

**CIRCUMSTANCES SURROUNDING THE DEATH OF A MAN
AT HMP NOTTINGHAM IN JULY 2005**

**REPORT BY THE PRISONS AND PROBATION OMBUDSMAN FOR ENGLAND
AND WALES**

OCTOBER 2005

This is the report of an investigation into the death of a man at HMP Nottingham on 4 July 2005. Although the cause of death is a matter for the Coroner, it is clear that the man took his own life. He did so on the second night after his return to custody. The man had been sentenced to life imprisonment in 1976, and was released on life licence seven years later. This was the third time he had been recalled to prison.

Unfortunately, Nottingham prison did not receive all the information about the man's current circumstances, and information that was available was not used at every stage during his reception.

My office investigates the deaths of all prisoners in custody. In this case the investigation was carried out by one of my team leaders assisted one of my investigators. One of my Family Liaison Officers made contact with the man's family. I hope that this report will answer their questions.

The Nottingham City Primary Care Trust was commissioned to carry out an independent clinical review of the man's healthcare in the short time he was at the prison. Their assistance is much appreciated.

I would also like to thank the Governor for her assistance, as well as her staff who were involved in the investigation, particularly the Governor and Officer who assisted with all the arrangements. I also appreciate the involvement of Derbyshire Probation Area whose staff had supervised the man's life licence and who were shocked at the tragic end to his life.

Finally, but most importantly, I take this opportunity to offer my condolences to the man's wife, step daughter, and other relatives. It is clear from the letters that he left that his last thoughts were happy memories of his family.

Stephen Shaw CBE
Prisons and Probation Ombudsman

October 2005

Contents

Summary	4
The investigation process	5
Background	
The man who is the subject of this investigation	6
HMP Nottingham	7
Key findings	
1 – 3 July 2005	8
4 July	14
Contact with the man's family	16
Issues considered during the investigation	18
Recommendations	21

Summary

1. The man was convicted of murder in 1976 at the age of 19 and sentenced to life imprisonment. He was released on life licence in 1983, but assaulted his then partner in 1988 and returned to prison until the following year. A similar offence was committed in 1994, when he returned to prison until 2002. All reports on his time in custody and his supervision in the community suggest that he behaved and responded well. At no time, during nearly 30 years under the jurisdiction of the criminal justice system, were there any concerns that the man was at risk of harming himself or attempting suicide.
2. Each of the man's offences was committed whilst under the influence of alcohol, and the offences committed on 30 June 2005 conformed to this pattern. He assaulted his wife and his next door neighbour, was arrested the following day and held in police custody. Derbyshire Police were warned by his wife that he had previously threatened to take his life, and were also told of other, more serious, allegations against him. The police recorded the information about self-harm on the PER form which accompanied the man as he went to Court and then to prison. However, the police did not pass on the intelligence that he was also to be interviewed about other offences.
3. The man was received at HMP Nottingham on Saturday 2 July and went through the standard reception processes. Not all the staff who interviewed him were aware of the police concerns about a threat of suicide, or that he had been on life licence and that this had been revoked. All the staff and prisoners who met the man at the prison were of the same opinion: that he showed no sign of distress or risk of harming himself.
4. As is customary at Nottingham, the man spent his first night in a shared cell in the First Night Centre. The next day he requested a single cell and, as one was available, it was allocated to him. Prisoners serving a life sentence often ask for a single cell and they are allocated according to availability.
5. At 6:00am, at the morning roll check on Monday 4 July, the man was found suspended by a ligature from the window bars of the cell. Staff and paramedics responded promptly to the discovery but, by the time he was found, he had already died. Four letters addressed to various friends and relatives were found in his cell, and a fifth was addressed to the priest who would lead his funeral service.

The investigation process

6. My office was informed of the man's death on the day he died. An assistant ombudsman, visited the prison to open the investigation the same week. She briefed the Governor, Independent Monitoring Board (IMB) and Prison Officers' Association (POA) together, and collected the man's prison records. The records of his previous periods in custody were forwarded later.
7. As well as gathering information from the man's prison and medical records, the investigators returned to the prison to carry out formal interviews with staff and prisoners. The interviews with health care staff were carried out in partnership with the clinical reviewer. A further interview was conducted with the man's probation officer and his line manager who were responsible for supervising his life licence. Either a note or transcript of the interviews is attached as an annex to this report. Telephone conversations took place with police officers from Derbyshire Constabulary and other prison staff.
8. Staff and prisoners at Nottingham were informed of the investigation, but none responded to the invitation to contact the investigation team.
9. One of my Family Liaison Officers, made contact with the man's family, and she and one of the investigators visited his wife and stepdaughter on 9 August.

Background

The man who is the subject of this investigation

10. The man was born in 1957 and brought up in Staffordshire where he lived with his parents and siblings. As a young teenager, he began to drink heavily, and all his offences were committed whilst he was under the influence of alcohol.
11. The man spent over half his adult life in prison. In 1976, aged 19, he had been sentenced to life imprisonment for offences of murder and attempted robbery. He was released on life licence in 1983, and his progress was so good that, in 1987, the supervision element of the licence was lifted. However, the following year he assaulted his then partner, and returned to prison between November 1988 and September 1989, when he was released on licence again. In January 1994, he committed a similar offence, and was recalled to prison a second time. On this occasion, he was in custody for more than eight years.
12. The man's prison and probation records state that, when he was not drinking, he was a friendly, hard working man who cared deeply for his family. While he was in prison, particularly the third time, he worked hard to address his problems with alcohol. His records show that, during his third period in custody, he concluded that the only way to avoid re-offending was never again to drink alcohol. He attended Alcoholics Anonymous meetings in prison and in the community. All the records speak of his determination to overcome his lifelong problem and build a good life for his family.
13. On release from prison in 2002, the man had a job and settled down in a new area with his wife and stepdaughter. He complied with the conditions of his life licence. His probation officer recorded that the man presented as a mature and well-balanced person, who kept his resolve to abstain from drinking. The cycle of recurring offences was acknowledged, and he was thought to have made considerable progress at dealing with any problems he experienced. He worked hard and, during the last three years, changed jobs twice, both times moving to a better position.

HMP Nottingham

14. Nottingham is a category B local prison holding adult male remand and sentenced prisoners. It has an operational capacity of 510. It first opened in 1890. Until 1997, it served as a closed training establishment for adult men, but that year it re-roled as a category B local prison, and now serves the courts of Nottinghamshire and Derbyshire. Approximately two-thirds of the prisoners at Nottingham are located in shared cells.
15. The prison has three wings, two of which were built ten years ago, and accommodate 150 prisoners in relatively new and modern conditions. In contrast, B wing is a Victorian building for up to 200 men which currently includes the First Night Centre and the Induction Unit. Concerns about the conditions in B wing were raised by Her Majesty's Chief Inspector of Prisons (HMCIP) and by the Independent Monitoring Board (IMB). The IMB report of February 2005 said that B wing had been improved by the reduction in numbers from 250 to 200 prisoners. There has been a considerable investment in redecorating, installing in cell electricity, and providing extra clothing, bedding and new floor coverings. The HMCIP report of the same month described the wing as too old, too cold and unfit for purpose. The wing is due to be closed for further refurbishment in October 2005.
16. Cell B3-12, where the man was located, is on the second floor of the wing. The investigator visited it on the day that the investigation was opened. The cell was in good condition and furnished with a bed, chair, cupboards, table, television, sink and toilet. The window was high up and could be opened to let fresh air in.

Key findings

1 – 3 July 2005

17. At 6:24am on Friday 1 July, the man was arrested by Derbyshire Police and charged with two offences of assault committed the previous day. The victim of one of the offences was his wife, and a next door neighbour was the other. The man admitted both offences and was held in police custody at a police station in Derby. The police told him that his licence would be revoked.
18. After his arrest, the police were informed by his wife that, the previous month, the man had threatened to commit suicide. The police were also informed of other serious allegations about him. All of these matters caused the police to be concerned about his well being, and to take action to ensure his safety. Because of the information about the man's state of mind, the police decided that he should be held in a safer cell, which was monitored by a video camera. Because of the other allegations, they decided that he should not be allowed to contact his home. The police intelligence about the other allegations was not passed to the prison when the man was returned to custody, and he had not been informed of them by the time of his death.
19. A couple of hours after the man's arrest, his wife telephoned the man's probation officer. She told him that her husband had committed the offences, been arrested and was held in police custody. The probation officer also had a brief conversation with the man's stepdaughter, who told him of the other, more serious, allegations. The probation officer passed this information to Derbyshire Police, and also made the police and his senior managers aware of the breach of licence. He subsequently visited the man's wife at home to collect information for the report that requested the revocation of his licence. She told the probation officer that there had been an incident a month earlier, when she found empty alcohol bottles in the house. She said that she had felt her husband was testing her. The man had asked her whether she was going to report the incident to the probation officer and get him recalled to prison.
20. When the man was arrested he had a head injury which was examined later in the morning by a police doctor. The doctor decided that the injury required hospital attention, and so the man was taken to the Accident and Emergency Department of the local hospital. He returned to the police cells at 2:50pm, after the injury was stitched and painkillers had been provided.
21. As part of this investigation, telephone conversations took place with the police officer who interviewed the man, and with the Custody Officer who authorised his detention. Both said that, whilst the man was in their custody, he appeared to be tired but was chatty and showed no inclination to harm himself. They had no concerns about risk of suicide or self harm. He did not ask for a solicitor to be present when he was interviewed.
22. The man remained in police custody until 11:57pm when bail was refused, and he was held overnight to appear at Derby Magistrates Court the next day. Before he went to court, another police officer completed the Prisoner Escort

Record (PER) form, which is attached as an annex to this report. As a result of the information about previous threats to commit suicide, the police officer recorded on the form that there was a risk of suicide or self harm and noted that there were "old self harm issues". The police officer failed to make an entry in either of the tick boxes stating No Known Risk or Risk which are at the head of the form.

23. The following morning, Saturday 2 July, the man appeared at court, where he pleaded guilty to both assaults and was sentenced to four months imprisonment.
24. He was transported to Nottingham prison by a private company contracted to carry out this task. The PER form was passed to the company for their information. Their record of the journey indicates that it was uneventful, and the man did not display any distress between the court and the prison. If the company had further concerns about risk of suicide or self-harm, they complete another form - the Suicide/Self Harm Warning form - but this was not felt necessary.
25. The man arrived at the prison at 2:05pm on Saturday afternoon, along with three other prisoners. Because it was the weekend, the prison's Reception Centre was quiet and there were only three staff on duty. All three staff shared the duties between them and were able to observe the prisoners. The man first met the Senior Officer. In interview the Senior Officer said that she saw the warrant from the court which authorised the man's imprisonment, the form which revoked his licence, and the PER form. These records were held in his Core Record which was passed between the staff working in reception. She said that a yellow carbon copy of the PER form was separated and held in a wall file for collection by the nurse who interviewed prisoners in Reception.
26. The Senior Officer said that she read the information about risk on the PER form, and so asked the man how he felt. He told her that he was fine. Her impression was that he was confident, and she did not identify any risk of suicide or self harm. Because he did not confirm any self harm issues, and because a GSL warning form had not been completed, the Senior Officer told the investigation team that she assumed that the information on the PER form referred to events of some years ago. She did not consider that it referred to current events.
27. Standing beside the Senior Officer as she talked to the man was another officer. It was this officer's task to record the man's personal details, list his property, take his photograph and search him. The officer also had sight of the warrant and the PER form. The officer was aware that the man had committed two assaults whilst on life licence. He recorded on the PER form that he had received the man from the private transport company and had sealed his property, but said that he did not read the rest of the information on the form.

28. The officer was also responsible for beginning the Cell Sharing Risk Assessment (CSRA) form. He completed the top two boxes which recorded the man's name, date and prison number. He should have completed Section 1 of the form which lists the available documentation, but omitted to do so. Had that section been completed, the officer said that he would have recorded that no other documentation had been received.
29. It was not part of the officer's responsibilities to ask the man about risks of suicide or self harm. In interview, he said that he thought that the man was subdued because he was back in prison again. The man's only request was for a Visiting Order to enable his stepdaughter to collect toiletries which he had not been allowed to keep.
30. After speaking to the officer the man was taken to a holding cell in the Reception Centre until the nurse was available to interview him. The interview with the nurse is the final stage of the reception process. The nurse said in interview that, when she meets new prisoners, she sees the Core Record and uses it to record whether the man is fit for work but does not look at other information in it. She also said that she does not see either the original PER form or the yellow carbon copy. When she interviewed the man, the nurse said that she had the Core Record but did not see the PER form which contained the police information about old self-harm issues. She had the CSRA begun by the officer, and it was her responsibility to complete Section 3 of the form. She also had a First Reception Health Screen and the Medical Record File, both of which are medical records.
31. The interview with the nurse is the only reception interview that is conducted in private. The nurse said that interviews vary in length, and she had plenty of time to talk to the man as only four prisoners were received that day. She said that she used the CSRA and First Reception Health Screen forms to structure the interview. As well as the man's replies to her questions, the nurse observed his manner and mood. She knew that he was serving a short sentence and had been in prison previously, but did not know that he had been on life licence which had been revoked. She said in interview that she does not check a prisoner's status and whether they were on remand or sentenced.
32. The nurse recalled examining the man's head injury, and was satisfied that it was beginning to heal. Her impression was that they had a normal, relaxed chat. He told her that he did not drink alcohol, which she accepted as he did not smell of alcohol, was calm and did not show any signs of withdrawal. When she asked him about self-harm, the man replied that he had neither tried to harm himself nor considered doing so. She said in interview that she verified his statements by observing that he made good eye contact with her, was relaxed and had no cuts to his wrists. This area of questioning was repeated when the nurse completed her section of the CSRA, when she assessed the man as being Low Risk.
33. On completion of the reception processes, the man returned to a holding cell, until he was taken to the First Night Centre (FNC). The FNC is part of the

ground floor of B wing, which is in the older part of the prison. It has had some refurbishment but is to be replaced in October 2005 by a purpose built wing where new prisoners will remain for their first five nights in custody.

34. In July 2005, the routine was for all newly received prisoners to be held in the FNC for one night before being transferred to the main prison. All the FNC cells are for two prisoners. If there are an uneven number of prisoners in the FNC, they are accommodated in pairs and the remaining man is located in a cell occupied by the Wing Orderly. This happened in the man's case. He was located with the Wing Orderly.
35. Each prisoner has two standard interviews in the FNC, one with an officer and the other with an Insider. (Insiders are prisoners who have been selected and risk assessed, before being employed to meet new prisoners and take part in their induction to the prison.) There was an officer on duty that weekend, and saw the man throughout his time in the FNC as well as when he interviewed him. In interview, the FNC Officer said that generally he has the Core Record and PER form with him when he meets new prisoners. However, he said that the records were not available when he met the man and so he was unaware of the self harm warning. He said that he had plenty of time on Saturday and Sunday to observe the man, and had no concerns about any mental health or self harm issues. He described the man as being chatty and making good eye contact. The only matter raised by the man was about the revocation of the licence, and the FNC Officer told him that this would be referred to the Lifer Liaison Officer on Monday. On the CSRA, the FNC Officer recorded that the man preferred to share a cell, and in interview he said that this was based on the man's acceptance that all prisoners at Nottingham share a cell on their first night. The man told him that he preferred to share for the first few days, so that he could talk to other men to find out what the prison was like.
36. The Insider who interviewed the man told the investigation team that, because he talked to the man at the weekend, the interview took place in the cell rather than in the room he uses during the week. He said that it was not a one to one interview, and the Wing Orderly was present throughout. The Insider said that he knew that the man had been in prison previously, and so he thought that the man would be able to deal with what was facing him. The Insider is used to considering whether there are concerns about a prisoner's state of mind, and he had none about the man whose only questions were about making a telephone call. The Insider prepared a list of telephone numbers for the man to use.
37. The Wing Orderly was interviewed for this investigation, and he too was not concerned that the man was at any risk. He said that the man asked for a single cell, and so on his behalf he asked if this would be possible as he was a lifer. Generally life sentence prisoners are held in prisons with single cells, and it is common for them to ask for a cell to themselves when they are in a local prison. Nottingham prison deals with such requests according to availability. On this occasion a single cell, B3-12, was available and was allocated to the man the next morning, 3 July.

38. The man made one telephone call to his home at 4:08pm that afternoon, when his wife put the phone down without any conversation taking place.
39. The FNC Officer said that he continued to see the man on B1 on Saturday afternoon and again on Sunday morning, starting from when he opened the cell door to allow the Wing Orderly to attend to his orderly duties. The man had breakfast and went on exercise. He wanted to make a telephone call. The FNC Officer noticed that the man interacted well with the other men on the wing, and did not think that he had any problems about being back in prison.
40. The FNC Officer interviewed the man a second time on Sunday morning, which was the induction interview. He explained about the induction programme, the services of the prison such as the gym and education, and the man signed the compacts that showed that he understood and agreed to the prison rules. He said that the man was more concerned about the licence recall than the assault charge, and he knew that the Home Office would be dealing with it. The FNC Officer told the man that he would refer his name to the Lifer Liaison Officer on Monday, and that the man was happy with this course of action.
41. As with his FNC interview with the man the previous day, the FNC Officer again thought that he was fine and was suitable to move. Because he thought that the man did not have any problems, he allowed him to move upstairs to the available single cell on B3 landing. The move took place early on Sunday afternoon.
42. There was an officer on duty on B3 landing on Sunday 3 July, when the man was transferred from B1 to B3. He checked the man's history sheet and the CSRA to confirm that there was no suggestion that a single cell should not be allocated. He briefly left the man in the unlocked cell, and then the man came to find him to ask for some cleaning materials. The officer told the man where the materials were. When he saw the cell later, he noticed that he had made a good job of cleaning it as all the surfaces were shinier than previously. The officer thought that the man seemed fine, and was polite and jovial.
43. During the morning the man made two more telephone calls, one to a friend to ask him to send some money and a message to his wife, and another to his home. He played pool in the afternoon, and no concerns were expressed by anyone about his wellbeing. The officers who supervised Sunday afternoon's association do not recall anything noticeable about his demeanour.
44. The B3 landing officer returned to the cell three times, to lock it, unlock it in the afternoon, and finally at the evening roll check. He could not remember having any further conversation with the man on these occasions. At the evening roll check, the officer said that he checked the door, shot the bolt, checked the cell flap and spoke to each prisoner as he did so. He recalled seeing the man standing near the toilet area, but did not remember anything unusual about his appearance.

45. Two officers were on overnight duty on 3 – 4 July. When they came on duty, day staff gave a briefing and both officers said that no information about the man was passed on. A Senior Officer was the Night Orderly Officer on duty, and he confirmed that no concerns about the man had been reported.
46. One of the overnight officers carried out the evening roll check, which she described as going to each cell, and lifting the flap in the door to see that each man was alright. She said that it is her routine to say goodnight to those who are awake and to observe the breathing of those who are asleep. She did not notice anything unusual during the check, and reported that all the men on the landings were fine. She and the other officer remained on duty overnight. They were responsible for carrying out regular checks of the landings, following the pegging routine, and answering any cell bells. In interview, she said that there were no occurrences during the night and nothing was heard from the man's cell. The record of the cell bell calls confirmed this.

4 July 2005

47. At 6:00am on 4 July, the overnight officers began the morning roll check. One officer, who shall be known as Officer A, checked the two upstairs landings and the other officer, who shall be known as Officer B, checked the downstairs landings. Officer A told the investigation team that she reached cell B3-12 and opened the flap in the cell door. She saw the man, who appeared to be standing in front of the window. She closed the flap to move on, but immediately realised that something was not right and looked again. The officer saw the man's feet on the floor, and looked above his head to see something around his neck which was attached to the window fastening.
48. The officer was carrying a radio and she used it at 6:05am to summon emergency assistance. She used the Code Blue, which is the prison term for a healthcare emergency for a prisoner who requires assistance with breathing. At the same time as she used the radio to get help, the other officer confirmed that she called out to alert him.
49. The Night Orderly Officer was in his office when the Code Blue alert came over the radio. He had received the first of five calls from the wings to notify him of the morning roll check. He ran to the wing and, on his way, asked the Control Room to request an ambulance. The request for the ambulance was logged at 6:09am.
50. The Night Orderly Officer arrived at the cell, followed by Officer B and they found Officer A present. All the staff carried emergency cell keys, and the Night Orderly Officer used his to open the cell door. The Night Orderly Officer and Officer B entered the cell and saw the man with a ligature round his neck, suspended from the arm of the window fastening. His feet were touching the floor. They both noted that the cell was immaculately tidy and the bed was made. Officer B saw a number of letters on the table and a razor blade on top of the bed covers.
51. The Night Orderly Officer and Officer B supported the man, and the Night Orderly Officer used his emergency knife to cut the ligature. He said that the man was cold to the touch, and rigor mortis had begun to set in. His body was placed on the cell floor, and Officer B said that his head was placed away from the wall so that healthcare staff would have room to work. Officer A remained at the door.
52. As the man was laid on the floor, a nurse reached the cell. She was on duty overnight in the prison's healthcare centre, and was responsible for looking after the inpatient beds and responding to any emergencies with other prisoners. Between 6:05 and 6:10am, the nurse said that she heard the radio signal for a Code Blue emergency, which meant that a prisoner had collapsed and was not breathing. She said that she grabbed the resuscitation bag and ran to B wing, arriving a couple of minutes later. She said that the bag was sealed, and all the contents were in order.

53. The nurse said that when she arrived at the cell, the Night Orderly Officer and two other officers were present. She confirmed that the man was lying on the floor, towards the rear of the cell, and she asked the staff to move him forwards. She thought that the staff were dealing with the situation appropriately.
54. The nurse said that when she examined the man, his body was stiff, slightly warm, but cyanosed (blue in colour) and rigor mortis had set in. She attempted to create an airway, but found it impossible, and appropriately did not start cardio pulmonary resuscitation. She estimated that the paramedics joined her within ten minutes, and they confirmed that there was no action to be taken to revive the man.
55. The log of the response to the man's death records that two paramedics arrived at the cell at 6:15am, and the Night Orderly Officer and Officer B then withdrew.
56. When the paramedics decided that they could not resuscitate the man, all the staff withdrew from the cell. The flap on the cell door was covered over, the Night Orderly Officer sealed the door and stationed an officer outside.
57. At 6:16am, the police were informed of events. The Night Orderly Officer began to put the prison's contingency plans into place by informing the Governing Governor, the Deputy Governor, Duty Governor and others.
58. The man's death was confirmed at 7:53am.
59. Later in the morning, a hot debriefing meeting took place, attended by all the staff involved. A chronology of events was discussed, tasks were allocated between different members of the team, and the support of staff care and welfare was arranged. All the staff interviewed for the investigation have confirmed that they were offered support and time away from work if required.

Contact with the man's family

60. A Governor was asked to make contact with the man's next of kin, who was listed as his wife, with his sister also named as someone to be informed of an emergency. The Governor spent some time assembling all the available information, and then left the prison by taxi accompanied by a chaplain and the Suicide Prevention Co-ordinator. Originally the governor and the chaplain had planned to visit the man's wife together, but at the last minute the Suicide Prevention Co-ordinator was invited to join them as he had recently undertaken family liaison training.
61. The three members of prison staff went to the family home, where they found the man's stepdaughter alone, her mother having gone to attend an appointment in the nearby town. His stepdaughter telephoned her mother to tell her about the visitors, and the Governor also spoke to her to ask her to return home. The man's wife declined to return, saying that she had to attend her appointment and asked the three men to meet her in town. She described what she was wearing, so that they would recognise her. Her request was agreed to as the staff wanted to inform her of her husband's death as soon as possible.
62. The three staff met the man's wife in the town, where she quickly realised that they were bearing bad news, and was told straightaway about the man's death. At first they were all standing in the street, but she agreed to sit in their taxi for a short time. She said that she wished to continue with her appointment and the Governor accompanied her.
63. After the appointment, the man's wife and the prison staff returned home together, where she and her daughter were given telephone contact numbers. At some stage during the visit, the man's wife said that the chaplain asked her whether there were any babies present. When she asked why he wanted to know, she says he said that he was recovering from shingles and did not want to infect a child.
64. The man's wife was invited to visit the prison and see the cell where her husband died. She accepted both offers. She was asked whether she wanted the cell to be left as it was when the man was found, and she agreed to this as well. She also asked to meet the prisoner with whom the man shared a cell the night before he died. She says she was told that her husband's body was found between 4:00am and 5:00am, and that his cell was untidy and the bed overturned. I have been unable to clarify where she got this information. I have confirmed with Nottinghamshire Police that he was found just after 6:00am and that his cell was tidy.
65. The prison staff also visited the man's sister to tell her of her brother's death. She has also visited the prison.
66. Shortly after the staff left the man's wife's home, she began to be contacted by friends and neighbours who had heard on the radio of the man's death.

Coincidentally, the IMB annual report which criticised conditions in B wing was published on the day that the man died, and the media linked the two events.

67. The Suicide Prevention Co-ordinator has continued to liaise with the man's wife, and arranged for her to come to the prison. He arranged for her to meet the Governing Governor, visit the cell and meet the Wing Orderly. The man's wife also asked the Suicide Prevention Co-ordinator to accompany her to the hospital mortuary the same day so that she could see her husband's body. The Suicide Prevention Co-ordinator asked her whether she wished to bring anyone with her but she came alone.
68. The man's wife told my FLO that she felt overwhelmed by the number of people who were present when she met the Governing Governor, and the Suicide Prevention Co-ordinator has confirmed that there were at least six people present. Her impression was that the number of people present created a confrontational situation, and she wished that she had not come alone. After the meeting, the man's wife's other requests were carried out and she went to the cell, met the Wing Orderly and saw her husband's body at the hospital.
69. The day after the man's death, his probation officer telephoned his wife to express his condolences. She then gave him some more information about the incident the month before his arrest when empty alcohol bottles had been found. She told the probation officer that the man had written a note in which he threatened to take his own life. She had destroyed the note and had not previously disclosed its existence to anyone.

Issues considered during the investigation

Information received by the prison

70. There are a number of matters regarding the information received by the prison that are of concern to the investigation team.
- After the man's arrest by Derbyshire Police, his wife informed them that he had threatened to commit suicide a few weeks previously. This was recorded by a police officer on the PER form as "old self harm issues". Prison staff who subsequently read the form thought that, as the man gave no indication of distress, it referred to incidents of self-harm which had occurred in previous years.
 - When the man was arrested, Derbyshire Police were also informed of other, more serious, allegations which the police planned to investigate. Had the prison authorities been made aware of this, they would have had the opportunity to consider the implications for his state of mind. (In practice, the man was not aware of these allegations before his death.)
 - The nature of the allegations meant that there were public protection issues, and so the police restricted the man's access to the telephone. The prison were not aware of the restriction, and the man made three unrestricted telephone calls, two of which were to his home.

The Governor should draw to the attention to the Chief Constable the vague and inaccurate warning about self harm on the PER form, the failure to share information about allegations of other offences, and the public protection issues.

Reception processes

71. The Reception Centre arrangements include interviews by three members of staff, all of whom are supposed to have the prisoner's Core Record in front of them when they carry out the interview. The Core Record contains the PER form and the details of the sentence or remand. However, the nurse who interviewed the man did not use the information which was available to her. Consequently her judgements in the First Reception Health Screen and Cell Sharing Risk Assessment were based on incomplete information.

The Governor and Primary Care Trust should review the reception processes. They should ensure that front line staff use all available information, including matters which might relate to the risk of suicide or self harm such as information on the PER form and the prisoner's status.

First Night Centre

72. An officer, who also should have the PER form, interviews each prisoner who is admitted to the First Night Centre. In the man's case, the form was not seen and so another opportunity to respond to the warning about self-harm was missed.
73. The current arrangements in the First Night Centre are for prisoners to stay for one night, before being allocated to the wings, in either a single or a double cell. This is a brief induction period which does not give prisoners time to settle in. In October 2005, a new First Night Centre is to be opened, and all prisoners will spend their first five nights in a shared cell. In the meantime, safeguards should be put in place, and no prisoners should be allocated a single cell so soon after their arrival at the prison unless the risk assessment identifies them as at high risk to others.

The Governor should take immediate steps to ensure newly admitted prisoners identified as being at low or medium risk to self or others are not allocated to a single cell.

Contact with the family

74. There are a number of aspects of the contact with the man's wife which do not appear to have been dealt with sensitively, and which cause me concern. Some, but not all, are matters which she raised herself when she met the investigator and FLO.
- Whilst the man's wife has not commented on the number of people who came to see her, I suspect that three staff was excessive and it would have been preferable for the governor to have visited with just one colleague.
 - No consideration appears to have been given to alternative arrangements should she not be at home when the prison staff arrived, such as waiting at her home or returning after her appointment.
 - The man's wife was alone, and in a public place, when she was told of her husband's death.
 - The chaplain's comments about shingles were inappropriate and she believed that he was still infected with the disease.
 - The media coverage was increased as the man's death coincided with the publication of the IMB annual report and its criticisms of conditions on B wing.
 - There were at least six people present when the man's wife met the Governing Governor, despite the fact that she had come to the prison alone.

I recommend that the Governor reviews all aspects of the prison's contact with the man's family, to ensure that lessons are learned for any future deaths in custody.

Recommendations

Operational

- 1 The Governor should draw to the attention to the Chief Constable the vague and inaccurate entry on the PER form, the failure to share information about allegations of other offences, and the public protection issues.
- 2 The Governor and Primary Care Trust should review the reception processes. They should ensure that all front line staff use all available information, including matters which might relate to the risk of suicide or self harm such as information on the PER form and the prisoner's status.
- 3 The Governor should take immediate steps to ensure newly admitted prisoners identified as being at low or medium risk to self or others are not allocated to a single cell.
- 4 The Governor should review all aspects of the contact with the man's family, to ensure that lessons are learned for any future deaths in custody.