

**Investigation into the circumstances surrounding the
death of a man at HMP Highpoint on in May 2007**

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

September 2009

This is the report of an investigation into the circumstances of the apparently self-inflicted death of a man at HMP Highpoint on 30 May 2007. In the year that the man spent in custody he moved between five prisons, each with different security conditions. His experience and his mood seemed to change significantly according to where he was located. However, his full records did not follow the man and information was lost along the way. Officers and the mental health team at Highpoint were not aware of his mental health diagnosis at Kirkham or his most recent suicide attempt at Pentonville.

I offer my sincere sympathies to the man's family in Manchester and London on their loss. I must also apologise for the delay in completing this investigation. I trust this report will address all the concerns the family has raised.

I appointed a senior investigator to conduct the investigation on my behalf. She is grateful for the support received from the team at Highpoint, particularly the investigation liaison officer. For my part, I would like to thank the then Governor at Highpoint and her Deputy for the time and support that they gave the investigation. I would also like to thank the investigation liaison officer at Pentonville for his assistance.

I am also grateful for the prompt clinical review, commissioned by Suffolk Primary Care Trust that examined the man's clinical care throughout his time in custody.

I make nine recommendations in this report, some more far-reaching than others. I am particularly concerned to ensure the prompt transfer of information to inform a prisoner's care, and to improve communication between healthcare staff and discipline staff. I have also commented on the primary mental healthcare available at Highpoint and the lack of purposeful activity.

The report was disclosed to the Prison Service and the Primary Care Trust in advance of the man's family and the Coroner. It is a critical report and I was able to correct factual inaccuracies before the full consultation took place. I am grateful to the Prison Service for their co-operation.

My final sentence of this report is a strong one: I conclude that the man did not receive care of the standard to which the Prison Service aspires.

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Prisons and Probation Ombudsman

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SUMMARY

The man was taken into custody in May 2006. He adjusted well to his first prison, HMP Elmley in Kent, taking on employment in the kitchen and apparently making friends. Following his own request to be nearer to his family home, the man moved to HMP Kirkham, near Preston. According to his medical record, the man developed depression at Kirkham and, at the end of January 2007, he escaped.

Seven days later, the man admitted himself to an Accident and Emergency unit in London, following a minor overdose. He was treated and the same day was taken into police custody. In accordance with national procedure, the man was taken to the nearest local prison, HMP Pentonville.

Suicide prevention measures were opened on his arrival, but closed the next day. The man did not settle well at Pentonville, repeatedly telling staff that he was shocked by the difference in conditions between Pentonville and those at the lower security prison, Kirkham. After a few weeks, he cut himself superficially and was again made subject to suicide prevention measures. These were stopped after three days.

In March, the man tried to set fire to his clothes, causing burn wounds. He told staff that he intended to kill himself. The man was put on suicide prevention measures for a third time, was referred for a mental health assessment and was admitted to the inpatient unit. After two weeks as an inpatient, the man was discharged. By this time, he had been allocated to Highpoint, a lower security prison, but could not be transferred, pending his mental health assessment.

At the end of April 2007, the man was transferred to Highpoint, although there is no record of a mental health assessment taking place beforehand. At the time of my investigation, the documentation relating to his last suicide attempt was missing. Therefore, it is not clear from the records whether he was still subject to suicide prevention measures at that time. The first reception healthscreen was completed and information relating to his attempt to set fire to himself noted by the reception nurse but not passed on to officers. The man was located in the induction unit and a mental health referral was made.

Following contact from the man's family, the primary care mental health nurse started his assessment of the man's mental health needs, including treatment for insomnia. Unfortunately, due to a combination of sickness and staff shortage, the assessment was not completed. The man remained unemployed for the five weeks that he was at Highpoint.

The man was found hanging in his cell at 9.40am on 30 May 2007. Despite signs that rigor mortis had set in, staff attempted to resuscitate him. When the nurse and doctor arrived, they found no signs of life and agreed that he had been dead for some time. The man was pronounced dead at 9.50am.

Not all of the man's records were available to my investigator. These included the man's last suicide prevention record. My investigation examines the transfer of records, reception procedures and levels of purposeful activity.

I have made nine recommendations.

THE INVESTIGATION PROCESS

1. I appointed a senior investigator to conduct this investigation on my behalf. The man visited Highpoint to open the investigation and collect the man's paperwork. The investigator met the then Governor at Highpoint, the liaison officer for the investigation, and representatives from the Independent Monitoring Board and the Prison Officers' Association.
2. Notices to staff and prisoners were sent to Highpoint, explaining the purpose of my investigation and inviting those with relevant information to come forward. There was no response to these notices.
3. The Prison Health Service Manager at HMP Hollesley Bay was appointed to conduct the clinical review on behalf of Suffolk Primary Care Trust. In his review, the clinical reviewer concentrated on the man's time at Highpoint, given the information that was available to staff at the time. I am disappointed that the clinical review makes no comment on the transfer of clinical information, which played a crucial role in the care offered to the man at Highpoint.
4. My investigator visited Highpoint several times during the course of 2007 to interview staff. As part of her investigation, she contacted HMP Kirkham and also conducted interviews at HMP Pentonville.
5. The investigator accompanied my Senior Family Liaison Officer to meet the family and their legal representatives in October 2007. Over the following months, the family shared their anxiety about the man's care while in custody. I hope this report addresses all their concerns.

HMP HIGHPOINT

6. Highpoint is a category C prison located in Suffolk. According to the report of the most recent full inspection carried out by Dame Anne Owers, Her Majesty's Chief Inspector of Prisons, fewer than seven per cent of the prisoners come from within a 50 mile radius of the prison. The man's experience was no different - his home was over 200 miles away, with very poor public transport links to the prison.
7. The Chief Inspector found that, "Highpoint was not an effective training prison." Its location and lack of purposeful activity were key factors in the failure to deliver the appropriate regime for a training prison. The Chief Inspector's team found that there were insufficient activities available for prisoners in a training prison. The Independent Monitoring Board also discussed employment opportunities in their Annual Report for 2006. Although they acknowledged the six activities for prisoners to be employed in, the report expressed frustration at the lack of facilities for a broader range of jobs.
8. The Chief Inspector's team found that mental health care for those suffering from severe and enduring mental illness was adequate, but primary mental health care for prisoners with anxiety or depression was "limited". In its Annual Report, the Independent Monitoring Board commended the healthcare manager for the delivery of healthcare services, despite significant staff shortages. My investigation will explore the use of agency staff.
9. The man's death was the second apparently self-inflicted death at Highpoint in 2007. There have been no other apparently self-inflicted deaths since then.

KEY EVENTS

10. The man lived with his wife and two children in the Stockport area of Manchester. He was born in Luton, although his family were from Bangladesh. He had no history of mental illness while he was in the community.
11. On 19 May 2006, the man appeared at Canterbury Crown Court. He was convicted of assisting illegal entry into the United Kingdom and sentenced to three years imprisonment. Upon conviction, the man was taken to Elmley prison, where he remained for five months until November 2006. (Elmley is a local prison, serving the courts in the Kent area.) The man's family remembered him being happy there. His father and brother would often visit him as they were from London. They remembered him talking about friends, and he enjoyed working in the kitchens. However, his wife lived in the north of England with his two children and the man wanted to move closer to home. In November 2006, he transferred to HMP Kirkham, near Preston.
12. The man arrived at Kirkham on 8 November and was immediately allocated work in the prison's kitchen. Kirkham is a category D prison that accommodates around 600 prisoners. Category D prisons have the lowest security level. Prisoners are trusted to leave the prison to attend jobs in the community but must return to the prison for roll calls and at night. His history of good behaviour meant that the man was suitable for such conditions.
13. However, the man's family were concerned about him during the time he spent at Kirkham. Despite weekly visits from his wife, they noticed his personality changed there. He did not say that he was being bullied, but seemed to have formed no friendships among the prisoners. The man's family told my investigator that he had not suffered from depression before he was at Kirkham. It is clear from his medical records from this time that the man's mood was depressive. Staff found activities to keep him busy, because he said that this helped him to deal with his low moods. Even so, after two months at the prison, he absconded from Kirkham on 22 January 2007. He wrote a note saying that he could not take it any more. An officer made an entry in the man's clinical record that he had left two "suicide notes", but no effort was made to tell the family of the existence of any such note. His whereabouts were not known by the Prison Service for seven days. In fact, the man returned to his father's house on 23 January. He told them he had taken an overdose of antidepressants. After persuasion by his family, the man went to the Royal London Hospital under an assumed name. He was diagnosed with possible psychotic depression and was visited daily by the Home Treatment team. When his family explained to the man that they would have to approach the police about his whereabouts, he was very upset and threatened to kill himself.
14. On 31 January, staff at Kirkham received a telephone call from Tower Hamlets police station. The police explained that the man was being taken

to a local hospital due to psychiatric problems. In fact, the man had presented himself at the Accident and Emergency department of a hospital in London, saying that he had taken an overdose of Zopiclone. The man had taken a small amount of paracetamol, and his physical condition was quickly brought under control. On 1 February, after his medical needs had been resolved, the man was taken to Bethnal Green police station. He was monitored closely on Closed Circuit Television (CCTV) because staff were concerned about his self harm history. The police contacted Kirkham to let them know that the man was in custody. In accordance with normal procedure following an escape, the man was then taken to the nearest local prison, Pentonville. When a prisoner is transferred between establishments, the originating prison and the escort company responsible for the transfer must complete a Prisoner Escort Record (or PER). The man's PER on this occasion, completed by Bethnal Green Police station, made no reference to his risk of self harm or suicide.

15. Pentonville is a busy local London prison that can accommodate over 1,000 prisoners. The contrast between Pentonville and Kirkham would have been pronounced for the man and he immediately complained to staff that he was not happy. It seemed that the man had expected to return to Kirkham to finish his sentence. However, a prisoner arrested after absconding will go to the closest prison and await recalculation of his sentence to take into consideration the time unlawfully at large. Including the day that he absconded and the day that he was returned to custody, the man was 'at large' for 11 days. However, due to an administrative oversight, no days were added to his sentence.
16. On the day of his arrival at Pentonville, the man went through a first reception healthscreen. The records from his time in hospital two days previously, a doctor's letter advising continuous observation and the letter from another doctor diagnosing possible psychotic depression and a detained person's medical form detailing the police's concerns about his history of self harm, were available to the prison.
17. When Kirkham had realised that the man's whereabouts were not known to the Prison Service, they had compiled an escape pack, with copies of all of his files ready to forward to another prison when he was recaptured. When Kirkham were notified that the man was no longer at large, it was their responsibility to send this file to Pentonville. Nor did Kirkham inform Pentonville that the man had left one or two suicide notes behind when he absconded. Pentonville did not request the man's records from Kirkham and Kirkham did not send them. After the man's death, my investigator contacted Kirkham where the man's medical record remained. The medical record was sent to Highpoint after the man's death.
18. The emergency mental health assessment and liaison team at the hospital where the man was treated for his overdose wrote to Pentonville to recommend treatment and medication for him. The author of the letter suggested that the man be prescribed Olanzapine (an antipsychotic), Mirtazapine (an antidepressant) and Zopiclone (used for insomnia), when

needed. The doctor was also under the impression that the man was going to return to Kirkham and made mention of this in the letter. The doctor went on to recommend “continuous observations due to risk of self harm”. This letter was filed in the man’s medical record but was not referred to by staff again, with the exception of a doctor at Bethnal Green Police station.

19. A secondary health screen was carried out by a consultant. The man’s “depressive episode” was noted but he told the consultant that he had no suicidal intent. Nevertheless, the consultant raised a Concern and Keep Safe form, which is the first stage in the Assessment, Care in Custody and Teamwork system, known as ACCT. (ACCT is the system used by prison staff to identify, monitor and support prisoners at risk of suicide or self-harm.) The consultant made the following entry on the Concern and Keep Safe form: “overdose three days ago, small quantity, unlikely to represent serious suicide attempt but still at risk of DSH [deliberate self harm]. Symptoms and signs of depression.”
20. There was an entry in the man’s ongoing ACCT record: “having handed himself into police, [the man] expected to go back to his D Cat prison – explained that the system does not operate that way – said he was not depressed but that he is on medication.”
21. In line with procedure, an ACCT assessment was carried out the following day. During the interview, the man explained that he had first become depressed at Kirkham and did not know what he was doing when he absconded. He said that he had good support from his family. The ACCT Assessor recorded: “says he doesn’t need to be on an ACCT as he is alright and won’t harm or kill himself – said he has learnt from his mistake.” The officer recommended that the ACCT document be closed. An hour later, a senior officer met with the man and the ACCT Assessor to discuss whether the ACCT document should remain open. Ideally, an ACCT case review is multi-disciplinary, but only officers attended on this occasion. During the review the man, “stated clearly that he did not intend to hurt or kill himself”. The senior officer recorded that a mental health referral had been made and the ACCT document was closed, one day after it was opened.
22. In accordance with policy, the man’s security category was reviewed in light of his escape from prison. He noted that the ACCT document had been closed, the man was on normal location and that he had no history of security risks. A recommendation was made that the man should be given his category C status. This recommendation was countersigned by a senior officer. As a category C prisoner, the man no longer needed to stay at Pentonville, a category B prison. However, on 6 February, a nurse recorded in error that the man could not transfer because he was “on ACCT and awaiting assessment by MH [mental health] team”.
23. On 23 February, the man cut his wrists. His wounds were treated but an officer observed that he was “withdrawn” and “he doesn’t respond to dialogue so won’t explain reasons for self-harm”. The man said that he was

worried about being away from his family and his children. His second ACCT document was opened. In the action plan drawn up to support the man, the officer suggested that he should be subject to “two hourly watches”, be encouraged to telephone his family and staff should help arrange for his family to visit.

24. Over the next few days, the man told staff that he was looking forward to being moved, now that his security category had been reviewed and he could go to a lower security prison. During the ACCT case review on 26 February, the man made good eye contact with staff. He told staff that he did not feel suicidal. He repeated that he wanted to go to a category C establishment. The man did not want to speak about his self harm. The review noted:

“it was just stupid and no serious attempt to harm himself. He is just frustrated because he was in an open prison and absconded. He wants to go back to an open prison or is waiting for [Home Detention Curfew].”

(The Home Detention Curfew scheme applies to prisoners whose sentence is between three months and three years. If assessed as suitable, the prisoner is released up to four and a half months before the end of their sentence subject to a curfew policed with an electronic monitoring device.) Under the section requesting details of previous acts of self harm, an officer noted, incorrectly, that the man had not attempted to kill himself before.

25. Following the case review, it was noted that staff should contact the office responsible for arranging transfers for prisoners and request that they prioritised transferring the man to Highpoint, a category C establishment in Suffolk. The ACCT document was closed. As far as my investigator is aware, none of the officers involved in the opening, reviewing or closing of this ACCT document were medically trained.
26. During a medical appointment on 27 February, it was noted that the man had no mental health problems or thoughts of self harm. He told the nurse that he had not slept for a week and that he could not eat. He went on to say that he had eaten some fish fingers the previous night and some cereal that morning. He told the nurse that he had “something wrong in his head”. He was referred to a doctor due to his depressed mood.
27. Officer Hunter made the final entry in the man’s wing history from Pentonville on 3 March 2007. He wrote:

“I have spoken to this inmate and his body language and personality shows me that he’s ok. I had a chat with him and he also said he’s fine. I have also spoken with some other officers that are familiar with the man and they also said that he’s ok so there are no concerns at this time.”

28. Although the man remained at Pentonville for a further eight weeks, there were no further entries in the wing history sheet made available to my investigator.
29. On 7 March, the man's security category was reviewed again. The officer acknowledged that the man absconded from Kirkham but upheld that he was a category C prisoner. He recommended that the man be allocated to Highpoint which is in the catchment area for Pentonville. A governor told my investigator that Highpoint takes most category C prisoners from Pentonville.
30. The next day, 8 March, an escape pack was put together because of the man's absconding from Kirkham. (An escape pack is put together when a prisoner has absconded and contains all of their files ready to be sent to the appropriate establishment when the prisoner is relocated.) A note was made on the pack that the man's ACCT document was closed.
31. At 3.35pm that afternoon, the man was found in his cell having attempted to set fire to his clothes. He was escorted to the Accident and Emergency department where he was treated for his burns. Staff recorded that he was "still actively suicidal" and that he had no regrets about his actions. A doctor made a note in the man's clinical record that he was having difficulty sleeping and eating since his transfer. The doctor requested a psychiatric assessment. The man was admitted into the healthcare centre in order to monitor his mood and to treat his burn wounds.
32. A third ACCT document at Pentonville was not available to my investigator during this investigation. It is only by reference to the documents in his clinical record that I can determine that an ACCT document was opened following his attempt to set fire to himself.
33. On 9 March, the psychologist carried out a review and found a "recent deterioration in mood due to worse conditions in Pentonville". The man said that he was complaining to his family all the time, which increased their anxiety. The psychologist noted that the man had no mental health problems before being in prison. The psychologist required more information about the man's personality in order to determine the difference that prison had made. The psychologist concluded:

"From history and current explanations I did not form the impression of genuine will to end his life. Nonetheless self harm can be repeated as he is expressing active dissatisfaction and distress. The actual attempt was painful but not significantly morbid or dangerous."

The psychologist found that the man had a moderate depressive adjustment disorder and a moderate risk of self harm. (An adjustment disorder is a short-term reaction to a stressful event or situation.) However, he thought that the man was a low risk of suicide. In his review, the psychologist questioned the reliability of the man's family as a source of information. Understandably, upon reading this in the documentation, the

family were upset by the implication that their input was not necessary to the man's care.

34. That same day, the family's local Member of Parliament (MP) wrote two letters, the first to the Governor and the second to the Healthcare Department at Pentonville. The MP asked the Governor whether the man was going to be transferred to a prison nearer his family. He passed on the family's worry that the man was isolated from them and had not contacted them, despite their sending him postal orders. This letter also mentioned that the man was confused about his sentence dates and sought confirmation of when he was due to be released.

35. In his letter to the Head of Healthcare, the MP explained that he had been contacted by the man's wife who was concerned about her husband, specifically whether he was taking his medication or not. He wrote:

"I would be grateful if this situation could be reviewed to ensure that the man is currently being prescribed his correct medication. The man's family would also be grateful if efforts could be made to ensure that this medication is taken correctly and if necessary ensuring that the man is supervised whilst taking his medication."

36. Pentonville's then Head of Healthcare told my investigator that he did not routinely see all complaints made to the Healthcare Department. He said that he did not recall seeing the MP's letter. Both letters were passed to the Head of Residence, and copies were filed in the secretariat's legal correspondence file. The Head of Residence wrote to acknowledge the MP's letter and indicated that he would respond directly to the man's wife about the concerns raised.

37. The man's previous ACCT document of 23 February 2007 recorded that a post-closure review interview should have taken place on 12 March. There is no record of this post-closure review. It is unclear from the records whether the review took place or not.

38. A week later, on 21 March, the Head of Residence wrote to the man's wife addressing the points that the man had raised on her behalf in both the letter to the Governor and the Head of Healthcare:

"[The man] has been categorised as a Cat C and allocated to HMP Highpoint in Suffolk. This is one of the prisons that we allocate to. His transfer there will be subject to the normal procedures of being made medically fit for transfer.

"[The man] is located in the Healthcare Department, where any mental health issues can be assessed accordingly.

"Since [the man]'s arrival in Pentonville he has not been made subject to prison discipline as a result of his abscond from HMP Kirkham.

“His current release date is 26 November 2007 and he will have received the customary sentence notification slip.

“The postal orders mentioned were credited to [the man]’s account on 15 February 2007. It may be of interest that he has a balance of £180.60.”

39. On 14 March, the man was given two Valerian tablets to help him sleep. (Valerian is a natural remedy used for insomnia.) He was recorded as being “more frustrated than hopeless” in his clinical record. During a psychology review the next day, the man said that self harm was a way of protest and he wanted to live. Over the following days, his physical wounds were monitored and, according to his medical record, he remained subject to ACCT in the healthcare centre.
40. Following a review of his burns, the psychiatrist assessed the man on 22 March to check that he was fit to discharge from the healthcare centre. The psychiatrist found that the man was suffering from an adjustment disorder and that there was still a risk of self harm. However, he concluded that the man could be transferred to a residential wing. The Head of Healthcare told my investigator that he would expect a note to have been made in his medical file if the man’s ACCT was closed while he was an inpatient in the healthcare centre. There is no such note.
41. Five days later, the man’s wife wrote directly to the Head of Residence to ask whether her husband could be supervised when he took medication. The governor responded to the man wife’s letter on 2 April and copied his reply to the man’s wing manager at the time. During interview, the Head of Residence could remember passing the letter to a residential member of staff. However, he could not recall the member of staff to whom he passed the letter and there is no record of the letter in the man’s wing history records. In his response, the Head of Residence wrote that the Healthcare Department would not make the man “medically fit for transfer” so he had not yet been moved to Highpoint. He concluded, “although this could be for a variety of reasons, it does indicate that the prison is aware of his medical needs”.
42. After another week, the senior nurse at Pentonville assessed the man as not fit for transfer to another establishment. The senior nurse decided that the man needed a mental health assessment before he was transferred.
43. In accordance with his care plan, the man was seen on 7 April to have his burn wound cleaned and dressed. Although it was still red, the wound was judged to be “healing nicely” and no further follow up was needed.
44. Highpoint does not have an inpatient facility and has set criteria by which prisoners can be accepted. A prisoner must have no ongoing healthcare needs which require “routine or regular interventions”. He should have no outstanding hospital appointments or be subject to a detoxification programme. The prisoner must also arrive with his medical record.

45. The man was not transferred to Highpoint until 23 April. There are no entries in his wing history record between his discharge from the healthcare centre until his transfer to Highpoint. There are no further medical interventions during this time. There is no record of the required mental health assessment taking place. My investigator showed the Head of Healthcare at Pentonville the man's medical record and he agreed that there was no evidence of a mental health assessment happening before the transfer. There is no reference in the man's medical record or his wing history as to whether the ACCT document, opened following the burn incident on 8 March, was closed.
46. It is not possible to determine whether his most recent ACCT document accompanied him. It is likely that the other ACCT documents were transferred with his files. The man's medical record from Pentonville followed him to the prison, but his Kirkham medical record had not been transferred to Pentonville, and consequently it was not transferred to Highpoint.
47. Staff who completed the man's PER recorded that he was an escape risk and ticked the box marked "suicide/self harm". In the section entitled, "further information about risk", it was noted "F2052 closed". (F2052SH was the suicide prevention system before ACCT.) When the man arrived at Highpoint, officers signed the PER to acknowledge receipt of the form and it was put in his core record that accompanied him to the wing.
48. An agency nurse who routinely worked at Highpoint completed the man's first reception healthscreen. The man told the reception nurse that he was not sleeping and had a loss of sensation in his arms. The nurse explained to the man that, as a healthcare professional, he only had access to the man's medical records. He said that he read the records and noted the man's attempt to self harm through fire setting. However, when asked by my investigator about his impression of the man during the healthscreen, reception nurse said that he understood his numbness to be a sign that he felt depressed.
49. The nurse said that he was not trained in or confident with ACCT procedures, nor was he trained in mental health. He was not concerned that the man was at risk of self harm or suicide during the healthscreen. The nurse thought that the man's serious attempt at self harm was an "isolated incident". During interview, he acknowledged that there is no direct question on the healthscreen form about feelings of suicide or self harm. However, he said he would have made a record on the form about any such concerns.
50. The man's records showed that he had previously been on an ACCT but it was now closed. The reception nurse said that it was not his responsibility to check whether the man's full records had been transferred. He did not make a record in the man's wing history file or his cell sharing risk assessment about the episode of self harm in March, which means that the

specific information in the medical record went no further. The reception nurse was concerned about the man's lack of sleep and numbness and referred him to the mental health team.

51. The reception nurse completed the cell sharing risk assessment. (The cell sharing risk assessment is completed every time a prisoner arrives at a new establishment. It is designed to determine whether a prisoner should be more safely located in a shared cell or single cell, depending on his history of violence or self harm. The third section of the form is completed by a healthcare professional, usually the same person who has completed the first reception healthscreen.) The reception nurse signed the healthcare section of the form, where he noted that the man's "agitation or aggression" and "previous behaviour" were indicators that he could be a risk to others. The last two questions on the form are: "Following the self-harm assessment have any concerns been raised? Yes No", followed by, "If so, what are they:" After this question there is a large space for the healthcare professional to complete the indications of self harm. The reception nurse left both questions unanswered. The man was located in a single cell on the induction wing.
52. The day after his arrival in Highpoint, the man's wife contacted a member of the prison's chaplaincy team. She was concerned because she had not heard from her husband for six weeks. The chaplain asked a mental nurse to speak with the man. The mental nurse said that he was going to the induction unit that day and so took the opportunity to visit the man.
53. The mental health nurse spoke to the man about his family's concerns that he had not contacted them. The man agreed that he would telephone his wife, but was more concerned about his lack of sleep. In interview, the mental health nurse described his impression of the man:

"He didn't seem like a normal prisoner, he wasn't one of the, you know, you come across quite a lot of prisoners who are, haven't got a long history of crime, so he didn't seem very prison-wise."
54. The nurse concluded that the man was suffering from a "moderate episode of adjustment or reactive depression due to first sentence and separation from family support networks". The man did not mention any thoughts of suicide or self harm during their discussion. Following their conversation, the mental health nurse decided to ask the doctor to prescribe Mirtazapine (an antidepressant) and speak to the senior officer on the wing. The nurse planned to check the man two weeks later. Mirtazapine was prescribed two days later to be reviewed in a further two weeks.
55. During the interview with my investigator, the mental health nurse said he was aware of the man's attempts at self harm at Pentonville. The nurse said that he knew there were ACCT documents but he had not realised that the most recent ACCT was missing. Given the man's presentation during their discussion, the mental health nurse did not have any concern about suicide or self harm at the time of their discussion.

56. The mental health nurse asked the induction unit senior officer, to encourage the man to contact his family. Although the mental health nurse could not remember the exact reason for this conversation, he told my investigator that the man's telephone credit might have taken some time to be transferred to Highpoint. The nurse was concerned that the man should be able to speak to his family as soon as possible, given their concerns. The mental health nurse said that the induction unit senior officer would arrange for the man to have some credit until his account arrived. The senior officer told my investigator that he remembered encouraging the man to telephone his family and offered him the office telephone. However, the man told the officer that he was content to wait until his balance arrived.
57. In the two and a half weeks that the man remained on the induction unit, there were no more entries in his wing history record. A personal officer scheme was in place at Highpoint. (Each prisoner is assigned two personal officers on their wing who they may approach with anything concerning them. The personal officer is expected to make quality entries in the prisoner's wing history record.) There were no personal officer entries in the wing history record while the man was on the induction unit. He was not allocated a personal officer until he moved to a residential wing.
58. When the man had been transferred to Highpoint, the custody office at the receiving prison calculated his sentence dates. The man's sentence was due to expire on 27 May 2009, his conditional release date was 29 November 2007 and he was eligible to be considered for release on a Home Detention Curfew on 15 July 2007. (The conditional release date is the halfway point in a prisoner's sentence when the presumption is that they will be released on licence.) During their meeting with my investigator, the man's family said they were worried that he did not know how long he was to remain in prison. However, on 27 April, the man signed to agree that he had been informed of his release date. He made no note to indicate that he disagreed with the calculation. I conclude, therefore, that the man was in fact aware of the length of his sentence.
59. On Friday 11 May, the man moved to a single cell on B wing, a residential unit in the prison. It was recorded that he was a standard prisoner who was "unemployed". He was given an induction talk his two personal officers, and they recorded their conversation in his wing history.
60. Later that same day, the mental health nurse was contacted by an officer on the wing because the man was complaining that he could not sleep. The mental health nurse examined the man's medical record and noticed that he was not collecting his prescribed medication. The mental health nurse spoke to the man later that day and asked why he was not taking his medication. The man told the nurse that the medication was not working. The mental health nurse wrote an exclamation mark next to this entry. He said that the man was adamant that the medication was not helping him sleep.

61. The mental health nurse agreed that officers would complete a sleep chart to check the man's sleeping patterns which he would review after the weekend. (A sleep chart is completed by staff on the wing who check a prisoner every hour to see if they are asleep and then make an appropriate entry in the chart.) The sleep chart was duly completed and the mental health nurse reviewed it on 14 May. During interview, he explained that rather than a "poor" sleeping pattern, the man's sleeping was "erratic" because he slept for only three hours for two nights but the middle night he slept for six hours. The mental health nurse made an appointment to discuss these findings with the man on 18 May. During interview, he explained to my investigator:

"I was going to come over and see him on the 18th. Unfortunately that day I had to take a prisoner who was very unwell to the nearest jail. So we didn't keep that appointment I had to cancel that ... I made another appointment for the 21st, unfortunately I was off sick."

62. The mental health nurse did not have any further contact with the man. The nurse explained that he is a primary care mental health nurse. As such, he cares for prisoners with mental health conditions such as anxiety and depression which are not classified as severe and enduring. The mental health inreach team treat prisoners with secondary mental health needs. That particular mental health nurse is the only primary care mental health nurse at Highpoint and there is no arrangement for his work to be covered during unplanned or short absences. The inreach team will take on his work during planned long periods of leave. As the absences on 18 and 21 May were unplanned, there was no one to take his place and no one from the mental health team saw the man after 14 May.

63. One of the man's personal officers recorded that burnt foil had been found in the man's room on 21 May. As foil is usually associated with drug use, a security report was submitted. In interview, the wing senior officer explained that the man was probably challenged about the foil but would not have known he was subject to a security report. Rather than have an adjudication, the man was due to have a mandatory drug test which was scheduled for 30 May. (An adjudication is a hearing conducted by a governor in the prison when a prisoner is alleged to have breached the Prison Rules.) This adjudication did not take place. There is no indication that the man ever participated in substance misuse. The toxicology report that was carried out after his death showed no illicit substances in his system. For a prisoner of the man's quiet and polite demeanour, it is likely that such a serious allegation would have caused him some anxiety.

64. The wing senior officer completed a cell sharing risk review on 24 May. He explained to my investigator that any prisoner assessed as a medium or high risk at reception must be reviewed within one month of their arrival. He said that he recommended that the man be reduced to a low risk. All cell sharing risk assessments have to be agreed by a healthcare professional. The nurse on this occasion considered the man's medical file and thought that he should remain a medium risk due to the outstanding

mental health issues being dealt with by the mental health nurse. The man therefore remained a medium risk and stayed in a single cell.

65. A governor completed a review of the man's wing history on 27 May. All wing histories are checked by governors to check the quality of entries. The governor found the completion of the man's wing history to be "below standard" and wrote, "re above, not good". For the five weeks that the man had been at Highpoint, there were five entries, the last being that of the governor.

30 May

66. As part of the night operational support grade (OSG)'s duties, they must carry out a roll check. To carry out a roll check, he is required to look through the observation panel of every door and see the prisoner. (Roll checks occur at the beginning and end of a night shift and staff ensure that all prisoners are safe and accounted for.) At 7.00am on 30 May, the night OSG rang the central office to confirm that there were 123 prisoners on A and B wings. At 7.35pm, an officer arrived on B wing to relieve the night OSG. In interview, that officer recalled a brief verbal handover that morning, when he was told that a prisoner, not the man, had been playing with his lights. There was nothing else to report and the OSG left the officer alone on the wing.
67. The officer checked that all the cell doors were secure. He explained to my investigator, "I walked round B wing, checked all the doors were secure, went round A wing checked all the doors were secure, then came back to obviously all the staff coming on." When my investigator asked about the purpose of the door check, he said that it was to check that no doors are left open. The officer said that he is not required to look inside the cell and does not do so.
68. Once he had completed his door checks, the officer went to the B wing office for a routine staff briefing. A second officer also attended the meeting. The first officer was assigned to work on A wing and the second was assigned to B wing. Following the meeting, the second officer unlocked the prisoners who had employment, at about 8.15am. The man was still unemployed so his cell was not unlocked. No other prisoners are unlocked at the same time. Once the employed prisoners have left the wing, officers unlock the wing cleaners who go about their duties. At about 9.00am, the second officer was accompanied by another officer to start the routine accommodation fabric checks. (Each cell is checked daily to ensure the security of the cells.) The second officer described the check to my investigator: "Go in, shoot the bolt, check the observation panel, the bars, just check the walls really and then make your way out, do the bell, the light." She guessed the checks took a couple of minutes at the most for each cell.
69. The second officer remembered that they started on the upper landing of B wing. The man was situated on the lower landing. The officer said that the

checks usually take between 15 and 20 minutes in total, depending if there are any interruptions. The officer could not recall any such delays on the morning of 30 May.

70. When the officer reached the man's cell she looked through the observation panel. She said that she did not "register" what she saw and continued to unlock the door and go into the cell. As she walked in, she realised that the man had turned his bed on its end and fastened a bootlace around his neck. She saw that he was hanging from the light fitting and tried to support his body. She called for staff to help her.
71. The officer accompanying her for the fabric checks, who had been completing the accommodation fabric checks with her, was nearby. He heard the officer's shout and followed it to the man's cell. He supported the man's body more successfully and the second officer used her ligature knife to cut the bootlace. Both officers lowered the man's body to the floor. The second officer made a "Code Blue" radio call. (Code Blue means that the medical emergency is due to breathing difficulties.) She said that she went to start cardio pulmonary resuscitation (CPR) but felt that the man was cold to the touch. As she stood back, a first aid trained officer arrived at the cell and started chest compressions. The man's jaw was stiff so staff were not able to give him mouth to mouth resuscitation.
72. The nurse assigned to respond to any healthcare emergency that day was in the healthcare centre when he received a radio call asking him to go to B wing. As he was collecting the emergency response bag, he heard a Code Blue radio call He was accompanied by a Healthcare Assistant and they went directly to the wing.
73. The emergency response nurse said he remembered that the cell door was closed when he arrived. In his interview with my investigator, the wing senior officer recalled that the door was "pushed to", rather than closed. Staff were inside the cell, still attempting resuscitation. He went into the cell and noted that the man was "blue black in colour". In a statement written later that day, the emergency response nurse recorded that during his first examination there were signs that "rigor had set into his joints". (Rigor mortis is a condition that occurs between two and four hours after death when the muscles stiffen.) The nurse found no pulse or heartbeat.
74. A prison doctor also heard the Code Blue radio call and was asked by a nurse to go to the wing in case he was needed. A prison doctor arrived as the emergency response nurse was examining the man. In his statement, the doctor also mentioned that rigor mortis had set in and he noted that the man's jaw was locked and mouth to mouth could not have been effectively administered. The doctor pronounced the man's death at 9.50am.
75. When the man's cell was cleared out following his death, an empty bottle of medication was found in his cell. The label indicated that it had been prescribed to the prisoner who had occupied the cell before him.

Contact with the man's family

76. The Deputy Governor asked the local police in Manchester to visit the man's family to break the news of his death. Prison Service Order (PSO) 2710 – Follow Up to Deaths in Custody provides guidance for family liaison. The guidance acknowledges speed and the importance of face-to-face contact in such circumstances. It also suggests that a Prison Service representative from the area nearest the family, such as a family liaison officer or chaplain, should be asked to break the news in the first instance, unless there are security issues about visiting a family's home.
77. The Deputy Governor had tried to contact HMP Manchester to ask for a representative from the Prison Service could visit the family to break the news. She was told that there was no family liaison officer available that day. She then contacted HMP Buckley Hall and was told that their family liaison officer was unavailable at that time. At this point, she contacted local police to avoid further delays in arranging for a Prison Service representative to break the news. After she had been in touch with the police, the Deputy Governor contacted the Head of Residence at Buckley Hall, at 3.30pm that afternoon. She explained to him about the man's death and asked if a local family liaison officer could meet his family.
78. I appreciate that the distance between Highpoint and the man's family home caused the prison some difficulty in breaking the news. As there were no security concerns in this case, it is unfortunate that the Deputy Governor had to rely on local police rather than a Prison Service representative. I hope that in future cases where the family live at a distance, Highpoint will have more success in contacting a local prison so that a Prison Service representative can break the news on their behalf.
79. Unfortunately, the man's wife was taken to hospital following the news of her husband's death. She was not at her home when Buckley Hall's Head of Residence arrived and instead he met the man's father and a family friend. The Prison Service representative explained what he had been told about the man's death, telling them that a family liaison officer would be appointed as a permanent point of contact. He left his details in case of any further queries.
80. The Deputy Governor continued the family liaison for Highpoint. Two representatives from Highpoint, the Head of Residence and the Imam, visited the family on 31 May. The prison acted in accordance with their obligations under PSO 2710, including his family's request for the repatriation of the man's body to Bangladesh. The man's sister visited the prison after the funeral to collect the man's personal possessions.

Prisoner support

81. The Deputy Governor posted a notice to prisoners to let them know that the man had died and reminding them that Listeners were available to provide support. (Listeners are prisoners trained by Samaritans to provide

confidential emotional support to fellow prisoners in distress.) My investigator was assured that a good Listener scheme was in operation at the prison. All staff who spoke to my investigator described the man as a quiet man who did not associate with many other prisoners.

Staff support

82. A hot debrief was attended by all staff involved in the discovery of the man. It was held in the dining room on another unit. The officer who found the man in his cell told my investigator that it was helpful to work out what had happened. A critical incident debrief was held some weeks later and run by the staff care and welfare service. The second meeting was not well attended. However, those who did attend told my investigator that it was a useful opportunity to share how staff were coping with what had occurred.

ISSUES

Clinical care

83. A Prison Health Services Manager completed a clinical review into the the man's care at Highpoint. Although he found that the care received was comparable to that in the community, the clinical reviewer notes that:

“this tragic incident could have been averted with effective communication between HMP Pentonville and HMP Highpoint, risk minimisation and a robust referral system for mental health assessment.”

The clinical review can be found as the first annex to this investigation report.

84. In their response to the draft, the family registered serious concerns with the clinical review. These were passed to Suffolk PCT for their comment, but they did not reply to my correspondence. I do not agree with all of the family's concerns, but it is regrettable that the clinical review caused the man's wife to be offended. As agreed, I include the following paragraphs, as written by the man's family:

“[the man's wife] is very distressed by the quality of the clinical review. She is particularly concerned that:

- a. “The reviewer does not appear to be a clinical and has not cited any medical qualifications. He describes himself as a Healthcare Manager but does not appear to be a doctor, let alone an independent clinical psychiatrist.
- b. “The reviewer is not independent. He appears to be employed not only by the Prison Service but also one of the very prisons under investigation. Indeed, he writes in his opening paragraph that he is “undertaking this clinical review on behalf of Highpoint prison”.
- c. “The reviewer makes fundamental factual errors. He asserts, for example, that: “[the man] has no history of any medical condition prior to transfer at HMPS Highpoint” and “he had no previous history of mental health problem”. This is not true. The reviewer then continues to contradict himself several times within the same paragraph.
- d. “The reviewer has not consulted with anyone involved in [the man]'s clinical care.
- e. “The reviewer fails to review any of [the man]'s clinical care prior to his arrival at HMP Highpoint. This is notwithstanding that [the man]'s clinical depression appears to have developed in December 2006 while at HMP Kirkham and his prison records refer to at least four

incidents of deliberate self harm by the time of his arrival at HMP Highpoint.

- f. “The reviewer does not attempt to address the disappearance of the ACCT form opened on 8 March 2007, nor to investigate whether an ACCT form was opened at the end of February, evidence of which only exists in a cell sharing risk assessment. He comments. Post ACCT closure was not done at HMP Pentonville”, without mentioning that the ACCT appears never to have been closed at all and was in fact lost entirely from [the man]’s records.
- g. “The reviewer makes no attempt to examine the adequacy of the medication that the man was given.
- h. “The reviewer makes no attempt to investigate the effect that [the man]’s failure to take his medication would have had on his mental health, despite acknowledging that he had “a history of non compliance with medications”. In fact, he incorrectly asserts that [the man] “failed to pick up his medication on three consecutive occasions which amount to nine days of medication”, when it is clearly documented that [the man] did not collect his medication for the last month of his life. In his conclusion, he asks “in this instance, could the outcome have been different if he had continued taking his medication and positive therapeutic interaction with nursing staff?” and then makes no attempt to answer it.
- i. “The reviewer makes no attempt to justify his assertion that [the man] “did not require referral to the Secondary Mental health Services, Tertiary Services and/or any Specialist Services.
- j. “The reviewer’s key findings list serious and fundamental failures in the care given to [the man]. Inconceivably, he then concludes, “it must be noted that he has received all relevant primary healthcare services comparable with the outside community, bearing in mind staffing pressure at HMPS Highpoint”. This lends the unavoidable impression of a naked attempt to exonerate the prison of any responsibility.
- k. “The reviewer concludes with the extraordinarily insensitive and unprofessional comment, “it appears that [the man] had a death wish” followed by “Rest in Peace”, all of which has further compounded [the man’s wife]’s distress.”

Family concerns

- 85. When the family met the senior family liaison officer and my investigator, they expressed their concern that the man developed depression in prison having never experienced mental illness before. While I cannot establish the reason for the man’s depression, I examine the identification and treatment of his mental health condition in the following sections of this

report. The family were also concerned that he did not contact them. His phone records show that contact with his family was infrequent, but that he always had sufficient funds to make contact should he have chosen to do so.

86. The man's family had contacted Pentonville to communicate their concern about his wellbeing. While I am pleased that the letters were dealt with at a senior level, I am unclear why the Head of Residence was tasked with responding to all of the matters, even those relating to healthcare. I am surprised that there is no evidence that the Head of Residence spoke to the man, and indeed, he told my investigator that he only spoke to staff about the man's wellbeing, rather than to the man himself. I am also surprised that the correspondence was filed in the secretariat's office, rather than in the man's personal records. The letters included reference to the man's non-compliance with medication and his outstanding mental health assessment, both of which would have informed his care at Highpoint.
87. A representative of the man's wife also contacted Highpoint to pass on concerns about his welfare. She spoke to the chaplain who appropriately asked the primary care mental health nurse to speak to the man. Following that conversation, the man was due to receive ongoing care for his anxiety and insomnia. The mental health nurse also spoke with the induction senior officer who encouraged the man to contact his family and offered the opportunity to use the office telephone. I am pleased that staff spoke to the man following this contact. I understand that the man's family felt that more could have been done to involve them in his care.
88. During their meeting with my colleagues, the man's family were concerned that he had bootlaces in his possession which he went on to use as a ligature. However, the man was not assessed as at risk of suicide or self harm while he was Highpoint. (I explore how that judgement was reached later in the report.) Unless someone is at risk, it would be undignified to remove everyday items such as bootlaces. If there was evidence that the man had made ligatures to self harm, I would have expected the prison to have considered removing items that might be used for this purpose. However, this must be balanced against the requirements of PSO 2700 – Suicide Prevention and Self-harm Management, whereby the removal of personal item is recognised that removing personal belongings can increase feelings of distress. As there was no evidence that the man had previously made ligatures, I am satisfied that the prison acted appropriately.

Communication failures

Missing Clinical Record

89. HMP Kirkham did not send the man's medical record to HMP Pentonville. The final ACCT document did not reach HMP Highpoint. This meant that Highpoint had neither the medical record documenting the apparent onset of the man's depression nor the details of what appears to have been a serious attempt at suicide at Pentonville.

90. It is the responsibility of the prison from which a prisoner absconds to put together an escape pack with all of the prisoner's files, including their medical record, as soon as the prisoner has absconded. Once the originating prison is notified that the prisoner is back in custody, they must forward the escape pack to the relevant police station or prison. Kirkham failed to do this.
91. I also note that Pentonville did not ask Kirkham for the man's previous medical history. There is no requirement for the receiving prison to request this documentation. However, Pentonville's Head of Healthcare, acknowledged that it is surprising that staff at Pentonville did not request the man's medical history before they treated him for depression.
92. The Healthcare Manager at Highpoint told my investigator that she was frustrated when she received the inmate medical record from Kirkham following the man's death. She said that there were ways in which the man could have been helped if the prison had the information at an earlier stage. For example, she said that she has previously come to an arrangement with staff on the wing to allow prisoners out of the cell to do some informal cleaning if they need time out of cell for mental health reasons. As a result, the prisoner is highlighted to staff who would keep a particular watch and encourage him to come out of his cell more often.

The Governor of HMP Kirkham should review information sharing procedures to ensure that, in the event of a prisoner absconding, all required paperwork is sent to the appropriate prison when he returns to custody.

Missing ACCT documentation

93. The man seriously injured himself at Pentonville on 8 March. He told staff that he intended to die. He required treatment for burns for a number of weeks. He was located in the healthcare centre where he received additional supervision and was subject to ACCT for at least five weeks. That ACCT document was not made available to my investigator. Pentonville could neither locate the ACCT document nor a record that it was sent to Highpoint. Highpoint have no record of receiving a third ACCT document, although they did receive two other ACCT documents from Pentonville.
94. During her interview, around eight weeks after the man's death, Highpoint's Healthcare Manager passed my investigator a bundle of documents that had been forwarded to Highpoint as routine documentation the previous week. The documents concern the man's suicide attempt at Pentonville at the beginning of March, but the third ACCT document is not among them. Both Highpoint's Healthcare Manager and the reception nurse said that Highpoint experiences particular difficulty with information expected from Pentonville. The Healthcare Manager acknowledged that the majority of Highpoint's prisoners come from Pentonville. She relies on an

administrator to extract what might be crucial information that she described as being sent on an ad hoc basis by Pentonville. The Healthcare Manager said that some efforts had been made in the past to improve information transfer between Highpoint and Pentonville. She said that Pentonville had agreed to visit Highpoint to see what facilities were available but, at the time of the investigation, the visit had yet to take place.

95. When my investigator put this to Pentonville's Head of Healthcare, he thought that it was unfair to say that Pentonville did not effectively transfer information. He said that the introduction of an electronic medical information system had improved communication because the record is printed and sent with each prisoner when they transfer. The Head of Healthcare thought that Pentonville previously had a poor history of transferring information but their systems had improved by the time the man moved.

The Governor at Pentonville should review procedures to ensure that all ACCT documentation is transferred with a prisoner who leaves his establishment.

Information sharing about risk of suicide or self harm

96. Staff at Highpoint were aware of the man's most recent serious suicide attempt. It is well documented in the medical record that did accompany the man to Highpoint. The PER indicated that he presented a risk of suicide or self harm and that he had a closed F2052. The reception nurse reviewed the medical record and noted on the first reception healthscreen that the man had self-harmed while in custody. He did not refer specifically to the incident on 8 March. After completing the first reception healthscreen and making a mental health referral, the mental health nurse completed the cell sharing risk assessment. On this form, he did not indicate whether the man had a history of self-harm or not. He did not write any notes about the recent serious suicide attempt.
97. My investigator showed the cell sharing risk assessment to Highpoint's Healthcare Manager during interview. Although not designed for this purpose, she agreed that assessment was the only formal opportunity that the reception nurse had of passing on information about a prisoner's self harm history. She said that there are no other medical forms that can be used for this purpose. I am surprised that the reception nurse did not respond to the question about the man's risk of self harm, given his recent suicide attempt.
98. A residential governor who checks record-keeping as part of her duties at Highpoint, was surprised that induction unit staff were not made aware of the man's most recent attempt at suicide. She said that she would have expected the nurse doing the first reception healthscreen to call the unit and let them know. She said that it was not a written procedure but what she would consider "good practice".

99. I agree that the information contained in the man's clinical record should have been made known to wing staff, either through the cell sharing risk assessment or through direct contact with the wing. However, I do not hold the reception nurse individually responsible, given his lack of training especially in the prison's suicide prevention procedures.

The Healthcare Manager at Highpoint should remind all healthcare staff, including agency members of staff, to use the cell sharing risk assessment to communicate with wing staff.

The Governor and the Healthcare Manager at Highpoint should consider formalising a system to ensure that critical information about a prisoner's level of risk is communicated between the healthcare department and residential wings.

100. The man's PER also indicated that he was at risk of self harm or suicide. The note on the form "F2052 closed" may have indicated that the risk was not current, but there is no evidence to suggest that staff spoke to the man about it.
101. Staff at Highpoint were unaware of the circumstances surrounding the man's diagnosis of depression. Officers on the wing were not aware of his most recent attempt at suicide. All of the information about the man's risk recorded by the Prison Service was not available to those staff looking after him at Highpoint. I am concerned about the failure to transfer information effectively in the man's case. If all of the information had been transferred in accordance with proper procedure, I would have expected actions to have been taken and safeguards put in place.

Wing history records

102. The man's wing history sheet for his time at Highpoint consisted of five brief entries about his location. There is no evidence that he had quality interaction with any officers during his time at the prison. I hope that this is not a reflection of the reality. Following a management check, a governor described the wing history as "below standard". My investigator spoke with a residential governor who is responsible for record keeping in the prison. She was disappointed with the standard of the man's wing history and told my investigator that it was not representative of the general completion of wing history sheets. I share the residential governor's disappointment with the standard of the wing history.
103. During the announced inspection in May 2007, HM Prisons Inspectorate found that the personal officer scheme "was aspirational and a long way from reflecting the actual personal officer work taking place". The man's personal officers recorded their first meeting with him but there is no detail about the conversation. I must agree with the Chief Inspector's findings in her inspection report that the wing history records lacked quality.

Cell clearance

104. The man was located in a cell on B wing on 11 May 2007. After his death, an empty bottle of medication, along with clothing and possessions, was discovered that belonged to the prisoner who had occupied the cell before him. It is unacceptable that a cell is occupied before the belongings of the previous prisoner have been cleared.

The Governor of Highpoint should introduce a system to check the quality of all cell clearances.

Was the man's level of risk appropriately identified and managed?

105. Staff at Kirkham identified the man as depressed. Staff at Pentonville opened three ACCT documents, following three separate episodes of self-harm. The man received mental health input and was managed on the healthcare centre to give him additional support in the prison. On 4 April, a nurse found that the man was not fit to be transferred to Highpoint until a mental health assessment had been carried out. There is no record of such an assessment being carried out between 4 and 24 April when the man was in fact transferred. The man was suffering from an adjustment disorder as he came to terms with the environment at Pentonville. It is a matter of concern that his transfer to a lower security prison was delayed for a mental health assessment which the records fail to show took place.

The Head of Healthcare at Pentonville should ensure that a robust system is in place so that mental health assessments occur within a reasonable time from referral.

106. When the man arrived at Highpoint without the last ACCT document and his medical record from Kirkham, he presented as quiet and was experiencing problems coping with prison. He told the reception nurse that he was particularly worried about his inability to sleep. The nurse made a referral to the mental health team because of the man's insomnia and his experience of numbness in his left arm. I am concerned that the reception nurse was not ACCT or mental health trained. I understand that he was not a permanent employee at Highpoint, but he told my investigator that he was one of a pool of nurses who were often posted to work at the prison. I expect the Healthcare Manager and the Governor to prioritise ACCT training for any regular agency staff to ensure that they are familiar with local suicide prevention procedures.

107. I was further worried by the failure of the first reception healthscreen used at Highpoint to explicitly ask whether a prisoner had any thoughts of suicide or self harm. I accept that prisoners might have difficulty expressing such feelings during a healthscreen. However, I do not underestimate the importance of such a question. I welcome the Healthcare Manager's assurance that the locally designed first reception healthscreen form is being reviewed to incorporate a direct question about suicide and self harm.

108. The mental health nurse engaged appropriately with the man at an early point in his time at Highpoint. However, he was unable to feed back the outcome of the sleep log. I am surprised that a prison of Highpoint's size has only one primary care mental health nurse. I accept that this might meet the needs of the population when the nurse is able to carry out his duties without interruption. However, as in the man's experience, all too often nurses can be taken from their core duties for reasons of staff shortage or sickness.

Suffolk Primary Care Trust should carry out a needs analysis of the prison population at Highpoint and ensure that staffing levels are adequate to meet the mental health requirements of prisoners.

109. According to his records from Kirkham, the man's mental health condition worsened when he had nothing to do. Medical assessments made following the onset of his depression clearly demonstrated that purposeful activity improved his wellbeing. Highpoint's Healthcare Manager described opportunities to increase a prisoner's activities if it is beneficial to do so for medical reasons. However, it is surprising that a prisoner, whether quiet or not, might be left on a wing for several weeks with no opportunity for employment or education. The Inspectorate found that the lack of purposeful activity was a contributing factor to Highpoint's disappointing performance as a training prison. They recommended that steps be taken to improve the number of vocational courses available to prisoners.

110. The man would have been in his cell most of the time. I am concerned about the impact that this would have on any prisoner's mental health.

The Governor should review the level of purposeful activity available to prisoners at Highpoint.

Emergency response

111. The clinical reviewer has commended the swift response to the radio Code Blue emergency. I agree that the response was timely and appropriate. Staff attempted chest compressions, but due to the man's physical condition could not attempt mouth to mouth resuscitation. The emergency response nurse arrived to discover signs of rigor mortis, which was confirmed by a doctor. I intend no criticism whatsoever of those staff who attempted resuscitation, especially as they were not medically trained to recognise signs of rigor mortis. However, if rigor mortis is present, it is respectful neither to the staff involved, nor to the deceased, for CPR to be attempted.

112. I am, however, concerned about the time of day when the man was discovered. He was found at 9.35am, during the third check of the day. The night OSG completed his roll check at 7.00am. He handed over to an officer who then carried out a door check at about 7.35am. The third check, the accommodation fabric check, was when the man was found, by

which time he may well have been dead for some time. My investigator was informed by the Coroner's office that it was not possible to be exact about the man's time of death. During her interview, the officer who found him recalled that the man was cold when she discovered him, but the temperature of the body can be affected by the environment in which the deceased is found, and by their weight, among other factors.

113. I am concerned that staff coming on to the day shift were not at the time instructed to check if each prisoner was in the cell. Instead, they checked the fabric of the door and the lock mechanism. During my investigator's feedback, the Governor acknowledged that this was the night instruction, which was being amended following the man's death.

The Governor of Highpoint should ensure that instructions to staff carrying out a morning roll check are amended to include checking prisoners in their cells.

CONCLUSION

114. The man's care was severely compromised by ineffective information sharing. Procedures in place were not followed and crucial information was not known to those caring for the man on the wing.
115. It is a sad feature of many of my investigations that those prisoners described as "quiet" often go unnoticed by staff. Few wing notes were made in the man's wing history. His latest ACCT document with critical information about risk was lost and no mention was made in his wing history from either Pentonville or Highpoint. I agree with the findings of the clinical review that more effective communication and information sharing would have meant safeguards could have been put into place.
116. I conclude that the man did not receive care of the standard to which the Prison Service aspires.

RECOMMENDATIONS

1. The Governor of HMP Kirkham should review information sharing procedures to ensure that, in the event of a prisoner absconding, all required paperwork is sent to the appropriate prison when he returns to custody.
2. The Governor at Pentonville should review procedures to ensure that all ACCT documentation is transferred with a prisoner who leaves his establishment.
3. The Healthcare Manager at Highpoint should remind all healthcare staff, including agency members of staff, to use the cell sharing risk assessment to communicate with wing staff.
4. The Governor and the Healthcare Manager at Highpoint should consider formalising a system to ensure that critical information about a prisoner's level of risk is communicated between the healthcare department and residential wings.
5. The Governor of Highpoint should introduce a system to check the quality of all cell clearances.
6. The Head of Healthcare at Pentonville should ensure that a robust system is in place so that mental health assessments occur within a reasonable time from referral.
7. Suffolk Primary Care Trust should carry out a needs analysis of the prison population at Highpoint and ensure that staffing levels are adequate to meet the mental health requirements of prisoners.
8. The Governor should review the level of purposeful activity available to prisoners at Highpoint.
9. The Governor of Highpoint should ensure that instructions to staff carrying out a morning roll check are amended to include checking prisoners in their cells.