

**INVESTIGATION INTO THE CIRCUMSTANCES  
SURROUNDING THE DEATH OF A MAN AT  
HMP WHITEMOOR IN FEBRUARY 2007**

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

**September 2007**

This is the report of an investigation into the death of a man at HMP Whitemoor in February 2006. The man was discovered hanging in his cell in the segregation unit, suspended by a bed sheet. His death has been investigated by Cambridgeshire Police who are satisfied that there is no third party involvement.

I offer my sincere condolences to the man's family and friends for their loss. I hope that this report answers their questions, but recognise that it may not alleviate their distress or lessen their grief.

The man was 40 when he died. He had served a number of prison sentences, and had been in continuous custody on this occasion since 1997.

The man was a resident on the Dangerous and Severe Personality Disorder (DSPD) unit at Whitemoor, one of two DSPDs within the Prison Service. It is a unit with specialised staff running a unique regime of group and individual support, with courses to help prisoners with their conditions and challenge their behaviour. Since I began investigating deaths in custody in April 2004, the man was the second prisoner in the Whitemoor DSPD apparently to have taken his own life.

The investigation was undertaken on my behalf by two of my colleagues. I would like to express my thanks to the Governor of Whitemoor, his staff, the chaplaincy and the Independent Monitoring Board (IMB) for their help and active cooperation throughout my investigation. I am grateful too to the doctor from Cambridge Primary Care Trust (PCT) for her assistance. I also thank Cambridgeshire Police who have willingly shared their information, and have been assisted by Her Majesty's Chief Inspector of Prisons' report of her inspection of Whitemoor between 30 January and 3 February 2006.

The man had been on the DSPD since December 2006. In this time he had been continually assessed by a team of psychiatrists, psychologists, nurses and discipline staff. On the morning of his death he boiled a pan of water, walked with it to a cell and threw the scalding water over a prisoner he believed had been calling him names. The man was escorted without restraint to the segregation unit. He cooperated fully with staff, was searched, and placed in a cell alone. The man was later found hanging suspended from the window frame with a bed sheet tied around his neck. Despite the best efforts of staff and paramedics he was pronounced dead at the scene.

The death of this man is one of a number of apparently self inflicted deaths to have occurred in segregation units. In this case, the man had given absolutely no indication that he might have been at particular risk at that time. Although I believe that his treatment at Whitemoor was of a high standard, I make five recommendations.

**Stephen Shaw CBE**  
**Prisons and Probation Ombudsman**

**September 2007**

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## SUMMARY

At the time of his death the man had been in continuous custody since 1997, and had numerous convictions using 23 aliases. He had been transferred from HMP Frankland for assessment by the Dangerous and Severe Personality Disorder Unit (DSPD) at HMP Whitemoor in December 2006.

Whilst at Whitemoor, he displayed a high level of anxiety and often sought reassurance from staff. He found it difficult to keep still and used to pace his cell and the landing. He would often approach and engage female members of staff as they entered the wing.

In January 2007, during a period of anxiety, the man threatened to cut himself with a razor blade that he eventually threw out of his cell window. He was supported and managed at that time by staff through the Assessment, Care in Custody and Teamwork (ACCT) process. The ACCT document was closed within 24 hours.

In February, the man was placed on disciplinary report as he was threatening and abusive towards a member of staff. Prisoners report that he was subject to name calling from two prisoners who called him 'stalker and paedo'.

On Friday 16 February, the man attended his adjudication in the segregation unit and returned to D wing. The following morning he telephoned his mother and discussed her next visit. The man then told a fellow prisoner of the name calling and the other prisoner said that he would speak to the two men allegedly responsible after he had been to the gym.

In an apparently premeditated act, the man boiled a large pan of water, walked along the landing from the kitchen to prisoner A's unlocked cell and went in. He threw the water over prisoner A, scalding his legs. Prisoner B was also present and the man hit him over the head with the empty pan.

Staff intervened and, without needing to use restraints, took the man to the segregation unit. He was seen by a nurse who declared him fit for segregation, and not in need of enhanced observations. The man was searched and placed in a cell. Shortly afterwards he was seen by the chaplain, whom he knew well. The chaplain recalled in interview with my investigators that the man was in good spirits, and he had no concerns for his welfare.

At 1.50pm, when officers went to the man's cell to collect his lunch plates, they discovered him hanging with a sheet around his neck from the window. Staff untied the ligature and commenced resuscitation. An ambulance was summoned but, despite the best efforts of staff and paramedics to revive him, the man was pronounced dead. He was aged 40.

## THE INVESTIGATION PROCESS

1. The investigation was formally opened by two investigators who visited Whitemoor on 21 February 2007. Notices were issued to staff and prisoners telling them of my investigation and its terms of reference, and offering the opportunity to participate. My investigators examined the cell in the segregation unit where the man died, and were given unrestricted access to the prison. They met the Governor, members of the Independent Monitoring Board (IMB), the chaplaincy and the Prison Officers' Association (POA), and received their full cooperation.
2. My investigators obtained the records relating to the man's imprisonment, and further records were subsequently provided. They received cooperation from Cambridgeshire Police, who had seized CCTV footage, and telephone recordings of the man's telephone conversations. The police have concluded that there was no third party involved in the man's death.
3. Staff and prisoners have been seen and, where appropriate, formally interviewed. Those interviewed include prisoners, prison officers, prison managers, members of healthcare and a member of the chaplaincy.
4. My investigators have referred to the investigation reports following deaths of prisoners at Whitemoor since 2004. They have also consulted the report of Her Majesty's Chief Inspector of Prisons (HMCIP) inspection of Whitemoor in 2006.
5. An independent clinical review of the medical care the man received in Whitemoor has been provided by a doctor for Cambridgeshire PCT. A further mental health clinical review of the man's healthcare in custody was led by a reviewer from Cambridgeshire and Peterborough Mental Health Partnership NHS Trust.
6. One of my family liaison officers has spoken to the man's mother who raised the following two concerns which my investigation attempts to answer:
  - The mother does not believe her son took his own life. He had already served nine years of his sentence. He was happy when he spoke to his mother on the morning of his death and discussed a family visit the following day.
  - The mother wants the investigation to consider a violent incident involving other prisoners which led to the man being moved to the segregation unit. The mother believes the violent incident to be out of character for her son.

## **HMP WHITEMOOR**

7. Whitemoor is a maximum security prison for men in security categories A and B, and is one of eight such prisons. The prison includes a pilot assessment spur which examines the links between a prisoner's dangerousness and severe personality disorder. The unit has developed in partnership with the Department of Health and Mental Health Unit. In February 2002, this was complemented by the opening of another spur which has a pilot regime for the management and treatment of dangerous and severe personality disorder.<sup>1</sup>
8. Whitemoor also houses a Close Supervision Centre (CSC) which opened in October 2004. The unit is a small therapeutic centre aiming to provide a supportive, safe, structured and consistent environment for prisoners who have been extremely disruptive in the prison mainstream.

### **Segregation Unit**

9. The segregation unit at Whitemoor is on E wing and is accessed through secure corridors. There are two parts of the unit, one referred to locally as the segregation unit and the other as E wing. However E wing is sometimes used as an overflow from the main segregation cells, and both sides are supervised by the same staff group. All prisoners are subject to risk assessment on location into the unit, and their risk assessment levels are discussed daily.
10. There are 32 normal cells, including 16 on E wing. They are large and have reasonable sized windows, with sufficient natural light. Stainless steel in cell sanitation units are carefully positioned to provide adequate privacy.

### **Dangerous and Severe Personality Disorder (DSPD) units**

11. There are currently four DSPD units, two in high security prisons (Whitemoor and Frankland) and two in special hospitals (Broadmoor and Rampton). Together, these units provide over 300 places. They are in high demand, with over 600 referrals received in an 18 month period. This is not surprising given that current estimates indicate that some 2000-2,500 people in custody meet the DSPD criteria.<sup>1</sup> By the end of November 2006, a total of 123 prisoners had been assessed at Whitemoor's DSPD unit and 75 were undergoing treatment.
12. The DSPD is situated on D wing at Whitemoor. The staff prisoner ratio is higher within the DSPD than the other wings, and is supplemented by a wide ranging multi disciplinary team. Prisoners have their own cells and the facility to cook their own meals in kitchens on their respective landing.

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<sup>1</sup> Data provided by the DSPD Programme Unit

## **The role of psychiatry in the DSPD**

13. Within the DSPD unit, the role of psychiatry fits within an overarching psychological model of treatment (in contrast to the predominantly medical model of most mental health service provision). The main focus of the treatment model is facilitating change in the personality disorder (and the associated risk), and management of mental and physical health problems is also important. One of the psychiatrists' specific contributions to treatment is prescribing and managing psychotropic medication. At the time of his death, the man was not prescribed medication.

## **Nursing interventions**

14. The nursing team also play an important role on the unit, especially with distressed prisoners. Many prisoners experience episodes of crisis throughout the phases of their treatment. The nurses' role is interwoven into the model of treatment. Through interpersonal, psychological and behavioural nursing techniques, it is hoped to reduce a prisoner's physical and psychological distress. Nurses play a key role in supporting prisoners and the manner in which this is done can enable the prisoner to see themselves in a more positive light.

## **Discipline staff**

15. The model of treatment on the DSPD unit builds substantially upon the traditional role of prison officers. It has been recognised that discipline staff working on the unit have had to adapt to a style of working that focuses on the treatment, rather than the management, of individuals. The senior officer (SO) told investigative colleagues that the discipline staff tend to fall into two distinct groups: those who consider themselves in the more traditional landing officer role and those who identify with their role as group workers.
16. All the officers receive some mandatory training, including a three day course on personality disorder awareness, but those who work with the groups are trained in skills to equip them to lead cognitive interpersonal groups. This training is delivered on an ongoing weekly basis. Discipline staff tend to work exclusively on one unit within the DSPD unit.

## **Occupational therapy**

17. Aside from their individual therapy and group work, prisoners in the DSPD unit have access to education, gym, employment opportunities and training workshops. Some prisoners work outside the unit as there are few employment opportunities within it.

## **Bullying**

18. The Prison Service has developed a number of strategies to help combat bullying. All prisons have a tailored anti-bullying strategy and the exact nature of the strategy depends on the type of prison, though each strategy has the

same core principles. If a prisoner is bullied or they know someone who is being bullied, they can open an Anti-Bullying Booklet when it is suspected that a prisoner is bullying. The purpose of the booklet is to monitor both the bully and the person being bullied.

### **Assessment, Care in Custody and Teamwork (ACCT)**

19. Being in custody can be a difficult time for many people, and it is not unusual for people in prison to feel that their problems are more than they can deal with. Some people feel so desperate that they may think of harming or even killing themselves. Usually, this does not last long but those identified as struggling can be placed on ACCT, which is a system for managing prisoners in severe emotional crisis.
20. As at all prisons, ACCT has been introduced at Whitemoor to monitor and support prisoners assessed to be at risk of suicide or self harm. Once placed on ACCT, the prisoner is observed at pre-determined intervals according to the perceived level of risk.
21. Each prisoner is assessed within 24 hours and then reviewed at intervals decided on an individual basis. The ACCT guidance says that, to be effective, the review should involve the key people who know the person at risk or are involved in their care. The key questions for each review are listed as:
  - have the problems that caused the ACCT plan to be opened now been resolved?
  - if not, what needs to be done to resolve them?
  - have any further problems arisen that are now causing distress and more risk?
  - if so, what action can be taken to address these?
  - is the person at risk now in contact with friends, family or other support?
  - does the person at risk now have something in their lives that they feel good about?
  - if not, how can this be improved?
22. Over time, the reviews should also consider other factors such as:
  - distress – has anything changed to make the person at risk more or less desperate?
  - resources – has anything changed that makes the person at risk now feel more or less alone?
  - previous suicidal behaviour – has anything changed that makes suicide more familiar or more acceptable to the person at risk?
  - suicide intention or plan – has anything changed to show that the person at risk is more or less prepared to kill themselves?
  - pattern of self harm – is self harm becoming more or less frequent?

23. Amongst other things, the ACCT guidance states that prisoners should be cared for in a safe environment. It is for the Case Review team to decide the most appropriate place to locate an individual prisoner.
24. Since the publication of Prison Service Order 2700 in November 2006, it has been mandatory for prison officers to carry anti ligature knives as they carry out their duties. The knives are to be used in the event of a prisoner being found hanging.

#### **Her Majesty's Chief Inspector of Prisons (HMCIP) Report**

25. The HMCIP inspection in 2006 found that the management of the DSPD, and the relationships within it, were extremely good. The unit provided individual multi-disciplinary support and treatment to enable very disordered men to progress through a three to five year programme.

## KEY FINDINGS

26. After many years in custody, the man was transferred from HMP Frankland to Whitemoor D wing on 4 December 2006. He was believed to have a dangerous and severe personality disorder, although a formal diagnosis had not yet been made. A cell sharing risk review was completed which showed a previous self harm history. However, he denied it, saying that he had not previously harmed himself.
27. On 21 January 2007, it was recorded in the wing observation book that the man was agitated and anxious and wanted to see a senior officer so he could go to the segregation unit. The man told officers that he was not sleeping and was worried about staying on the unit. During the night he produced a razor blade and threatened to cut his throat. He subsequently threw the razor blade out of his cell window. Staff opened an ACCT document and he was monitored by the multi disciplinary team throughout the day. An ACCT review took place at 6.15pm which the man attended. He said that he had been tired and anxious when he threatened to harm himself. Those present decided that his actions were a feature of his personality disorder and the ACCT document was closed.
28. Three days later, on 24 January, an entry was made in the man's wing history sheet about concerns that he was watching a female member of staff. The following week, on 3 February, he was placed on report by the prison officer as he had been continually threatening and abusive towards him. On 13 February, an entry was made in the man's wing history sheet that he was making the wing officer feel uncomfortable. In interview, the wing officer told investigators that the man was a bizarre person whose moods varied and who was constantly argumentative with her. She felt that he was bullying her as he used to invade her personal space and make her feel uncomfortable. In accordance with D wing protocol, the wing officer shared this information at the staff briefing.
29. The adjudication hearing in respect of the man being placed on report took place on Friday 16 February. He was found guilty of abusive conduct and 14 days of earnings and his private cash were stopped. The duty officer works in the segregation unit and met the man at his adjudication. The officer recalled that the man was not happy about the hearing, but complied with everything that was required of him.
30. One of the people the man talked to was a Roman Catholic chaplain at the prison. He remembered the man's arrival in December 2006, and saw him several times on the wing. He told my investigators that the man would always engage him in small talk, but did not ask to see him privately and he could not recall him attending a mass.
31. The man became friends with a fellow prisoner. They cooked together and the man's friend told the interviewers that he looked out for the man. He described him as very erratic, and a pest at times, but very likeable. The man would always try to be the first to speak to women as they entered the wing.

The man's friend told the investigators that two prisoners (prisoner A and prisoner B) bullied the man daily by calling him names. He said that at least once the man went to the wing senior officer and told them he was being bullied.

32. A registered mental health nurse (RMN) who works on D wing has worked at Whitemoor since 2006 knew the man well. She described him as a likeable person and said they used to talk about cooking and meditation. The RMN said it was difficult to have serious conversations with him as he was always joking. She described him as a jolly character. The RMN was there on one occasion when a prisoner called the man a 'stalker'. The nurse challenged the prisoner who was name calling and he told her that the man stalked women. The man gave the nurse the impression that he was not troubled by the name calling. She did not believe he was being bullied and did not initiate the prison's anti bullying policy.
33. Prisoner C lived in the cell next to the man's cell. He told the investigators that prisoner A and prisoner B had decided that they were going to make the man's life a misery. He said that prisoner A called the man a 'stalker' and a paedophile virtually every time he stepped out of his cell. Prisoner C also said that the staff were aware of the name calling.
34. Another prisoner, prisoner D, told investigators that he got on well with the man whom he described as impish and happy go lucky. He said that the man always had a lot to say for himself and was always rushing about. Prisoner D said that two weeks before his death the man had told him that prisoner A was calling him a stalker, and he had heard that prisoner B and prisoner C and were also calling him names.
35. When asked about bullying on D wing, prisoner D told investigators that there is a lot of self policing in prison and that bullying is stamped out quickly. He said he could understand why people called him a stalker, as he used to target women coming on to the wing and ask for a lot of their time. He also said the man had reported it to staff, although he was unsure when this was. My investigators have found no record of the name calling having been reported.

### **Saturday 17 February**

36. After the prisoners were unlocked on Saturday 17 February, the man used the wing telephone to speak to his mother. She has told us that they discussed a future visit, and she did not detect anything untoward during the conversation. He was looking forward to seeing her.
37. The man then went to his friend's cell and told him about the name calling by the two prisoners. His friend told him not to worry and said that he would speak with the two prisoners after he had been to the gym. Prisoner B, another prisoner on the wing, said that prisoner A was always calling the man names. He said that from the moment the man left his cell on the morning of

17 February, prisoner A shouted to the man 'paedo, nonce, sex case'. Prisoner D also said he heard more name calling that morning.

38. After making the call, the man went to the kitchen and boiled a large pan of water. He took the pan and walked along the landing to the prisoner's A unlocked cell where he and prisoner B were sitting. The man threw the boiling water over prisoner A, and then hit prisoner B across the side of his head with the empty pan. A fight between him and prisoner A started and prisoner B screamed for help. Staff arrived quickly and separated the man and prisoner A.
39. The RMN was on D wing at the time and her attention was drawn to a noise on the landing below. She looked over the landing and saw the man and prisoner A being separated by officers. The alarm bell sounded and staff were calling for a nurse. The RMN was directed to the showers where prisoner A and prisoner B had been taken. Prisoner A was sitting in a cold bath to minimise the scalding. Prisoner B told the nurse that the man had thrown hot water over him and prisoner A, and she treated their injuries. Prisoner A had burns to the insides of his legs, his arms and stomach. She later learnt that the man had been taken to the segregation unit.
40. The Principal Officer (PO) was working as the Orderly Officer. He was in operational charge of running the prison, using the radio call sign Oscar 1. He responded to the alarm bell and was told that the man had assaulted two prisoners. The PO spoke to the man to see if he was okay, and he nodded that he was. The PO thought the man expected to go the segregation unit because of his actions, and he was escorted there, unrestrained and of his own free will.
41. The PO remained on the wing, arranging for prisoner A and prisoner B to be taken to outside hospital. He then went to the segregation unit to ensure that the man had been dealt with appropriately, and that the correct paper work had been completed.
42. The second RMN had previously been a member of the permanent nursing staff at Whitemoor. On 17 February, she was working there on behalf of a nursing agency. She went to D wing to treat prisoner A and prisoner B and then to the segregation unit to establish if the man was fit for segregation. The second RMN firstly checked the man's core medical record, noticing that he had not been at Whitemoor on this occasion for long.
43. The second RMN then went to the man's cell to assess his fitness. In interview for this investigation, she recalled that he was very angry and pacing the cell. She said that he was quite dismissive of her and she could not engage him in conversation.
44. The nurse completed the segregation safety algorithm, referring to his core medical notes. In answer to the following three questions, the second RMN recorded that the answer was no:

- has the person self harmed in this period of custody or are they on an open ACCT or is the person currently taking anti psychotic medication?
- does the prisoner show signs of being acutely unwell, psychotic or withdrawal from drugs, does he have significant physical injury at the present time?
- do you think that that prisoner will be unable to cope with a period of segregation?

From the information available to the second RMN and her observation of the man, she believed that the segregation was the right place for him, and that he did not need an enhanced level of observation. The duty governor then signed the algorithm, thus authorising the man's detention in the segregation unit.

45. As part of his chaplaincy duties, the chaplain was in the unit at 11.10am whilst lunch was being served to the man. He said the man was in good spirits and asked the officers various questions about receiving his property from the wing. The chaplain asked the man if he was well, and he replied that 'everything's fine thank you'. The chaplain said he had no concerns about the man's safety or well being, and felt confident that had he wanted to say more to him, he would have done so.
46. After lunch, the second and the third wing officers and the senior officer (SO) collected the meal plates and went to the man's cell at 1.50pm. The second wing officer looked through the observation panel in the cell door, and saw the man facing him with a green prison sheet tied around his neck, and attached to the window. The man's head was tilted to his left side. His legs were not supporting his body but were bent at the top. His tongue was protruding from his mouth.
47. The second and third wing officers went into the cell together and supported the man's body, whilst the SO went to the unit's office to collect an anti ligature knife. At the same time healthcare staff and an ambulance were summoned by prison radio. The man was moved out onto the landing to make more space to conduct resuscitation. The second and third wing officers started resuscitation, joined by the RMN, and they used oxygen, a face mask and defibrillator.
48. The SO told my investigators that, when he first looked in the cell, he thought the man was sitting facing the door. However, he then saw that he was hanging from a ligature made from his bed sheet, tied around his neck and attached to the cell bars at the window. He ran to the office for the anti ligature knife. The RMN, who had been in the office, followed him back to the cell. The SO told investigators that the man had not rung his electronic segregation cell bell for staff assistance prior to him being discovered hanging.
49. The RMN went to the cell as the two officers were putting the man in the recovery position. She saw that his colour was grey and his tongue was

sticking out. She touched him and he was cold. There was a ligature around his neck, and no pulse could be detected. The nurse commenced resuscitation and was quickly joined by other healthcare staff. They continued resuscitation until the arrival of ambulance technicians.

50. At 2.00pm, the PO received a radio message to contact the control room. He learnt that the man had been found hanging in his cell, and he immediately went to the unit. When he arrived the man had been removed from his cell and was on the landing outside where staff were carrying out resuscitation.
51. The PO controlled the scene, tasking staff and dispersing those staff who were not required. The ambulance arrived at 2.10pm and the paramedics reached the unit at 2.16 pm. They assisted prison staff with resuscitation until 2.31pm when they assessed that the man had died. The local out of hours service would not send a doctor to the prison to confirm death. However, a police doctor attended on behalf of the police to formally pronounce death.
52. The PO preserved the area as a potential crime scene, and placed a sheet over the man pending the arrival of the police. At 2.15pm, the chaplain received a telephone call to inform him that the man had been found hanging, and the paramedics were in attendance. He went to the unit and administered the last rites of the Roman Catholic Church and made an entry in the segregation observation book. Screens were placed around the body to help preserve the man's dignity.
53. The duty governor ensured that the prison contingency plans for an emergency were implemented, and he was later involved in a hot debrief.
54. When the man's friend returned to D wing after having been to the gym, he was told that the man had been taken to the segregation unit and the reason for the move. After the man died, his friend was taken to a private office and staff broke the news to him. Prisoner B was also informed later that day that the man had apparently taken his life. He said that, even though he had been taken to the segregation unit, the man gave no indication that he wanted to take his own life.
55. Later in the day, the second RMN was told that the man had hung himself. She subsequently learnt that D wing keeps additional medical records on each prisoner, which are supplementary to their main medical record and which she had not been aware of when she completed the segregation safety algorithm.
56. The police visited the man's family later on 17 February and told them of his death. The duty governor met the man's mother and other family members the following day at the prison and explained what would happen afterwards. The chaplain was in the prison at the time of the family visit, but was not asked to meet them. He told the investigators that he believes this was a missed opportunity for him to engage with them, as he knew the man reasonably well and was one of the last people to speak to him. The chaplain

subsequently held a memorial service in the chapel, which was attended by prisoners and staff.

## **POST MORTEM**

57. The man's post mortem examination was carried out by a Consultant Forensic Pathologist . He concluded:

“There is no evidence of natural disease that caused or contributed to death.

“There are mild findings of asphyxia in the skin of the eyelids and conjunctiva. Such findings are consistent with there having been a period of compression of the neck. In support of compression of the neck is the presence of a rather faint, parchmentised ligature mark. Although the ligature was no longer in situ, in my opinion, all the findings are entirely in keeping with the scenario presented to me, with the deceased's neck having been compressed through suspension from a soft ligature such as a sheet. In relation to this I had the opportunity of viewing the sheet in question, which appears to be largely if not completely intact. It is contained within an exhibit bag. It is associated with a pink label, 'Wisbech crime property number 119/07'. The lack of any injury beneath the ligature mark over the neck would not be unusual in a case of self suspension, particularly if only part of the weight went through the ligature and also bearing in mind the soft nature of the ligature itself.

“There is no evidence to suggest any third party involvement such as through an alternative means of compression of the neck, including manual compression or compression through the use of a narrower ligature.

“There is also no evidence of any other injuries of an assault or restraint.”

## ISSUES

### Bullying

58. Several prisoners told my investigators that the man was subject to repeated name calling by the two prisoners he went on to attack. The prisoners also alleged that the man had reported their behaviour to staff, although my investigators found no evidence of this. However, at least one member of the healthcare team was aware and heard for herself that the man was being called names. Although she challenged the prisoner and decided that the man was not troubled by the incident, she did not take the precaution of implementing the prison's anti bullying procedure. In my view it is not appropriate for behaviour such as this to be managed by prisoners, and staff should respond assertively to all bullying.

**The governor should remind staff and prisoners of the anti bullying strategy.**

### Clinical care

59. Two clinical reviews were undertaken, one in the form of a panel review was carried out by Cambridgeshire and Peterborough Mental Health and National Health Trust. The second review was commissioned by my office and was undertaken by a doctor of Cambridgeshire Primary Care Trust.
60. The panel review was carried out by a number of professionals, some involved in the man's care, and others independent of his care. They evaluated the care afforded to him, and concluded that his death was a tragic incident and, with hindsight, not something anyone was able to predict.
61. The independent clinical reviewer concluded that the man was an emotional man who was prone to sudden anger and abusiveness, alternating with joking and apologetic demeanour. He was needy and could be charming. He constantly targeted the female staff and tended to monopolise the attention of staff, particularly women.
62. The man was halfway through an assessment programme, and no diagnosis had been reached for him. However, it seems likely that he would have been confirmed as having a personality disorder. He was not thought to be depressed, and was not being prescribed any medication. He had daily access to mental healthcare staff, which is substantially above the level of care he could have expected to receive in the outside community.
63. The clinical reviewer considers that the man's attack on the other prisoners was triggered by a two week exposure to verbal abuse and name calling. It was a premeditated assault, unlike his usual behaviour, which was generally impulsive.
64. The man was assessed when admitted to the segregation unit by an experienced registered psychiatric nurse in accordance with good practice.

There was no evidence that he was suicidal, or at risk of self-harming behaviour in the main medical record, and the nurse did not have access to his unit record. Although the review panel did not believe that the additional information from D wing would have changed the nurse's decision making, I believe that there are risks inherent in the practice of keeping duplicate records.

**The Primary Care Trust should ensure that there is a system in place to enable health care staff completing the segregation safety algorithm to have access to all the medical information.**

65. Resuscitation was prompt, appropriate and in accordance with best practice. Both healthcare staff and non-medical staff were involved. The ambulance and paramedics arrived swiftly, and were not delayed by prison security arrangements in attending the segregation unit.

### **Assessment, Care in Custody and Teamwork (ACCT)**

66. The man was correctly placed on an ACCT document after being found with a razor blade and threatening to cut his throat on 21 January. Although the document was closed the same day, it was after the full range of multi disciplinary staff in the unit had continued to work with him, and I am satisfied that their decisions were correct. His behaviour that day was deemed to be consistent with the likely diagnosis of dangerous and severe personality disorder, and did not resemble the actions which led to him taking his life the following month.

### **Anti ligature knives**

67. Since November 2006, it has been mandatory for prison officers to carry anti ligature knives as they go about their duties. However, the staff who found the deceased were not equipped with the knives and had to retrieve one from the unit office. In this case it is unlikely that the short delay whilst the knife was collected made a difference to the outcome for the man, but other situations may differ.

**The governor should ensure that all officers are equipped with anti ligature knives.**

### **Decency**

68. The prison's contingency plan required that, after the man's death was pronounced, he was left on the floor of the segregation unit pending the police investigation. Screens were placed around him after the Last Rites had been delivered, but he remained on view of those on the landings above. An evidence tent would have further preserved his dignity.

**The governor should consider a method of isolating a body from the view of prisoners and non essential staff.**

## **Chaplaincy Involvement**

69. The chaplain knew the man well from visiting him and other prisoners regularly on the unit. The chaplain was one of the last people to speak to the man when he saw him at lunch time. Later that day, the chaplain administered the Last Rites. The following day, the man's family visited the prison and saw the senior manager on duty, but did not speak to the chaplain. Like the chaplain, I believe this was a missed opportunity to engage with the family and to offer them the comfort of meeting someone independent of the prison who knew their son.

**The governor should consider using the services of the chaplaincy when facilitating a family visit to the establishment after a death.**

## CONCLUSION

70. The man was subject of name calling by at least one prisoner on D wing but, contrary to what some prisoners believe, there is no documented evidence that he reported it to staff. On the morning of his death, he telephoned his mother and discussed her visit, which he was looking forward to. He then told his friend that he was subject to name calling by two prisoners. The man then boiled a pan of water, walked to the cell of one of the prisoners and threw the contents over one and hit the other on the head.
71. There was no need for staff to restrain him when he was taken to the segregation unit, as he fully cooperated. He was seen by a registered medical nurse who did not consider that he needed any enhanced observation and was fit for segregation. He told the chaplain, whom he knew previously, that he was fine.
72. Sadly, he was found hanging little more than an hour of last being seen alive. Despite the best efforts of staff and paramedics, his life could not be saved. His act of premeditated violence earlier in the day may have been the catalyst for his death, fearing a criminal investigation, court case and a further sentence of imprisonment.
73. I conclude that the treatment and care that the man received at Whitemoor was of a high standard.

## **RECOMMENDATIONS**

### **The Governor should:**

1. Remind staff and prisoners of the anti bullying strategy.
2. Ensure that all officers are equipped with anti ligature knives.
3. Consider a method of isolating a body where life has been pronounced extinct from the view of prisoners and non essential staff.
4. Consider using the services of the chaplaincy when facilitating a family visit to the establishment after a death.

### **The Primary Care Trust should:**

5. Ensure that there is a system in place to enable health care staff completing the segregation safety algorithm to have access to all available medical information.