

**Investigation into the circumstances surrounding the  
death of a man HMP Whitemoor  
in November 2007**

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

**November 2009**

This is the report of an investigation into the circumstances of the death of a man in his cell in the segregation unit at HMP Whitemoor in November 2007. He was being checked at 9.20pm by medical staff due to an injury sustained earlier in the day and was found collapsed with a ligature round his neck. Cardio pulmonary resuscitation was carried out, but at 10.06pm he was pronounced dead. He was 65 years old and had been in Whitemoor for four years.

I would like to offer my sincere condolences to the man's family and friends on their loss. A key objective of all my investigations is to ensure the bereaved family has the opportunity to raise any concerns and contribute to my inquiries. He nominated his sister as his next of kin and one of my family liaison officers has been in touch with his sister, brother and son. I hope this report offers answers to their questions.

The investigation was carried out by my colleague. A clinical review was conducted by the clinical reviewer for the local Primary Care Trust and I am grateful for her assistance. I would also like to thank the Governor and staff at HMP Whitemoor for their co-operation with this investigation.

The man had been sentenced to life imprisonment in March 2001 and had previously spent 11 years in custody from 1988 until 1999. He had been at HMP Whitemoor since February 2003. In November 2007, two unauthorised articles were found in his cell (one of which suggested that he was a drug user). The following morning, he received a punishment of 14 days cellular confinement. At lunchtime that day, he was seen by a number of medical staff following what the man described as a 'fall' and was deemed fit to remain in his cell. He left no note to explain why hours later he apparently took his own life.

I have made two important recommendations regarding the checking of prisoners in the segregation unit, and record keeping. I must apologise for the delay in issuing this report.

This version of my report, published on my website, has been amended to remove the names of the man who died and those of staff and prisoners involved in my investigation.

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

**February 2009**

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## SUMMARY

In July 2002, the man was sentenced to life imprisonment. At the time of his death, he was said to be preparing his third appeal against conviction. Since 1988, he had only spent two years out of custody.

He arrived at HMP Whitemoor in February 2003. Familiar with prison life, the man had a small group of friends on his wing and tended not to rely on staff to help with any problems. In February 2007, he suffered a heart attack and was taken to outside hospital. He discharged himself the next day and continued to manage his condition with the use of an inhaler and other medication.

In November 2007, during a lock down of the prison (when prisoners are unable to leave their cells) and a subsequent search of all cells, two unauthorised articles - a mobile telephone charger and a bottle of urine - were discovered in his cell. As a result, he was served with adjudication papers (for a disciplinary hearing) and the following day was taken with two other prisoners to the segregation unit. A short time later, he was seen by a nurse for the purpose of completing a safety algorithm, a document necessary for those who might serve a period of cellular confinement. The nurse assessed him to be fit to be held in the segregation unit.

The man was found guilty on both charges and received a total of 14 days cellular confinement. He was located into a single cell on the segregation unit. Later that day, at 12.45pm, he pressed his cell bell and was found to have sustained an injury to his right cheek, just below his right eye. He was quite vague about what had happened but said that he thought he had fallen. He was seen by the doctor almost immediately and again deemed fit to remain in the unit. He was seen throughout the day by various healthcare and discipline staff. At approximately 6.00pm, he was again assessed by a nurse. She had no concerns but wrote a memo to the night nurse to check him later in the evening.

At 8.00pm, the man was seen alive for the last time by an officer who was carrying out a roll check. In interview, he recalled the man giving him the 'thumbs up' to indicate that he was okay. At 9.20pm, during medication rounds on the segregation unit, another nurse asked to see him. One of the accompanying officers looked through the door flap of his cell and saw him collapsed on the floor between the toilet and the end of the bed. Staff immediately entered the cell and, after the nurse checked for signs of life, he was moved into the recovery position ready for cardio pulmonary resuscitation (CPR) to begin. It was at this point that staff saw a ligature around his neck. Staff performed CPR until the ambulance staff arrived and took over. He was pronounced dead at 10.06pm.

## THE INVESTIGATION PROCESS

1. One of my investigators conducted a preliminary visit to HMP Whitemoor in November 2007 to open the investigation. She visited the cell where the man died. On 4 December, the investigation was transferred to another colleague and she visited Whitemoor and also viewed the cell and wing where the man died in December.
2. Notices were issued to staff and prisoners telling them of the investigation and offering the opportunity to speak with my investigators. Two prisoners came forward as a result and recorded interviews were carried out with both of them.
3. My investigators met representatives of the local branch of the Prison Officers' Association (POA) and the Independent Monitoring Board (IMB). No specific concerns were expressed.
4. The clinical reviewer, a general practitioner reviewer from the local Primary Care Trust, undertook a clinical review of the healthcare provided for the man. She conducted a number of joint interviews of medical staff with my investigator. She was provided with transcripts of these interviews and, in addition, with copies of the man's medical records.
5. Seventeen members of staff, both discipline and healthcare, were interviewed and number of staff were spoken to informally. The chaplain and the IMB member who had seen the man in the segregation unit were also spoken to informally. In total, six prisoners were interviewed. Recordings of the last two telephone calls made by him in November were listened to by my investigator.
6. One of my family liaison officers contacted the man's family. A meeting was held with five members of the family in January 2008. Subsequently, his sister appointed solicitors and direct contact has taken place between the investigator and the solicitor concerned. The family liaison officer has kept in contact with the man's son. Prison records and transcripts were disclosed to the solicitors in the middle of 2008.
7. The family have two main concerns which they put in writing and discussed at the family visit. First, the family were very concerned and suspicious regarding the extensive bruising and injuries they saw on the man's face at the funeral directors. They feel that he might have been assaulted by staff. They took numerous photographs which they showed to my investigator. The investigator advised the family to contact HM Coroner for clarification as she believed that some of the bruising may have come about as part of the post mortem process. The post-mortem report states that 'there is no other evidence of external injury' other than the ligature mark and the injury on the cheek. The nurse and one of the officers who discovered the man did not recall seeing any other injuries. An account of how he received the cheek injury is provided in this report. Secondly, the family feel that he was very ill due to his heart condition and should not have been placed in the segregation unit regardless of his breach of prison rules.

8. A copy of the draft report was sent to the prison service and the family and their solicitors. Both recommendations were accepted by the Prison Service.
9. A lengthy letter was sent by the family's solicitors in response to the draft report and my investigator offered the solicitors and the family the opportunity for a meeting to discuss their points. The family declined. The points raised by the solicitors have been mainly dealt with by means of a letter. An additional paragraph (83) has been added to express the view of the man's sister regarding his suspected heroin use.

## HMP WHITEMOOR

10. Whitemoor is a maximum security prison for men in security categories A and B, and is one of eight such prisons. The segregation unit at Whitemoor is on E wing and is accessed through secure corridors. There are two parts to the unit, one referred to locally as the segregation unit and the other as E wing. However, E wing is sometimes used as an overflow from the main segregation cells, and both sides are supervised by the same staff group.
11. All prisoners are subject to risk assessment on location into the unit and their risk assessment levels are discussed daily. Initially, all prisoners brought to the segregation unit are deemed to be a 'level two unlock' which means that they are unlocked with three members of staff. As time passes, the level of unlock is usually reduced and they become a 'level one unlock' with two members of staff. They are also then allowed to go to the hot plate to collect their meals.
12. There are 32 normal cells, including 16 on E wing. They are all large with reasonably sized windows and sufficient natural light. Stainless steel in-cell sanitation units are carefully positioned to provide adequate privacy. There is no policy about which prisoner is placed in which part of the unit. However, as a general rule, prisoners with more demanding behaviour are located in the segregation unit, whilst more compliant prisoners are placed on E wing which tends to be quieter and in better condition.
13. The most recent inspection by Her Majesty's Inspectorate of Prisons prior to the man's death was conducted in early February 2006. Her report concluded that compared to the previous inspection (July 2002) 'relationships and regimes in the segregation unit had improved' but 'record keeping was surprisingly poor'.
14. There were four apparently self-inflicted deaths in Whitemoor in 2007, including the man, one of which has been to inquest. There do not appear to be any similarities in the circumstances of his death and these other three, although one also occurred in the segregation unit.

## KEY FINDINGS

15. In February 2007, the man was admitted to Peterborough District Hospital as an emergency following a heart attack. He discharged himself the next day. Despite results from the hospital confirming cardiac damage and advising him that he should return to hospital for treatment, he declined. Due to his category A status, he had been cuffed to prison officers during his stay in hospital. His family said that he found this uncomfortable. He also refused to be admitted to the healthcare centre within the prison (where he would not have been cuffed).
16. There are 15 entries in the man's medical records over the few days following his hospital discharge. Nursing staff sought specialist advice from the hospital and attempted to persuade him to take measures to reduce any risk. These included moving cells to be nearer the servery (so he would not have to walk so far for his meals) and not to work for six weeks. He did not want to make any changes although, as a short term measure, he agreed to use a wheelchair to get to work. He was prescribed a number of in-possession medications, which he did not consistently take, and used an inhaler spray as and when required.
17. One of the entries is by a nurse who saw the man in February and described him as being in low mood, feeling angry and frustrated, and having difficulty in getting to sleep at night. The nurse considered whether he was depressed and asked him if he would see a member of the in-reach mental health team. He did not want to do this. He was given a prescription for Mirtazapine (an anti-depressant) which, in interview, the nurse said was to help him sleep.
18. The man was seen in his cell by another nurse in May complaining of chest pains, having returned from work feeling unwell. When the nurse saw him, he was feeling better and his blood pressure and pulse were normal. In June, his medical record states that he had now agreed to take all his medicines and they were re-prescribed. In August, he was seen with chest pains which later subsided.
19. The man telephoned his sister in November 2007 and they spoke for about 15 minutes. During their general conversation, he spoke about Christmas and said he had sorted out his lunch as he was in a 'food boat' (a group of prisoners who buy and cook food together). He said that the heating on the wing had been broken for a week but that it had been fixed the day before. In terms of his health, he said that he was 'not too bad' and the 'spray I got for it [chest pains] does it'. The next day, he called an ex-prisoner friend and they spoke for about seven minutes. During both conversations, the man did not sound obviously distressed about anything.
20. In November, the man was seen by a further nurse who asked if he wanted to attend the Coronary Heart Disease (CHD) clinic. In the medical notes she has recorded, 'he feels he has already had the tests, he feels well and will let us know if he is not, declined to attend CHD clinic.' In interview, she recalled, 'he looked fit and well at the time, he was cheerful without problems'.

21. The next day, following intelligence received, the entire prison was 'locked down' which meant that prisoners were unable to leave their cells during this time whilst all the cells were searched. Such a process normally continues for two days.
22. The man was located in a single cell on A wing, 3-24, at the time. At 9.20am, two unauthorised articles – a mobile telephone charger and a bottle of urine – were found in his cell. (Storing bottles of urine is not permitted as they may be used to avoid the detection of drugs which might otherwise be found if a random urine drug test is carried out.) As a result, he was placed on a disciplinary report pending adjudication the next day. Notification of the charge and impending adjudication were issued to him at 6.45pm that evening. The prison remained locked down overnight so none of the prisoners was given the opportunity to leave their cells and associate with others.
23. My investigator spoke with an officer, one of the officers conducting the search who found the articles. He knew the man as he was a long-term prisoner at Whitemoor, although he did not work on the same wing. He said that during the search the man was chatty and, when they found the charger and urine, he was 'blasé' about it and not 'unduly worried'. The officer said that the bottle was discovered behind the wardrobe and the charger was found in the back pocket of a pair of trousers in his wardrobe.
24. The following morning at about 8.25am, three prisoners including the man were taken from A wing to the segregation unit for the adjudication hearings. My investigator spoke to both the other prisoners who walked with him to the segregation unit. They knew him from the wing; one knew him to say hello to only, and the other was in the cell next door. They both said that they all walked to the segregation unit together and that the man did not have any injuries. One recalled being accompanied by one officer whilst the other prisoner thought maybe two officers had taken them. The man was described by them as being 'upset', 'looked sick' and 'worried'. The movement sheet records that he and the two prisoners arrived at the segregation unit at 8.26am.
25. Prior to an adjudication, and before a prisoner is given a punishment of cellular confinement (PSO 2000, 2006), a Segregation Safety Algorithm must be completed by either a nurse or a doctor. The purpose is:
- 'To determine if there are any healthcare reasons against holding a prisoner in segregation.
  - To provide a "snapshot" of the prisoner's mental health well-being at the time of the "screen". However, any immediate physical health concerns should also be considered.'
26. The algorithm asks four questions:

- 'Is the prisoner awaiting transfer to / being assessed for a bed in an NHS secure setting?
- Has the person self-harmed in this period of custody / are they on an open F2052SH/ACCT OR is the person currently taking any anti-psychotic medication?
- Does the prisoner show signs of being acutely unwell (eg. psychotic / withdrawal from drugs / significant physical injury) at the present time?
- Do you think that the prisoner will be unable to "cope" with a period of segregation?'

27. A nurse completed the algorithm on the man at 9.30am and answered 'no' to all of the above questions. In interview, he said that he knew him quite well from speaking with him on the wing and felt that they had built up a good relationship. He said that he saw him in his segregation unit cell for a very short time as the consultation was rushed due to staff asking him to hurry. The cell door was unlocked and staff stood at the door whilst the nurse spoke to the man. He asked how he was to which he replied that he was fine. The nurse thought that he did not seem concerned about anything.

28. In interview, the nurse said that he was aware of the man's heart condition but did not have any particular concerns that a man of his age, and with his condition, would be vulnerable in the segregation unit. He thought that he would cope in the same way as he managed on the wing, and that being in the segregation unit presented no more difficulties than being on a locked down wing. The nurse was also aware that the man might have used heroin in the past although the man did not confirm this to him. Again, the nurse said that this did not give him any concerns about the man's ability to cope with being in the segregation unit.

29. The first adjudication, regarding the bottle of urine found in the man's cell, was heard at 10.10am. A duty governor was the adjudicating governor on the day. The record of hearing indicates that when asked 'how do you plead?' the man's response was recorded as 'not guilty owing to refusal to plead'. (This means that the prisoner does not want to plead either guilty or not guilty.) In interview, the governor confirmed that the following extract from the record of hearing covers the salient points what was said:

'The man understood and accepted it was found.

The man: Where found?

RO [reporting officer]: By small locker in the corner – behind the locker on the floor.

The man: If I had known it was there, I would have emptied it. It's not mine, it's the first time I'd seen it.

Gov: How long have you been in that cell?

The man: Ages – a couple of years.

Gov: When did you last look behind that locker?

The man: Within the last week, when I swept it out.

Gov: How do you think it got there?

The man: I guess someone was going to get a cell spin, my door is always open, and they dropped it in without telling me.  
Charge proven on the basis of enquiry – there was every reason to expect him to know the presence of an article of this sort.'

30. It is recorded that in response to the charge being proven, the man was asked if there was anything he pleaded in mitigation. He replied, 'I didn't know'. He was punished with four days cellular confinement (CC).
31. There are punishment guidelines in relation to each offence outlining factors contributing to seriousness of offence and mitigation factors. The guidelines for unauthorised articles give minimum and maximum penalties. In terms of CC, the minimum is seven days and the maximum is 21 days.
32. In addition, prior to making a judgement of the appropriate punishment, the adjudicating governor is provided with information about any previous disciplinary reports (during the current sentence) as well as a wing report. The information provided said that the man had had three previous disciplinary reports (the last on being in 2001) and none at Whitemoor. His Conduct Report for Adjudicator prepared for the hearing stated:

'The man is normally a polite prisoner who gets on with his sentence creating little bother or fuss to anyone. He rarely asks staff for assistance in any matter and is quick to express thanks when any even trivial thing is done for him. He is deceptively cheerful individual who can always be relied on for good humour even when the atmosphere on the wing is tense. There has only been one negative entry in his wing file over the last 10 months this being a minor argument over metal zips in workshop.'

33. The second adjudication, in relation to the telephone charger, was heard at 10.25am. The man pleaded guilty to the charge but said, 'it's not mine. I found it in my cell. I was hoping someone would collect it over the weekend, but they didn't. I don't know who put it there.' The charge was found proven on enquiry and admission. He did not offer anything in mitigation and received ten days cellular confinement which was added to the previously four days making a total of 14 days.
34. The adjudicating governor said of the man's demeanour at the adjudication,
- 'I think I used the word a bit upbeat, and I think he was, his presentation was, gave me no cause for concern at all and I am sure I would have given him the opportunity to say whether there were any concerns.'

Although storing bottles of urine is interpreted as a way of avoiding the detection of drugs which might otherwise be found if a drug test is carried out, in interview the adjudicating governor said that he did not recall asking the man about any (potential) use of drugs.

35. The officer who had conducted the search the day before was present throughout the adjudication in the role of reporting officer. He described the man as 'very jovial'. He added, 'it was a pleasant adjudication, if adjudications can be pleasant.'
36. Prisoners serving cellular confinement have to be observed hourly in recognition of the fact that segregation can be extremely stressful. One member of staff, known as the collator, is responsible for completing all the necessary paperwork and adding prisoners' names to the list of those who receive CC. For some reason which is not known, the man's name was not added to the day shift list (7.30am – 8.30pm) but did appear on the night shift list (starting 9.30pm) for those needing to be checked.
37. Following the adjudication, the man was placed in cell E2-06. The unit, like the rest of the prison, remained in lock down for the duration of the day so prisoners were not allowed out of their cells. Meals were brought to the cells by staff. Lunch was served from 11.15am until about 12.00 noon, followed by a roll check at 12.30pm just before the majority of staff took their lunch break between 12.30 and 1.30pm.
38. Cell bell records show that the man rang his cell bell at 12.44pm and that it was cleared (meaning an officer had attended the cell to turn the bell off) two minutes later at 12.46pm. An officer wrote in the segregation observation book at 12.45pm that he 'answered cell bell. The man informed me and showed me that he had banged his head/eye, large swell to right eye area. HCC informed. Oscar 1 [Orderly Officer] informed.' In interview, the officer said that the man was not clear about exactly where he had banged his head and was not sure whether he had fallen or tripped over.
39. A nurse went to see the man and said in interview that he explained that he had fallen over and banged his eye against the sink. (The nurse said that, with hindsight, he thought that this might in fact have been a first attempt by the man to hang himself.) The nurse contacted the prison doctor, who also knew the man well, to come and examine him. At 1.00pm, an entry in the observation book states, 'The man opened up HCC and the prison doctor in attendance along with seg staff Oscar 1 and Zulu in attendance. The man secured again at 13.10hrs.' (This means that, as required prior to any cell being opened up during a period of patrol, three members of staff must be in attendance with a dog.) The nurse said that he had only seen the eye injury and no other injuries.
40. A Principal Officer was the Oscar 1 that afternoon. He is also the safer custody manager for Whitemoor. In interview, he said that he spoke with the man about what had happened and he was a bit vague saying that he had been fiddling with the television. Oscar 1 said that he looked round the cell for any signs of anything being broken or suspicious which might have suggested some form of self-harm, such as footprints on the sink, but there was none. He explained that he did not have any concerns about the man undergoing cellular confinement. If he had, he could have spoken with a governor. He said that the man was given some blankets as he was cold.

41. A nurse accompanied the prison doctor when he went to see the man. She recalled in interview that the man had said that he had collapsed. He had a haematoma (blood collection under the skin) to his cheek and laceration on his cheekbone. She wrote an entry in the medical record, 'seen in segregation unit following collapse, hit right cheek on side of sink, haematoma visible and small laceration, BP 138/82, P74 seen by prison doctor.'
42. The prison doctor also wrote an entry in the medical record following the visit and amongst his conclusions stated, 'fully conscious and orientated'. He said that the man said he was fine. In interview, the prison doctor said that he did not have any concerns about the man's statement that he had fainted and hit his face on the sink. He said the injury under the eye was the only one he had. The nurse said that the prison doctor told him that the man would need to have a tetanus injection later that day.
43. The prison doctor said that he went back to see the man at about 4.30pm, just prior to going off duty. This does not seem to have been as a result of any particular concern. The prison doctor said that he had told the man when he saw him at lunchtime that he would come and see him again before he left for the day. He recalled that he asked him if he was alright and he had replied that he would see him in the morning. The prison doctor did not put an entry in the medical record about this visit to him.
44. The nurse recalled seeing the man twice later that evening, just before and after 6.00pm. She knew that he would need his medication for his heart problems so she collected them from A wing. (He usually kept his medication in his own possession but did not have it with him in the segregation unit.) However, when she returned with the medication, he told her it was the wrong one so she returned to A wing and then back again to the segregation unit. She recalled another nurse being with him on one of her visits, giving him a tetanus injection. She asked the man if he was okay and how he was feeling. She said that he replied that he was fine.
45. She finished her shift at 8.30pm. As part of the handover she wrote a note in the healthcare communication book to the night nurse. This said:

'Seg the man – night nurse  
Please can you keep an eye on the man overnight as he collapsed today in cell and hit head, obs and pupils ok at time and seen by Dr.  
Thanks nurse'

46. PSO 1700 – Management of Segregation Units – states that:

'Prisoners held in segregation are visited regularly by prison management and others who work in the prison.  
The visits ensure that prisoners are being treated fairly, with dignity and with decency and that prisoners have the opportunity to raise any concerns they have.'

Management visits also provide support to staff who work in the segregation unit.

The Segregation daily records are kept up to date.'

47. The E Wing prisoner location sheet shows that visits were made by the chaplain, nurse rounds, Duty Governor, IMB and Governor (weekly) rounds. By every other prisoner's name, all visiting staff have ticked that they have seen the prisoner. In the man's case, only the duty governor has ticked seeing him. The document clearly shows that the man's details have been written by a different member of staff to the other names. This may have been because he was the only new prisoner that day and the rest of the names may have been written earlier before he arrived.
48. In interview, the duty governor said that he saw the man as part of his duties as duty governor (all prisoners in the segregation unit have to be visited by a governor grade at least once in every 24 hour period). He was on the wing from 3.50pm until 4.45pm. The duty governor recalled seeing him and asking if he was okay due to the eye injury. He said that the man was standing up and seemed fine. He checked with staff that the man had been seen by healthcare.
49. The Governing Governor was doing his weekly round to the segregation unit and was there between 5.53pm and 6.15pm. He recalled seeing the man in the segregation unit and was also familiar with him from the wings. He said he spoke to him and asked him what he had been up to. He did not have any concerns about him at the time.
50. The IMB member with responsibility for the segregation unit said he thought he had seen the man at about 11.45am (so before his fall as he could not recall seeing any injuries). (The IMB member is recorded as being on the unit between 11.25-11.45hrs and 13.55-16.40hrs.) He said that he knew the man from the wing although he was 'a low profile prisoner as he was not someone who put in applications to the IMB'. The IMB member said that he said hello to him and asked him how he was. He said that he was fine and the IMB member did not have any concerns about him.
51. My investigator spoke with the chaplain who visited the unit that day. The chaplain said he remembered seeing the man. (Records indicate that he was on the wing between 11.25-11.30am. However, he told my investigator that he thought this should have read 12.30pm.) He did not remember seeing any injuries on him. He said that the man looked 'glum' but he did not want any help from the chaplain.
52. The prisoners either side of the man's cell in the segregation unit spoke to my investigators. Neither had any contact with him on that day, although one said that he banged on the cell wall a couple of times but did not get a response. One had been aware of the staff going into his cell and hearing talking which he thought was at about 1.00pm.

53. A Senior Officer (SO), one of two senior officers on duty that day on the wing, recalled in interview seeing the man at about 6.45pm when he gave him a hot flask for the night. He recalled seeing the bruise and thought that he looked quite withdrawn. He said that he complained of being cold so the SO asked for some more blankets for him. He described the man as appearing like 'a tired old man' but he did not have any wider concerns about him.
54. An officer was on night duty on the segregation unit. At approximately 7.55pm when he started his shift (this was early as he was not actually due to start until 8.45pm), he went around the unit and checked on all the prisoners. (The Report of Night Patrol for the segregation wing indicated that the night officer had completed the roll count by 8.00pm.) In interview, he recalled checking on the man and that he got a 'thumbs up' from him when he enquired through the flap if he was alright. He said that the man was sitting on the bed at the near end. This is the last record of him being seen alive.
55. The night officer stated that he noticed the man's injury and asked the officer, from whom he was taking over, what had happened. He said that she explained about the events at lunchtime.
56. The medication round for the prison begins at approximately 9.00pm and usually includes two senior discipline staff (although there were three on this occasion as one was training), a nurse and a dog handler moving round the prison unlocking prisoners' cells and letting the nurse give the medication. The round starts in the healthcare centre and moves to the segregation unit next door before moving to the rest of the prison.
57. In interview, a nurse said she had been carrying out her medication rounds on the segregation unit when she remembered that she needed to look in on the man. At approximately 9.20pm, a second SO looked through the flap and saw him slumped on the floor between the toilet and the bed as if wrapped around the toilet. (The night officer described him as being 'slumped' on the toilet but all other statements say he was on the floor.) The second SO unlocked the cell door and the other staff went in. The nurse said that she checked for any signs of life, which she could not find, and described the man as cold to touch. She asked the officers to move him out and onto the floor whilst she ran back to healthcare to get the ambubag emergency equipment. Due to the proximity of the healthcare centre and the fact that all the gates were unlocked, the nurse estimated that this only took her about a minute.
58. When staff had first entered the cell they were unable to see that the man had a ligature around his neck and it only became apparent when they laid him on the floor. He was wearing a hooded top and a third SO described this as being 'all bundled round his throat'. The ligature was made of shoelaces and the drawstring from his tracksuit trousers. The third SO cut the ligature with an anti-ligature knife. The police report recorded that a piece of ligature was attached to the shelf above the toilet.
59. In interview, the nurse said she returned to the cell just as the man was being laid on the floor. The ligature was removed as she came in. She said she

started chest compressions and then swapped with the night officer while she used the ambubag. They continued like this until the ambulance crew arrived and took over. The nurse estimated that this could have been as much as 20 to 30 minutes. The night officer said it was 40 minutes (in written statement he said it was ten minutes until the paramedics arrived) because he had continued chest compressions even when the ambulance staff arrived.

60. The control log said that a PO (Oscar 1) informed the control room of a possible death in custody at 9.23pm and that an ambulance was called at 9.24pm. The log stated that at 9.32pm the first ambulance 'arrives at establishment and on route to healthcare'. According to the 'scene attendance log,' the ambulance reached the cell at 9.46pm with a second crew arriving six minutes later. The duty doctor arrived at the cell a minute later. At 10.06pm, the man was declared dead by the duty doctor.
61. The man had named his sister as his next of kin. She had been living in Brighton at the time. The prison's family liaison officer and a colleague went to the address in Brighton the following morning to discover that she had moved. Her new address was eventually found by looking at the telephone records for the man. The prison's family liaison officer arrived at the man's sister's house at about 10.30am and broke the news. She asked that the prison's family liaison officer contact the man's son and she did this by telephone. (The prison FLO has told my investigator that regular checks now take place to ensure that next of kin details are kept up-to-date.)
62. The man's family were offered the opportunity to visit the prison but declined to do so. The maximum contribution was paid to the family by the prison for the funeral expenses and, with the agreement of the family, the prison FLO attended the funeral. The man's property was later returned to his son in person by her.
63. A memorial service was held for the man within the prison and 45 prisoners attended. The member from the IMB played the organ at the service which was conducted by the chaplain. A eulogy was read by one of the man's friends.

## ISSUES

### Clinical issues

64. In her clinical review, the clinical reviewer writes in detail about the treatment she would have expected the man to have received in relation to his heart condition, and finds wanting what was actually delivered. Specifically, she writes:

‘There is evidence that the lack of systems within the healthcare department at the time of the man’s illness led to poor follow up and review of his medical conditions including his anaemia, his indigestion and following his heart attack. It is possible that with a more formalised review of his care, he may have been persuaded to take recommended medication at an earlier stage, and more consistently.’

65. She has identified a number of lessons to be learnt and I suggest that the Head of Healthcare and the Governor consider her comments carefully.

66. From a non-clinical perspective, I judge that the immediate responses from medical staff following the man’s discharge from hospital were robust. There are 15 entries in his medical record following his heart attack on 6 February 2007. There are extensive notes regarding his discharge (against hospital advice), and the subsequent attempts by prison nurses to persuade him either to return to hospital or be admitted to the healthcare centre. He declined to do either. He was also resistant to the idea of being signed off from work or being moved to a cell nearer the servery etc. Two days prior to his death, he declined to attend a Coronary Heart Disease clinic.

67. The clinical reviewer has also found:

‘There is no documented evidence of the man suffering a clinical depression in the weeks before his death. However, review of his mental state following his heart attack was not systematic, and the responsibility for this aspect of his health care was unclear. There is no documented evidence that his mental health state or suicide risk was assessed prior to his admission on the segregation unit in November 2007.’

68. The man had been asked whether he wanted to see a member of the in-reach mental health team in February 2007 following his heart attack. He had declined. He presented as someone who dealt with any problems privately, and would not have sought out help from staff. Given this, there was only so much staff could do to encourage him to seek outside help. His family did not feel that he was depressed. When the nurse completed the Safety Algorithm, he did not consider that there were any concerns for his well being. Again, the clinical reviewer has made a number of recommendations which I suggest are considered by the Head of Healthcare and the Governor.

## **Cellular confinement observations**

69. The regime for a prisoner serving a period of CC is laid down in the Prison Discipline Manual and repeated in Prison Service Order 1700. Following the imposition of a punishment of cellular confinement, the collator (the officer in the segregation office completing the paperwork) should be informed and the prisoner's name added to the list of those needing to be checked hourly. This is in recognition that CC can be extremely stressful. However, the man's name was not added to the list and there is no record of him being checked hourly.
70. In November 2007, the man was seen regularly throughout the day because of his visit from healthcare staff and the routine visits staff made to his cell for meals and roll checks. As a category A prisoner, he would also have been seen every two hours although my investigator was not provided with details of these checks. He was last seen alive at approximately 8.00pm by the on-coming night officer, making the last roll check of the evening. At 8.30pm, there should have been a check of all CC prisoners as part of the day shift. However, this did not take place as the night officer was only aware that he should do the night shift checks which began at 9.30pm.

**The Governor of Whitemoor should ensure that segregation unit staff are aware of the documentation to be completed for those undergoing a period of cellular confinement and of the importance of hourly checks.**

## **The segregation unit visitors' record**

71. PSO 1700 states that those in the segregation unit must be seen regularly by prison management and by staff from other areas of the prison. At Whitemoor, the observations of each prisoner are recorded on the E Wing Prisoner Location which provides confirmation that they have been visited by certain staff. The chaplain, nurse, and duty governor all need to visit daily and a member of the IMB and the governing Governor each week. In the man's case, the only person who has signed to confirm that they saw him is the duty governor (although in interview all the other staff recalled seeing him and I have no reason to doubt that this was in fact the case).
72. The record clearly shows that the man's details have been written by a different member of staff to the other names – this may have been because he was the only new prisoner in the segregation unit in November and the other names were completed earlier in the day. As I have said, I do not doubt that he was seen as described by staff and the governing Governor, but it is worrying that four people omitted to sign their names to confirm this.

**The Governor should review procedures to ensure that segregation unit records are completely correctly.**

## **The ambulance**

73. According to the two logs that were kept (one in the control room and one outside the man's cell), it took the first ambulance crew 14 minutes to get from the gate to the wing. The logs show that the ambulance reached the gate at 9.32pm and arrived at the cell at 9.46pm. The distance from the gate to the segregation unit, via the healthcare wing, is not huge and, whilst there would have been a number of gates to pass through, all but two were already unlocked. An estimate provided by one of the staff present on the night was that it would have taken between three and five minutes. None of the records of events in November, nor the accounts of staff, identify a particular problem at the time or subsequently. According to the safer custody manager, a dog handler and dog were waiting for the ambulance at the gate and it was escorted immediately to the segregation unit.
74. In another of my reports into the death of a prisoner in the Whitemoor segregation unit in February 2007, I found that it took ambulance staff six minutes to reach the unit from the gate (although this was at 2.00pm when the prison would be fully staffed). Similarly, there was no recorded problem with access for the ambulance in the other two deaths that occurred in 2007.
75. I understand that both staff and the governing Governor share my view that 14 minutes from gate to wing represents too long a time. However, it has not been possible to find an explanation for the delay. My investigator has not had access to any report from the gate (should one exist) or the hot debrief but it seems unlikely that these would shed any light on the matter. Enquiries by my investigator suggest that, until she mentioned the issue, staff were not aware of any delay.
76. My investigator obtained the East of England Ambulance Service report provided to the Coroner to see whether this provided any explanation. The report gives the time of 'arrive scene' (assumed to mean the prison) at 9.32pm and 'at patient side' at 9.46pm. She also contacted the now-retired Oscar 1 (the most senior member of staff in the prison at night) by email to ask if he could recall any problem or offer any explanation for the 14 minute delay. He replied that he was not aware of any hold up to the ambulance.
77. As should be the case with all prisons, Whitemoor has a local search policy regarding emergency access for ambulances into the prison. The delay in reaching the man causes me concern, and the Governor may wish to consider whether any revisions need to be made to the policy.

## **Conclusion**

82. The man's death appears to have come completely out of the blue. I have uncovered no 'trigger' for his actions, and his motives must remain a matter for speculation. I have considered whether enforced abstinence from heroin may have been one explanation, but have judged that the evidence is too weak to come to any conclusion.

83. At consultation, the man's sister, via her solicitor, have questioned the lack of action staff took regarding their suspicions that he was a heroin user. With the benefit of hindsight, these judgements can be questioned. However, he did not ask for any medication or help regarding his (suspected) use, either just prior to his death or at any time during his sentence, and was not showing any signs of withdrawing. If there is a suspicion that a prisoner is using drugs then staff need to be encouraged to share the information through the appropriate measures.

## **RECOMMENDATIONS**

1. The Governor of Whitemoor should ensure that segregation unit staff are aware of the documentation to be completed for those undergoing a period of cellular confinement and of the importance of hourly checks.

This recommendation was accepted by the Prison Service.

2. The Governor should review procedures to ensure that segregation unit records are completed correctly.

This recommendation was accepted by the Prison Service.