, he had not been concerned for his safety, adding that had he been, he would have told prison staff. The son said his father's death was something "out of the blue" and believes he would have left a goodbye note had it been planned.
45. The son said help is available at the prison for anyone wanting it. He said he felt well supported by prison staff and other prisoners following his father's death.
46. I understand the Governor informed prisoners of the man's death. Prison staff were on hand to support any prisoner affected by his death. Additionally, the prison care team were available to any member of staff requiring their support.
47. On 14 March, a prisoner at Sudbury told an officer that he and the man worked together in the officers' mess. The prisoner told the officer that the man had been "depressed" because his relationship had broken down. Having been given this information the officer reported it to the prison security department. In a note to the Security Department, the officer said a prisoner had told him that the man had been on home leave the previous weekend. He was depressed when he returned to the prison depressed due to his

relationship breaking down. The officer added that the prisoner had been given no indication that the man was intending to “commit suicide”.

48. As part of the investigation process the investigator met an officer who knew the man well. The officer said he had known the man since his arrival at Sudbury in August 2009. He described him as someone who did not come to the attention of staff but would chat about everyday things. The officer said the man never mentioned anything to do with his relationship and was unaware of a breakdown. He added that there had never been any suggestion that he was suicidal.

49. On 19 March, two members of staff both of whom act as prison family liaison officers, travelled to the man’s home address to speak to and offer what support they could to his wife and family. Additionally they offered the man’s wife the opportunity to visit the prison and see where he lived. They also offered to assist with the cost of his funeral.

ISSUES

Release on temporary licence

50. The man had been out of the prison on a number of occasions and returned successfully, without incident. There appears to have been no reason to prevent the licence being issued for 13 March. I am satisfied that had any been risk identified, a new risk assessment would have been completed.

The man's son

51. Prison staff and prisoners do not always receive the credit they deserve and I have been pleased to learn that the man's son felt well supported by staff and prisoners. At a time when he was deeply upset at the death of his father he clearly recognised the support offered to him and appreciated the kindness shown to him. I invite the Governor to share my comments.

Clinical care

52. The clinical reviewer said the man's healthcare whilst in prison was equivalent to that he could have expected to receive in the community. He added that all the assessments and practices were consistent with accepted practice. The doctor went on to say there had been no indication at any stage of the man intending to harm himself, adding that by seeking health advice it suggested there were no major depressive episodes or suicidal intentions. He does however make a number of recommendations aimed at improving processes.

General practitioner medical notes

53. Under the heading "Health Services", the Chief Inspector of Prisons said in her "Expectations" document "Prisoners should be cared for by a health service that assesses and meets their health needs while in prison and which promotes continuity of health and social care on release. The standard of health service provided is equivalent to that which prisoners could expect to receive in the community". At section four, paragraph 32 she said:

"The prisoner's GP and any relevant care agencies are contacted at the beginning of custody, with the prisoners consent, to provide relevant information to ensure continuity of care".

54. In his clinical review, the clinical reviewer said that had the prison healthcare requested the man's medical notes from his own community doctor, it would have allowed them to confirm his medical history. For example, he told a nurse that he had no problems relating to drug misuse while his medical notes showed that he has previously been dependent on amphetamines. He said that had the man had been transferring from one NHS practice to another it is something that would have been routinely done. He stressed that by not requesting the man's medical notes from his own doctor the care was not equitable but does add that in his case it would not have identified any history of suicidal ideation.

55. The clinical reviewer makes a specific recommendation in his clinical review that prison healthcare should request patient medical notes, or a summary from the prisoners own doctor when received into prison custody. However, I am content that the omission had no bearing on the circumstances of the man's death. The Chief Inspector of Prisons has made it clear what her expectations are and, although I make no formal recommendation, I suggest prison healthcare managers are reminded of what is expected.

Blood sugar tests

56. The clinical reviewer said that blood sugar results of 7.00 or more should be followed up by a fasting test. This, he said, is to investigate the possibility of diabetes. He said that in the man's case this did not take place straight away and was only carried out as a result of cardiovascular tests. He stresses there had been no harm done as the subsequent test had found the level to be normal. As the issue refers to a time when the man was at HMP Nottingham a copy of the clinical reviewers' review has been forwarded to the prison Head of Healthcare for consideration.

Recording medical information

57. The clinical review has identified that a number of consultations with prison medical staff took place but no entry was made in the clinical entry record. The clinical reviewer is satisfied that the information relates to what he describes as administrative matters rather than clinical contact. He does though suggest the record keeping should be improved. Again there is no bearing on the circumstances of the man's death and so I do not make a recommendation. However, the Head of Healthcare at HMP Sudbury will wish to ensure that entries in patient medical records are written in such a way as not to cause confusion.

The attempt to resuscitate the man

58. Although a matter for the police and not for my report the clinical reviewer does make a recommendation to the ambulance service in his report, a copy of which will be sent by the PCT to the service for its consideration. The police would not allow the paramedic to attend the man and from what we know it would appear to have been too late to effect a successful resuscitation attempt. The clinical reviewer suggests the ambulance service should ensure that there is a clear record of why they have been refused permission to attend to a patient.

CONCLUSION

59. I am satisfied that the man had given no indication that he had thought about harming himself or taking his life and that prison staff did not identify any risks around the planned day release for 13 March. His actions that day appear to have been planned after he left the prison, or if they were considered beforehand, he kept his thoughts to himself. I am pleased that Sudbury took good care of his son in what must have been difficult circumstances.
60. I make no recommendations in my report but do identify learning points for healthcare at HMP Nottingham and the ambulance service local to HMP Sudbury.