Investigation into the circumstances Surrounding the Death of a Male Prisoner At HMP Hull on 12 March 2006

Report by the Prisons and Probation Ombudsman for England and Wales

October 2006

This is the report of an investigation into the circumstances surrounding the death of a man at HMP Hull on 12 March 2006. He was found hanging in his cell shortly after 3.10pm that day. At the time of his death, he was serving a sentence of eight years. He was 31 years of age.

I offer the man's family and friends my sincere condolences for their loss.

The investigation was carried out by two of my senior investigators, who were able to meet with members of the family, and I very much appreciate the family's willingness to discuss what had happened so soon after their bereavement. I do not underestimate how difficult this must have been.

I also commissioned an independent clinical review of the management of the man's health needs while he was in custody. This was conducted by the Director of Professional Development for the Eastern Hull Primary Care Trust. I am most grateful for her assistance.

I should also like to thank the Governor and staff at Hull for their ready help and co-operation throughout the investigation.

Following this investigation, there remains uncertainty as to the extent to which HMP Hull was aware of family concerns about the man's safety. His mother has said that she rang with her concerns on several occasions, including on the afternoon her son died. The prison has no record of this occurring. I have been able to verify that at least some of these calls were made, although I cannot be certain of their content.

My report includes a number of recommendations which I hope will assist in preventing a similar tragedy in the future.

Stephen Shaw CBE
Prisons and Probation Ombudsman **October 2006**

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Summary

1. At the time of his death on 12 March 2006, this man was 31 years of age.

2. He had been arrested on Wednesday 11 May 2005 and remained in police custody until a court appearance at Hull Magistrates' Court on Friday 13 May. He was then remanded in custody for two offences.

3. The man arrived at HMP Hull around 2.00pm on the afternoon of 13 May. This was his first time in prison custody. He underwent initial interviews in the prison's reception area before transferring to A Wing, which is the prison's First Night and Induction Wing. At his request and due to the nature of his alleged offences, the man asked to be considered for Vulnerable Prisoner (VP) status.

4. On 19 May 2005, he was taken to court by the escort contractor. On the prison escort record (PER) form, the suicide/self harm box was ticked. The man was interviewed by a Prison Custody Officer, and said that he had never attempted suicide or self harmed, and that this must be a mistake. Content with the man's response, no further action was taken. The man returned to the prison later that day.

5. Four days later (23 May), following visits, information was received by the prison that the man might be at risk of self harm. He was interviewed by staff but said he had absolutely no intentions of self harm and that his visitor had just over-reacted. Again, no further action was taken.

6. Between arriving at Hull on 13 May, and 14 October, when he was sentenced, the man went to court a number of times. He underwent further reception health checks on 15 August and 14 October, neither of which revealed any issues of concern to staff.

7. On 15 July, he learned that his father had died. He was very distressed and was offered the services of Listeners (prisoners trained by the Samaritans), but declined. He was regularly observed during the night. The man spoke frequently to his mother, and was permitted to attend the funeral, after which his personal officer said that he appeared more positive.

8. Between 16 and 20 September, the man's mother contacted the prison to tell staff that she had received death threats against her and her son from a prisoner on B wing. On 19 September, a prisoner who was the man's friend was injured and warned to stay away from him. The man was interviewed and it was arranged that he should remain on his wing and have an escort if he went anywhere else. The man told his personal officer that he was being bullied when he went to work because of issues to do with his family.

9. On 4 March 2006, the prison received information about drugs in property which the man received from his mother. This was confirmed when he was searched. The man was placed on closed visits and was also subject to an adjudication hearing, held on 6 March, when he pleaded guilty. He provided

a written response which was read by the adjudicating governor. It said that the man found prison life hard to cope with and that he had been "thinking of ways to end his life". His case was adjourned for the independent adjudicator (circuit judge) to impose a punishment. In the meantime, the man's mother was banned from the prison for six months (after which she would be subject to closed condition visits for a further three months).

10. During the morning of 12 March, the man was described as being his "usual self". However, at lunchtime, he asked his cellmate to help him write a card for his son and, whilst doing so, he began to reminisce and become upset. After lunch, he said that he would not play pool as he was going to telephone his mother, which he did at approximately 2.10pm. His cellmate returned to the cell an hour later, and found the man hanging by ligature from the grill of the vent built into the wall.

11. The cellmate raised the alarm and staff responded immediately and tried to resuscitate the man. Paramedics attended shortly afterwards and continued to try to revive him. Sadly, they too were unsuccessful and he was declared dead at 3.35pm.

12. The investigation has been presented with conflicting evidence as to the extent to which the man's family alerted the prison to their concerns about his welfare. However, it is clear that some phone calls were made, although what was said during them is not recorded. It is also apparent that no follow up action was taken in respect of the man's written statement at his adjudication.

13. I make four recommendations and there are two learning points in the clinical review.

Investigation methodology

14. The investigation began on Tuesday 14 March 2006 at HMP Hull. My investigators met the Governing Governor, the chairman of the Independent Monitoring Board, the branch chairman of the Prison Officers' Association and the prison's Healthcare Manager. The lead investigator explained to them the nature and scope of the investigation and the report handling process.

15. On the same day, notices were issued to staff and prisoners announcing the investigation and inviting anyone with concerns or information relating to this man's death to make themselves known to my investigators. Only one prisoner came forward as a result. My investigators also interviewed 15 members of staff who had contact with the man during his stay in prison. Some staff were re-interviewed, following information about the adjudication hearing.

16. My office also contacted the office of HM Coroner for the East Riding and Kingston upon Hull, and the investigating police representative.

17. On 20 April 2006, my lead investigator and a Family Liaison Officer visited the man's mother and sister. The family raised the following matters which are addressed in the report:

   * His mother said that she made several telephone calls to the prison to express concerns that her son might be at risk of harming himself. She believes that she was labelled as over-protective and that the prison did nothing in response to her concerns.

   * She was informed of her son's death by telephone rather than face to face and was alone when she received the call.

   * At the time of our visit, some of the man's property was missing, although I believe this matter has since been resolved by the prison

   * Whether the man used the Listener service.

   * How someone of this man's size and build could hang himself in the way that he did. The family suggested that someone else could have been involved.

Background

The Man

18. The man at the centre of this report was born on 5 November 1974 in Warwickshire and was 31 years old when he died At the time of his arrest he was living with his partner, with whom he had a six year old son, but their relationship ended when he went to prison. His mother described him as a loveable rogue who was kind and caring and had cared for his father during his illness. He had a love for fishing and cars.

19. The man had a number of previous convictions and had received a range of community based penalties. This was his first time in prison.

HMP Hull

20. HMP Hull opened in 1870 and is now a Category B local prison serving the courts in East and North Yorkshire and North Lincolnshire, and a Young Offender Institution. The maximum number of prisoners who can be held in the prison is 1,071, and the certified normal accommodation is 812.

21. In March 2004, HM Chief Inspector of Prisons carried out an announced visit and reported that the prison was providing a largely safe and decent environment. Additionally, the prison has undergone a full Standards and Security Audit in 2004 and has been rated "good" in both areas.

22. There are nine residential units. The man was located on I wing where the cells meet the Safer Cell specification, meaning that the number of possible ligature points is reduced in an attempt to prevent impulsive acts of self harm and suicide. Prisoners on this wing also have their own keys to their cells.

Assessment, Care in Custody and Teamwork

23. Hull has implemented the Assessment, Care in Custody and Teamwork (ACCT) approach to helping and monitoring prisoners at risk of self harm. The key aims of ACCT are to create a safe and caring environment, to identify prisoners' individual needs and to offer individualised care and support before, during and after a crisis.

Telephone calls to the prison

24. There are two systems for dealing with telephone calls to the prison, one during the week and the other at weekends. Between 7.30am and 5.00pm, Monday to Friday, relatives ring the prison switchboard, explain their concerns and then are put through to either the Orderly Officer or the Duty Governor to take appropriate action. At other times, the prison switchboard is transferred to the prison's control room. The call is then logged by the Operational Support Grade (OSG) on duty, who passes it to the relevant

wing. There is a record of the calls, the Concerned Relatives Log, which is kept in the control room.

Standard and enhanced regime

25. Prisoners at Hull are first placed on the standard regime under the Incentives and Earned Privileges Scheme (IEP) unless they have transferred from another establishment at a higher level. Prisoners remain on standard for a period of eight weeks followed by which they can make an application to upgrade as long as they can comply with the following criteria:
    a) remained in employment working to standard;
    b) no disciplinary reports;
    c) complied fully with prison regime;
    d) been drug free, i.e. passed a drug test;
    e) complied with sentence plan (if applicable).

Adjudication hearings

26. All prisons conduct adjudications - disciplinary hearings - against prisoners following an alleged breach of prison rules. The prisoner is notified the night before or the morning of the hearing, and receives Form F1127 (Notice of Report) which has to be delivered at least two hours before the hearing begins. When the time comes, the prisoner is collected from their wing and taken down to the Separation and Care Unit where all the adjudications take place.

Medical emergencies

27. In emergencies, the prison has three medical codes used over the radio communication network to alert staff. Code red refers to injuries in which there is blood loss, code blue to airway or breathing difficulties, and code amber asks for normal medical assistance.

Insiders and Listeners

28. Hull operates both the Insider and Listener scheme. The role of an Insider is to welcome newly arrived prisoners, highlight any concerns they may have, and to explain the processes they will encounter in the early days of custody. Listeners assist those prisoners who require additional support at any time in their period in custody.

Public Protection

29. Any prisoner who is subject to Prison Service Order (PSO) 4400/1 is prevented from making unauthorised contact with certain identified individuals outside of the prison. The prison tries to balance security and good order, protection of the public and the prisoner's need to keep in contact with their family.

30. In this man's case, PSO 4400/1 required that his letters were read and his telephone calls were restricted, recorded and subsequently listened to. The prison has the facility to listen to live calls, but this man was not subject to this level of monitoring.

Events leading up to the death

31. Until his arrest, the man lived with his partner and their son. He was interviewed by the police about matters concerning a member of his family and arrested on 11 May 2005. The following day he was charged with two serious offences, which he denied, and remanded to appear in Hull Magistrates' Court on 13 May.

32. On 13 May at 7.25am, the man was taken from Humberside Police station to court, where he appeared at 10.00am, after which he was remanded to Hull prison to await his case being heard at the Crown Court. He arrived at the prison at approximately 2.00pm. The first reception health screen was conducted by a nurse, who at the time worked in the healthcare centre induction/reception team. He is a Registered Mental Health Nurse, but no longer works at the prison.

33. The nurse did not identify any health concerns, and ticked the appropriate box on the Cell Sharing Risk Assessment (CSRA) form which denotes "fit for normal location, work and cell occupancy". The primary purpose of the CSRA is to assess an individual's risk to other prisoners if they were to share accommodation, but there is also some reference to self-harm. The nurse recorded that this man displayed no evidence of risk to himself or mental health problems at the time of assessment. The man was asked if he wanted to see the medical officer but declined. When asked whether he had used drugs in the last month, the man said that he used cannabis. No further action was recorded and there is no evidence to suggest he was referred for detoxification.

34. As well as the healthcare interviews, the man was also interviewed by prison staff. A second officer completed sections one and two of the CSRA document and recorded "states no problems, not suicidal or likely to self harm". When asked by the second officer if he "would describe yourself as a person who gets angry/frustrated quickly", the man responded with the answer of "frustrated".

35. The second officer and the nurse both ticked the appropriate section on the CSRA form pertaining to the man being considered as a "LOW" risk of harm to others – no current indication/evidence of risk, suitable for multi-cell location.

36. The man was transferred to the first night centre on A wing around 4.00pm that afternoon. A Wing is where newly received prisoners go to receive their prison induction. Staff reported no problems on his first night centre interview when he was issued with the prison information booklet and offered the services of Insiders. The man said in the interview that he had problems reading and writing. Because of the nature of his offence, he was subject to PSO 4400/1 and so a telephone pin number was not issued immediately. On induction the man also asked to be considered for Vulnerable Prisoner (VP) status, meaning that he would be located on a specialist unit. He completed the prison's "Vulnerable Prisoner/Poor Coper

Unit Declaration" form. (I think the Governor may wish to consider whether use of the term 'poor-coper' is appropriate.) The next day, the man received his induction and chaplaincy talk.

37. On 19 May at 8.10am, the man was transferred to court by the escort contractor. On the Prisoner Escort Record (PER) form, the suicide/self harm box was ticked. (The PER form records information about a prisoner being escorted between a prison, court or police station.) At around 9.00am, Part B of the PER form, which records events, shows that the man was interviewed by the Prison Custody Officer. The man told him that he had never attempted suicide or self harm, and that this must be a mistake. Content with this response, no further action was taken. Following his court appearance, the man returned to the prison later in the morning.

38. On 23 May, information was received from visits staff that the man might be at risk of harming himself. Consequently the man was interviewed by officers and said that he had no intentions of harming himself and his visitor had just over-reacted. Throughout the interview he appeared happy to discuss his situation and made good eye contact with the staff speaking to him. No further action was taken.

39. The next day the man telephoned his former partner, against the requirements of PSO 4400/1. She then telephoned the prison the same day to express her concern that the man had been able to contact her. She followed her complaint up in writing, and the letter arrived at the prison on 26 May. She wrote that she had an injunction against members of the man's family that prohibited all forms of contact between them, herself and her son. The prison informed her that the man's mail was subject to controls, and that he was prohibited from telephoning her. This was confirmed in writing on 1 June.

40. Prisoners remain on the induction wing for a short period of time and it is normal procedure that, before a move is approved, the CSRA is repeated. The man's assessment was completed, no issues were found or raised, and the move was approved. On 9 June, he moved to I wing where he was assigned a third officer as his personal officer. (All prisoners at Hull are assigned a personal officer whose role is to meet on a regular basis to discuss any concerns.) The man and his personal officer regularly spoke together in private to discuss his progress, how he was feeling, and to identify and assist with any problems. The personal officer confirmed that, as far as possible, they tried to meet every week, although the prison requirement was only for bi-monthly meetings. The personal officer made regular entries on the man's personal wing history sheet summarising their meetings.

41. The man's personal officer described the man as a happy individual, who was quiet and with a small circle of friends; he had had the same cellmate throughout the rest of his imprisonment. He said that the man would not always say if he had problems, but instead would talk to his cellmate, who occasionally would tell the personal officer what was wrong on the man's

behalf. The officer was aware that the man and his cellmate were very close, and he said the cellmate never mentioned that the man had said he was thinking about taking his own life.

42. On 7 July, the man applied for enhanced regime status. Staff, including the personal officer, endorsed his application as he was considered a good group member, eager to learn and caused no problems in the wing. He was described as "a quiet inmate who complies to the wing regime – no problems". His application was submitted to the Incentives and Earned Privileges Board for consideration.

43. A week later, at around 6.45pm on 15 July, the man was informed that his father had died. He was very distressed and was comforted by his cellmate. The services of Listeners were offered, but not accepted. The man was kept under regular observation throughout the evening and night. His personal officer said he was aware that the man was upset, but that he seemed to be dealing with it. During this period, the man frequently spoke with his mother on the telephone.

44. The IEP review board convened on 27 July to consider the man's application for enhanced regime status. This was approved. The same day, following a risk assessment, the man was permitted to attend his father's funeral.

45. On 6 August, the man had his normal meeting with his personal officer. He reported that he felt a bit more settled following attendance at his father's funeral, and had no problems. These comments were recorded on his wing history sheet.

46. Between arriving at Hull on 13 May and 14 October when he was sentenced, the man attended court on a number of occasions. He underwent further reception health checks on 15 August (when he was convicted), and 14 October (when he was sentenced). The checks were carried out by a nurse, and neither revealed any concerns. On the last reception health check, the nurse recorded:

> "No problems at present. Was expecting sentence.
> No suicidal/self harm thoughts evident at present.
> Declined medical officer (mo)"

47. On several occasions between 16 and 20 September, the man's mother telephoned the prison to report that she and her son had received death threats from another prisoner on B wing. She said she was also being threatened by a local family, and that the man was aware of the threats. The mother reiterated her statements in a letter to the Governor. This was passed to the security department, who carried out an investigation.

48. Whilst the security investigation was continuing, on 19 September, a prisoner who was a friend of this man was slashed by another prisoner as he returned from work, and warned to stay away from the man. When

interviewed as part of the investigation, the man said that he was fine and would approach staff if he had any concerns for himself. Wing staff also spoke to the man about his safety on the wing. It was decided that he should only work on I or J wings, and should be escorted by staff to and from any other part of the prison.

49. The man's personal officer said that the man spoke to him on one occasion to tell him that he was being bullied when he went to work, but it was unclear whether this meant he was being bullied whilst moving around the prison or whilst at work. At the time, the man's work location was in another wing and, as a result of his admission, the matter was also investigated and his work location was changed to wing based education. The man's personal officer said he asked the man if he was aware why he was being bullied, to which he replied that it related to his family.

50. The man's mother told my investigators that she knew the family of the prisoner who had been assaulted, and they had informed her that his injuries were due to mistaken identity, and the intended victim was actually the man himself. She said that there was bad feeling between her family and that of her son's former partner, and that a relative had called in a favour from another prisoner, asking him to stab the man, which the man would have been aware of.

51. From 21 September to 6 February 2006 the many entries on the man's personal wing history sheet typify comments to the effect of:

- "No problems at present"
- "Sticks to wing regime, quiet approachable"
- "Complying to wing regime"
- "Polite and approachable"

However, on 12 December, a fourth officer (who was a member of the child protection team) recorded that threats were made against another prisoner because of his friendship with the man. At interview, the officer said that the man was aware of the threats but, as far as she was aware, he felt safe, especially because he no longer went to work, and was escorted by staff when he went to other parts of the prison.

52. The officer spoke to the man on a number of occasions, and also assisted him in dealing with correspondence. She described him as polite, courteous and generally no problem on the wing, although she felt that he was not the type of person to tell staff how he was really feeling. She was aware that, being subject to PSO 4400/1, his correspondence was monitored and screened, and therefore at times some of it took slightly longer than normal to reach him. This tended to be the correspondence that related to his son, which had to be directed via the social worker.

53. The man continued to have meetings with his personal officer, who further commented that there were no issues or problems, and that he conformed to the wing regime.

54. From December 2005 to February 2006, the man attended Hull County Court on a number of occasions regarding his application for access to his son. The last appearance was on 6 February. The next day, the man refused to attend work, saying he had had "a bad day yesterday at court – strike me" and was given a warning. (Strike is a term used within prison to mean the giving of an IEP warning.) The man's mother subsequently told my investigators that the man eventually lost his case, which upset him and caused him to worry.

55. On 2 March, security staff became aware that another prisoner, located on a separate wing to this man was having a relationship with his former partner. No further action was deemed necessary as they were on different wings. My investigators were unable to confirm whether the man was aware of the information, although he had had telephone conversations with his mother asking if she knew whether his ex-partner had another man in her life.

56. On 4 March at approximately 4.00pm, the man's mother and her neighbour visited him at the prison. The two women frequently visited together. After the visit ended, drugs were found stitched into the lining of underwear she had brought in and handed to staff. The man was searched and the next day he was informed that he was to be placed on closed visits. He was told about the appeal procedures, and said that he had no problems being placed on closed visits. In addition, the man was subject to an adjudication. His personal officer said he was surprised that the man had attempted to smuggle drugs into the prison. In his written response to the adjudication, the man said he took full responsibility for his actions and that his family were unaware that he had arranged for the drugs to be brought into the prison. He also confirmed that he had taken cannabis in the past to block out any problems he was having.

57. The man was served with the notice of the adjudication by a fifth officer at 07.50am on 6 March. He had not had an adjudication previously. Being unable to read or write, he asked his cellmate to write his response to the charge at his dictation. My investigators confirmed with his cellmate that he had written the man's reply to the charge. According to him, the man wanted to say that he was feeling suicidal as he wanted the governor to be lenient to him, and not because he actually felt like harming himself. The cellmate said that he was close to the man, but did not believe that he was suicidal, and the man had given no signs that he felt like harming himself.

58. His personal officer recalled that the cellmate had written the man's response to his adjudication, and that the cellmate was allowed to remain off work temporarily around 08.20am on the morning of the hearing. He did not see what was written and was unaware of its content. He recalled asking the man how he felt about the hearing and his reply that he was okay. The man did not suggest to him that he would take his life.

59. At 09.30am the man was escorted to the Separation and Care Unit (segregation unit) for the adjudication hearing. The adjudicating governor opened the hearing and confirmed that the man understood the reason for the hearing, as well as the process it would follow. This governor then completed the adjudication form, and signed his name to confirm that he had read the man's written response to the charge. His response contained the following statement:

> "I have been in prison I have found it very traumatising. I have had the death of my father, I have been denied contact with my son, I've split up with my son's mother whom I was with for 11 years. I have never had to deal with anything as traumatising as this on the outside and I have found this very hard to cope with and disturbing on my mind. I find myself lying awake at night thinking of ways to end my life and I find this very disturbing as I have never self harmed or had these thoughts on the outside."

60. The man pleaded guilty to the charge, but the adjudicating governor adjourned the matter to be heard by the independent adjudicator (the district judge who conducts the more serious hearings every month). This was the usual procedure for charges involving drug smuggling.

61. The senior officer in attendance at the hearing also works in the Separation and Care Unit and attends all adjudications. At interview, the SO was able to remember this man's adjudication and described him as being in an upbeat mood. He could not recall whether the adjudicating governor read out the man's statement, but did remember some reference being made to his comments. The SO said he knew that, because the governor brought them to his attention, he should consider whether to open an ACCT document. The SO told my investigators that, due to the pressure of work in the unit, he had not acted on the information and no action was taken. He also said that he did not have a system for recording any action he should take, and by the end of the morning's hearings the concerns about the man had slipped his mind. The SO said that there is a great emphasis in the Separation and Care Unit on suicide awareness and he was fully aware of the ACCT procedures.

62. After the hearing, the man returned to I wing at approximately 10.36am.

63. The same day (6 March) the adjudicating governor, in his role as Head of Security, wrote to the man's mother to inform her that she was banned from the prison for six months because she had tried to smuggle drugs into the prison. She was also informed that she would be subject to closed condition visits for three months after this period.

64. Three days later, on 9 March, the next entry on the man's personal wing history sheet records that he had his normal 1-2-1 meeting with the third officer. It was recorded that there were "No issues or concerns".

Events on 12 March

65. During the morning of 12 March, the man's cellmate said the man seemed to be fine. After the cells were unlocked, at approximately 9.00am, the man went to play pool on the landing below with other inmates. He borrowed his cellmate's snooker cue, whilst the cellmate remained in the cell. Around 11.30am the man collected lunch for his cellmate as well as himself, and returned to their cell. This was his usual routine as the cellmate had a bad ankle and used crutches. They ate their lunch together in their cell, which as usual was locked.

66. Over the lunch period the man's cellmate helped him to write a card for his son, something which he had done on several occasions. Whilst writing the card the man became upset about missing his son. The cellmate said that when the man was upset, he would lie on his bed with his headphones on listening to loud music, which he did on this occasion. The man reminisced about time spent with his son, which again was not unusual according to his cellmate. In previous conversations the man had expressed his unhappiness with the social worker responsible to the court for providing the man with monthly updates about his son's progress. The information did not arrive regularly and, as far as the man's cellmate was aware, none was received in February or March.

67. After lunch prisoners were unlocked as usual at about 2.00pm. The cellmate went to play pool, after asking the man if he was coming too. The man said that he intended to make a telephone call and so remained in the cell. The cellmate told my investigators that there was nothing unusual with the man's intended actions and he seemed fine when he left the cell.

68. The man's landing officer described him as a pleasant man. He told my investigators that he had dealings with the man regarding child protection matters, but nothing that appeared to cause the man any concerns. He saw the man at about 2.05pm going to the telephone, but was not aware if he actually made a call.

69. The prison's telephone transcripts show that the man telephoned his mother at approximately 2.03pm. The call was not monitored by staff and so the prison was not aware that he had spoken about "topping" himself and having no intention of coming out of prison. The man's mother referred to having spoken to other members of the family, including the man's ex-partner, about his intention to harm himself.

70. When my investigators met the man's mother, she confirmed that he telephoned her during the afternoon. She said that the nature of the conversation worried her and so, minutes later, she telephoned the prison to express her fears. She said that she got through to the prison switchboard and a female member of staff replied. The man's mother said that she was concerned about her son who was located on I Wing. She gave his full prison number. She told the member of staff that she knew that he was going to harm himself. The man's mother told the investigator that the

member of staff replied that, “we are aware of it, we know all about it,” or words to that effect. His mother said that she recognised the voice of the member of staff, but could not recall her name.

71. The man’s cellmate played pool for about an hour, then returned to the cell at about 3.10pm and found that the door was locked. He said this was not unusual and he used his own key to unlock the door. When he went inside, his cellmate saw him hanging from the air vent grid above the toilet. Although the cell was deemed to be a safer cell, there was a grill over the air vent with small holes which provided a point where the man could attach a ligature to a piece of wire.

72. The cellmate immediately tried to take the pressure of the sheet off the man’s neck by lifting him from the top of his legs. He shouted as loud as he could for help, and officers arrived immediately. The cellmate continued to help, and one of the officers tried to cut the sheet which was thick and caused some initial difficulty. When the sheet was cut, the officers placed the man on the floor. The cellmate said he was taken outside the cell and offered support by other staff.

73. A sixth officer was on escort duty that afternoon, which meant that he escorted prisoners to various parts of the prison. Having returned a prisoner to the second landing on I wing, he stopped at the end of the landing to speak with the man’s landing officer and heard a cell bell and shouts from the landing. The two officers went straight to the cell, arriving at approximately 3.10pm. When they went in they saw the man’s cellmate with his hands around the top of the man’s legs, attempting to hold him up. The man was suspended by a ligature above the cell toilet. The cellmate was distressed and panicking. The escort officer described the ligature as made out of pillow cases and attached to a piece of wire threaded through the grill of the vent built into the wall.

74. The man’s landing officer was the first officer to go into the cell. He immediately used his radio to call Code Blue, and then assisted the escort officer and the cellmate to release the man. The escort officer attempted to cut the ligature with his fish knife, but found it difficult because it was made of thick material. He decided to use his strength and pull at the ligature, which came free. The pressure on the man’s neck was relieved and he was lowered initially to a sitting position on the toilet. The ligature was removed by the man’s landing officer. Together with the cellmate and the escort officer, they laid the man on the floor. The escort officer said that a further two officers arrived and took over, and the man’s landing officer took the cellmate away from his cell.

75. The first officer at the cell told my investigators that he had seen the man earlier in the day. He had been his normal jovial self, chatting and joking with other prisoners. At the time the alarm was raised, this officer was unaware what the incident was and believed it might have been a fight. He immediately made his way to the cell, and saw the man’s landing officer and

the escort officer laying the man on the cell floor. The first officer at the cell noticed a ligature mark around the man's neck.

76. A second officer arrived and, together with the first officer at the cell, relieved the escort officer and the man's landing officer. They checked the man's pulse, breathing and eye movements. They were unable to obtain a response and began to administer cardio pulmonary resuscitation (CPR). The first officer breathed into the man's mouth, whilst the second carried out chest compressions. They continued until the paramedics arrived. The first officer said that a female nurse arrived, and assisted by holding the ambu-bag over the man's mouth. An extra nurse also arrived soon afterwards, relieved the second officer and continued chest compressions.

77. The second officer had just left J Wing to go to the tea room between I and J wings when the call Code Blue came over the radio net at approximately 3.10pm. He went to the second landing and saw some commotion outside the man's cell. This officer therefore ran to investigate and saw the first of the further officers in the cell with the man laid on the floor. He went in and immediately checked the man's pulse, pallor, pupils and breathing. At that time there was no pulse, and no breathing.

78. The second officer informed the first that they needed to carry out CPR. He applied his gloves and cleared the man's airway. At this time the man was quite blue. Upon clearing his airway, the first officer gave a couple of breaths and then both officers administered CPR with the second doing the compressions. The first officer found it difficult to keep the seal of the air bag over the man's mouth, which was wet. The second officer said the female nurse arrived and assisted the first. This was helpful because the female nurse made the seal tight while the first of the further officers squeezed the air bottle. CPR continued for what the second officer believed to be approximately 15 minutes, and at intervals they checked the man's pulse and breathing.

79. At approximately 3.15pm, the extra nurse arrived and took over compressions from the second officer, who was physically exhausted. A minute or two afterwards, the paramedics arrived at the cell. Further attempts were made to revive the man, including the paramedics using their equipment to provide shock treatment, but without a response. The second officer then left the cell area.

80. The female nurse told my investigators that she had gone to G and H wing to give out medication when she heard the Code Blue on the radio. She made her way as fast as she could to I wing, which took around 30 seconds. When she arrived, she was directed to the man's cell where the two further officers were carrying out CPR. She said that it was obvious to her that the man had attempted suicide as his face was blue and there was a mark around his neck. She quickly assisted the first officer, who was giving air, by ensuring the airway was clear and holding the ambu-bag mask over the man's mouth. The second officer was carrying out the chest compressions.

81. The female nurse said that she thought the officers were doing an excellent job at administering CPR. The cell had become quite hot. She continued to try to keep the man's airway open and get a good seal around his mouth. She noticed that there was vomit in the man's mouth, so CPR was temporarily stopped whilst she attempted to clear his airway. She moved to the side of the man and knelt down by the side of his head, kept his airway open and continued to assist the first of the further officers. She checked the man's pulse but there was still no output. The extra nurse arrived very soon afterwards and took over chest compressions from the second officer.

82. A Principal Officer (PO) explained to my investigators that he was responsible for the smooth running of the establishment and day to day matters. At about 3.10pm on 12 March, he received a radio message reporting a Code Blue emergency on I wing. He left the Orderly Office and proceeded to I wing where he was directed to the cell. There he found the female nurse and the extra nurse, with the two further officers, performing CPR on the unconscious man. The PO arranged for a Log Keeper to keep a log of everything that happened surrounding the cell, and any future movements in and out of the cell. All other prisoners had already been moved away from the landing and returned to their cells. The PO spoke to the man's cellmate, who was agitated. The PO then offered the cellmate the services of Listeners, but this was refused.

83. The PO knew that Control Room staff had called for an ambulance, and he arranged for security staff to wait at various access points to ease the passage of the ambulance through the prison to the entrance of I and J wings. The ambulance arrived at 3.20pm, and shortly afterwards the paramedics reached the man's cell. So that they had enough room to work, the female nurse left and went to console the man's cellmate, who was on the landing. He was in shock, crying and very emotional and distraught.

84. The paramedics placed their equipment on the man to determine whether his heart was still working. They continued to administer CPR and attempted, unsuccessfully, to resuscitate him. The paramedics pronounced the man dead at approximately 3.35pm. The prison staff told my investigators that the paramedics commended those administering CPR as having done an excellent job.

After the man's death

85. Governor A took over as Duty Governor at 8.00am, carrying out his normal duties: visiting all the residential wings, conducting management checks and dealing with any issues. The Duty Governor said that around 3.00pm he heard a Code Blue announced over the radio. The PO told him shortly afterwards that there had been an incident on I wing, resuscitation was being attempted and an ambulance had been requested. The Duty Governor went to the Command Suite so that he would be in the correct place to carry out the prison's plans for dealing with a death in custody, should that be required. At about 3.30pm, the Duty Governor was told that the paramedics were on site and had pronounced the man's death. He began to implement the contingency plans and the instructions from PSO (Prison Service Order) 2710.

86. The Duty Governor asked a second PO to go to I wing and relieve the original PO, as he needed to be briefed about the background to events, and as the original PO was the Security Principal Officer with a sound working knowledge of the Command Suite.

87. At 3.35pm, the man's cellmate was taken to K Wing, supported by two Listeners. His clothing was retained by staff as it would be required by the police as evidence. A privacy screen was requested from the Healthcare Unit to be placed around the doorway of the man's cell. Between 3.43pm and 3.55pm, prisoners on both sides of cell I2/29 were relocated to alternative accommodation on the wing. All the prisoners currently on an open ACCT form were interviewed by wing managers and offered support where required.

88. The Independent Monitoring Board was informed of the man's death at 3.50pm, and the Samaritans at 4.00pm. Humberside Police were also called and first arrived at the prison at 4.30pm, with further officers arriving throughout the evening. The police have confirmed that, despite the man's size and build, no-one else was involved in his death.

89. The Duty Governor said that, when the man's death was confirmed, he was concerned about contacting his next of kin (his mother) as she lived some 50 to 60 miles away. He asked the police officers already at the prison if they could assist. In turn, they provided the telephone number for a police station in South Yorkshire, believed to be situated in the area where the man's mother lived.

90. The Duty Governor telephoned the police station, explained the situation, and asked for someone to go to the home. He described the person to whom he spoke as unhelpful, and said the conversation was terminated abruptly when the line went dead. The Duty Governor rang back, and a different person answered the phone but who was also unhelpful. He was concerned that time was passing and did not want the man's family to be informed by an unofficial source. At around 3.51pm, the Duty Governor

decided to telephone the man's mother himself and tell her of her son's death.

91. The man's mother answered the telephone and the Duty Governor passed the news to her. He said that the line went quiet and he could hear the background noise of what sounded like a tumble dryer. In two or three minutes, he said that another woman came to the phone. He explained again what had happened and after a few moments spoke to the man's mother again. She told the Duty Governor about telephoning the prison that afternoon, as well as the previous day, which he said he would investigate. The Duty Governor spoke with the man's mother on two further occasions that evening and visited her at her home a couple of days later to help discuss funeral arrangements.

92. The Duty Governor carried out a hot debrief meeting at approximately 5.00pm, attended by the wing staff and managers, Healthcare staff and the Staff Care and Welfare team. The events of the afternoon were discussed, as well as the initial actions of staff. The Duty Governor took the opportunity to enquire whether anyone had spoken to, or was aware of any other member of staff speaking to, the man's mother that afternoon. No-one present said they had any knowledge of any contact. Following the debrief, the staff directly involved were sent off duty, a member of the Care Team first obtaining their contact numbers to ring everybody at home later in the evening to check that they were alright. One member of staff said that they felt support for management staff was inadequate, and they were expected to be able to cope with such situations. The clinical reviewer has approached the Primary Care Trust to request specialist support for Healthcare staff.

93. The police conducted their enquiries throughout the evening. At 9.00pm the undertakers attended to remove the man's body, after which the cell was again secured. The police are content that there were no suspicious circumstances surrounding the man's death.

94. Notices to inform staff and prisoners were issued the next day by the governing Governor, who wrote to the man's mother to offer condolences and provide contact details for her to use. It was arranged that the Duty Governor would keep in contact with her, and subsequently the prison offered assistance with the funeral costs.

95. A post mortem was conducted on 13 March, which confirmed that the man's death was by hanging. The toxicology report was negative apart from traces of Amitriptyline and Nortriptyline; the Amitriptyline concentration was said to be within the range for therapeutic use. The man was not prescribed any medication whilst he was in prison and so it must have been obtained by other means. We have no information about the period of time when the man took the drug, or when he might have stopped taking it, and so it is unclear whether it might have affected his mood.

Issues considered in the investigation

The contact the man's mother's had with the prison whilst he was alive

96. The man's mother told my investigators that she made several telephone calls to the prison as she was worried that he might be at risk of harming himself. She believes she was labelled as an over-protective mother, and the prison did not act on her concerns. She says that both she and her neighbour spoke to the adjudicating governor on several occasions and once heard him telling another member of staff to say he was not there to speak to her.

97. His mother states that she telephoned the prison's main switchboard on Sunday 12 March, five minutes after she had finished speaking to her son. She said that she used the main number, as she had done on previous occasions. She got through to a recorded message, and waited for the operator whom she told of her worries that he was going to harm himself. She says that the member of staff replied to the effect that the prison was aware of her concerns.

98. His mother told us this was not the first time that she made such a telephone call, previous ones being the preceding week on Monday 6 March, Wednesday 7 March and Thursday 8 March. Her calls on the Wednesday were at 11.15am, 2.00pm and 6.00pm, and each time she was crying as she was upset and worried.

99. She provided my investigators with copies of her phone bill, but it only showed six calls made between 3 and 4 March, with a duration of 28 minutes 11 seconds. She told the investigators that other calls were made from her pay-as-you-go mobile phone, for which an itemised bill was not available.

100. My investigators interviewed the adjudicating governor twice and he denies having spoken to either the man's mother or her neighbour. He said that he did not know whether she had spoken to another member of staff, although he is the only one with this surname. He signed the letter sent to the man's mother that banned her from the prison; it was a standard letter prepared by one of his team. The adjudicating governor also says that he did not have a conversation with her about the letter, as she has alleged.

101. The prison's Concerned Relatives Log has been examined. It contains no entries made between 1 December 2005 and 10 April 2006. The man's personal wing history sheet and the I wing observation book were also checked. They too have no records of concerns reported to the prison. Governor A told my investigators that he also checked the prison records for any evidence of the telephone calls, but had found nothing.

102. My investigators were given the names of female staff on duty on the wing or in the control room on the day of the man's death. All those interviewed denied having spoken to anyone about concerns regarding this man. My

investigator came to the view that all the staff were fully aware of their responsibility to record any concerns about prisoners. However, I am obviously concerned that, when the man's mother was told of his death, she immediately said that she had informed the prison earlier that afternoon because she was worried. Although there is no evidence to substantiate her statement, the absence of any entries in the Concerned Relatives Log for more than three months is worrying. The man's mother's telephone bill evidences six telephone calls, none of which were recorded in the log as having taken place.

Previous references to the man harming himself

103. Whilst in prison, the man showed no signs to wing staff that he was at risk of suicide or self harm. The staff repeatedly described him as pleasant and giving no problems. Three risk assessments were completed during his imprisonment, none raising issues of risk of self harm. The man also had numerous opportunities to share his anxieties with staff. His personal officer exceeded his responsibilities and had weekly meetings, but there is no evidence that the man used the conversation to share any worries. He and his cellmate were close friends, and he too confirms that no risks were disclosed.

104. The man spoke to his family about harming himself, and his mother has said that she reported her worries on a number of occasions, the last being on 12 March - the day that he took his life. There are no records of her calls within the prison, but her telephone bill confirms that six were made from her landline between 2 and 3 March. We cannot confirm whether his mother actually got through to a member of staff, hung up or was cut off. However, what can reasonably be assumed is that, given the number of calls, she must have been worried. Previously, when the man's friend was injured, the prison did respond to information from the man's mother about his safety and she was clearly aware how to report her concerns.

105. The man's sister told my investigator that once, when visiting her brother, he told her that he was going to hang himself with a shoe lace. She thought this happened soon after their father's death. She said that she was very concerned and so made a fuss to prison staff. She believes that, after passing on the information, the man was put on a 'suicide watch'.

106. My investigator found two entries in the man's records relating to matters of possible self harm. The first was on 19 May 2005, six days after he was taken into custody, when the suicide and self harm box of the Prisoner Escort Record is ticked. The second entry was found on the man's personal wing history sheet dated 23 May 2005, following information from visits staff that the man might be at risk of harming himself. This entry is likely to have followed his sister's concerns. When he was interviewed, the man assured the staff that he had no intention of harming himself.

107. The man made a written statement for his adjudication hearing, to the effect that he was struggling with his sentence and threatening to harm himself. It

was written on 6 March, six days before he took his life. His cellmate, who wrote the statement on his behalf, did not believe that this was a risk and so did not report what had been dictated to him. The statement was read by the adjudicating governor, who told the senior officer to act on the information. However, the man was not questioned about his intentions at the hearing, and the staff involved did not detect any indication of distress. Regrettably, the matter was subsequently overlooked and no action was taken.

108. The staff responsible for the hearing were fully aware of their duty to prisoners at risk of harming themselves, and it is to the credit of the Senior Officer that he has admitted his error. Clearly, the man should have been fully assessed and consideration given to opening an ACCT document. I am pleased to note that, since the man's death, the prison has implemented a system for staff at adjudications to list any other action identified during the hearing and to nominate the person responsible for dealing with it

109. The man's family asked whether he used the services of the Listeners at any time. He was clearly aware of their role, having been offered their support after his father's death, but there is no evidence that he ever accepted their support. Although the Listener service is confidential, there should be a record of any request in the prisoner's history sheet.

Events which caused the man distress

110. The man's mother was barred from visiting her son for six months after drugs were found in property which she had brought in. She said that she was unaware of the drug and, when she received the letter from the adjudicating governor, telephoned him to explain this. The decision to ban her from the prison was not revoked, which she said would have upset her son.

111. Given that the drugs were found in the man's possession, my investigators considered that banning his mother from the prison was reasonable and justified. However, she was his main visitor and there is no evidence that the impact of the ban on the man was considered. His mother said that her son was also distressed about losing his application for parental rights. There was no evidence that the man raised either matter with any member of staff, including his personal officer or the members of the child protection team.

112. I am pleased to note that the bullying incidents and the threats to the man's life were taken seriously and dealt with appropriately. However, he is likely to have continued to be worried, and his mother contacted the prison to inform them of his fears. These calls were logged by the prison.

Informing the man's family about his death

113. The man's mother was upset that she was informed of her son's death by telephone, when she was on her own. I appreciate that Governor A wanted

her to know of the tragedy as quickly as possible, and from an official source. Unfortunately, his attempts to obtain police assistance so that she could be told face to face were unsuccessful. His telephone call was made with the best of intentions, but it would have been better if he had first ascertained that she had someone with her before delivering the news.

114. I have also said on many occasions that reliance upon the police to inform bereaved relatives of a death in prison custody is to be avoided wherever possible.

Conclusions

115. Other than the statement written for the adjudication hearing, the man gave no evidence to his cellmate, friends or staff on the wing or at the hearing itself, that there was any risk of him harming himself. It is therefore all the more tragic that neither his statement for the adjudication hearing, nor the telephone calls his mother says she made that afternoon, were acted upon. Had the appropriate actions been taken, it is possible that events would not have turned out as they did.

116. The man was located in a safer cell, not because he was deemed to be at risk, but simply because that is the standard for a modern cell. Regrettably, the cell was not entirely safe as it contained an air vent from which the man was able to hang himself. In my view, a cell with such a ligature point should not be designated as one which meets safer cell standards.

Recommendations

National

1. The Prison Service should review its safer cells and remove any grilled air vents similar to that used in this man's death. Alternatively, cells with the vents should not be designated as safer cells.

   The prison service has referred this issue to the Safer Custody Group.

Local

2. The Governor should instruct all staff at adjudication hearings to record and respond to any concerns about prisoners.

   The prison service has accepted this recommendation.

3. The Governor should review the arrangements for informing the next of kin of a death in custody, particularly relatives who live outside the locality of the prison.

   The prison service has accepted this recommendation.

4. The Governor should remind staff of the importance of logging concerns about prisoners made by their relatives, and others, and ensure that they are reported to the appropriate member of staff.

   The prison service has accepted this recommendation.