

**Investigation into the circumstances surrounding the
death of a man at HMP High Down,
at hospital in August 2008**

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

May 2010

This is the report of an investigation into the death in August 2008 of a man, a prisoner at HMP High Down. At about 2.10am that day, he was found hanging in a room known locally as a Listener suite, to which he had been taken so that he could telephone the Samaritans. He was transferred to hospital where, at 11.30am, he was pronounced dead. It was just two months before his 19th birthday. He had been subject to formal self-harm monitoring procedures since 20 August.

I extend to the man's family and friends my sincere sympathy and condolences for their tragic and untimely loss.

The investigation, conducted by my colleagues, has been complex and protracted as many issues have had to be examined. As important as it has been to ensure that the report is accurate and thorough, I recognise that the delay in issuing it will have added to the anxiety felt by the man's family. I offer them my apologies for this.

As part of the investigation, I commissioned a clinical review of the management of the man's health needs while he was in custody. This was conducted by two clinical reviewers. A Quality and Clinical Governance Manager at the local Primary Care Trust oversaw their work. I am most grateful to them all for their major contribution to the investigation. The man's parent have commented that the Manager's oversight of the review detracts from its independence. I have considered their view carefully and am satisfied that both clinical reviewers have the appropriate qualifications and experience to draw independent conclusions about the care given to their son. The Manager's role has merely been to co-ordinate and ensure that the Primary Care Trust is fully apprised of the findings of their review.

I should also like to thank the Governor and his staff at High Down for their co-operation and assistance. I owe special thanks to the liaison officers for their help and to their colleagues in the Safer Custody Department who offered invaluable advice.

The investigation has raised a number of concerns, the most serious of which relate to the events surrounding the man's last hours, organisational inefficiencies in the Control Room, and the family's initially unhappy experience of the family liaison offered by the prison. I hope the recommendations that I and the PCT have made will be implemented as a matter of priority, and that this will help prevent a similar tragedy occurring at High Down or at any other prison.

At the consultation stage, the man's parents raised a number of concerns, as well as proposing amended and additional recommendations. I have undertaken both to represent their personal views directly in the relevant sections of this report, and to advise them that any further concerns they may have can be raised at the inquest should they wish to do that. As a consequence of their concerns, I have reviewed the report, and have made some amendments to the recommendations.

My report tells a sad story of a vulnerable young man. The man was on remand awaiting sentence, having been arrested for having a broken glass bottle in his

possession. Like so many other prisoners who have taken their own lives, he had mental health and substance misuse problems and found it difficult to cope with the pressures of living within a closed institution.

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.

Jane Webb
Acting Prisons and Probation Ombudsman

May 2010

CONTENTS

Summary

Investigation process

HMP High Down

Key Events

Issues

Principal conclusions

List of recommendations

SUMMARY

The man was born in October 1989. His early years were disrupted by poor health and difficult behaviour. In 2005, he was diagnosed with Attention Deficit Hyperactivity Disorder (ADHD). As a teenager, he became involved in the illicit use of drugs and heavy drinking, committing acquisitive crimes to feed his habit.

He had served two previous sentences at High Down, the most recent of which was a nine week sentence from which he was released on 9 May 2008. During that period, he was subject to formal self-harm monitoring procedures after telling staff he had nothing to live for.

On 7 June, less than a month after his release, he was arrested in Croydon for being in possession of an offensive weapon - a broken bottle. He told the station sergeant he was suffering from ADHD, paranoid schizophrenia, autism and asthma. He claimed he was a heroin and crack user and that he drank heavily. He also said he had tried to slit his wrists, hang himself and taken an overdose of drugs in the past.

The man was detained overnight in a police station where he was examined on three occasions by different doctors, each of whom recorded their findings in a Detained Persons Medical Form. One of the doctors thought he presented a high risk of self-harm. He appeared in court the next day and was remanded in custody. He was taken to HMP High Down near Sutton in Surrey. The Prisoner Escort Report covering the journey between the police station and the court, and later between the court and High Down, indicated that he had a 'mental condition' and that he presented a risk of self-harm.

His presentation during the reception procedures at High Down was such that he was not considered to be at risk of self-harm. However, the investigation found no clear evidence to show whether the reception staff had sight of either the PER or the Detained Person's Medical Form, or whether they took their contents into account when judging his risk. Neither his previous prison record nor his previous clinical record was available during the ten week period he spent at High Down before his death in August.

The doctor who examined the man on the day of his arrival judged that he was not withdrawing from alcohol but did need treatment for his opiate dependency. She therefore prescribed a Subutex based detoxification regime. Upon the completion of a Cell Sharing Risk Assessment which concluded that he presented only a low risk of harming others, he was placed initially in the induction unit in house block 3 and subsequently in the detoxification unit in house block 6.

The local Counselling, Assessment, Referral, Advice and Throughcare Service (CARATs) completed a Comprehensive Substance Misuse Assessment and drew up a care plan for him, with his agreement, on 16 June. However, he did not attend the sessions that were programmed for him.

In June and July, the man's behaviour began to deteriorate. He received written warnings about his conduct and attitude towards staff. He told staff on five occasions that he was being threatened by other prisoners but, except in one instance when he was assaulted, he gave no names. The investigation found no clear evidence of the extent to which his claims were investigated.

On 17 August, the man told an officer that his mother had died of cancer three years earlier, that his father had committed suicide, and that his girlfriend had also committed suicide after giving birth to their stillborn baby. The officer later had the presence of mind to check the facts with his father over the telephone, and found the claims to be false. No-one from the prison thought of consulting him as to whether he might give his formal consent for staff to inform his parents that he had self-harmed and that Assessment, Care in Custody and Teamwork (ACCT is the Prison Service's system for supporting and monitoring prisoners at risk of harming themselves) monitoring procedures had been initiated.

In the light of the man's reported family circumstances, the officer completed a form for his referral to the Mental Health In-Reach Team. The form was returned to the referrer because it had not been completed correctly. This was not in keeping with the procedures agreed within the prison's mental health in-reach team. The form did not reach the author until after the man had died. However, by the time he was referred, an appointment had already been booked for him to see a Consultant Psychiatrist.

Three days later, on 20 August, Assessment, Care in Custody and Teamwork (ACCT) procedures were invoked after the man inflicted a minor injury to his wrist and appeared to be in distress. Before the ACCT plan was opened, he had spoken to Listeners (prisoners trained by the Samaritans to support other prisoners in distress). There was a suggestion that a blanket ban may have been imposed on him seeing Listeners as he allegedly told them stories about himself that were hard to believe.

At about midnight on Friday 22 August, he asked to speak to a Listener but quickly changed his mind and asked instead to be allowed to call the Samaritans using a dedicated portable telephone provided by the prison. However, as the telephone was already in use by another prisoner, he had to wait until it became available at about 1.10am. As only a poor signal could be achieved in the vicinity of his cell, the Governor had given his permission for prisoners to be taken out of their cell to make their call to the Samaritans from the Listener suite on the landing above. He was allowed out of his cell for this purpose at 1.17am, and arrived at the suite about a minute or so later. At 2.10am, he was found hanging from a metal conduit in the ceiling of the suite.

The investigation found no clear evidence that documents containing important information about events that had occurred immediately prior to the man's admission to High Down on 9 June 2008 were available to reception staff or taken into account in the process of assessing his risk. The documents included a Prisoner Escort Record, a Detained Person's Medical Form (from the police station), his previous prison record, and his previous clinical record, all of which contained clear evidence of risk of self-harm. Although there was no evidence that the absence of these records had any significant impact on the quality of care he received at High Down, I cannot overstate the importance I attach to the need for prisoners' previous records to be available at the earliest possible point of any subsequent periods of imprisonment.

There is a significant discrepancy between the timing of some of the entries made by an Operational Support Grade in his ACCT ongoing record regarding him moving from his cell to the Listener suite and the unrefutable timings shown on CCTV

footage. There is no evidence to prove beyond doubt that the OSG monitored him during the 53 minutes he spent in the Listener suite before finding him hanging.

The room used as a Listener suite in house block 5 was a multi-functional facility, not dedicated solely for use by prisoners in times of personal crisis. It was scruffy, poorly decorated and, at the time of the man's death, littered with ligature points and equipment that could be used for self-harm. When my investigators inspected Listener suites in other house blocks, they found in one a small pile of rubble left by contractors.

It took staff in the prison's Control Room nearly two hours to make contact with the duty governor after the man had been found hanging. His parents were not informed of events until four and a half hours had elapsed.

The initial family liaison between the prison and his parents was not well-handled, and the officer in question was replaced as the prison's FLO.

These matters, and a number of other observations and criticisms I make in this report, need to be addressed.

Along with the PCT, I make a number of recommendations which I urge the National Offender Management Service to accept and implement. Back to Life Ltd (a Surrey based training company that provides resuscitation services to Community Trusts and prisons) make nine further recommendations about the emergency response made by staff when the man was found hanging.

I understand from the Governor that some measures have already been taken in respect of the issues described in this report and in reports published by Her Majesty's Chief Inspector of Prisons.

INVESTIGATION PROCESS

1. The investigation was opened on 28 August 2008. On that day, both investigators met the Governor, other senior members of staff, and a representative of the Independent Monitoring Board at High Down, in order to explain the nature and scope of the investigation. (Independent Monitoring Boards are made up of local members of the public appointed by the Secretary of State for Justice to monitor the treatment of prisoners.) The Prison Officers' Association were also invited to the meeting but did not attend. On the same day, notices to prisoners and to staff were displayed in prominent places around the establishment inviting anyone with concerns about the man's death to make themselves known to my investigators. No-one came forward.
2. I also asked the local Primary Care Trust to conduct a clinical review of the management of the man's health needs while he was in custody. Two clinical reviewers undertook the review. Their work was overseen by a Quality and Clinical Governance Manager from the local PCT. Upon receipt of the PCT's first draft report, my investigator asked for further information. A subsidiary report was later submitted by Back to Life Ltd.
3. Three prisoners and 35 members of staff at High Down were interviewed formally during the course of the investigation. I am particularly grateful to the Samaritans Coordinator for High Down, who agreed to be interviewed and to conduct enquiries of his own in order to assist my investigators. Informal discussions were held with three other members of staff, two of which were conducted by telephone. (At the consultation stage, the man's parents expressed their view that the fact that my investigator did not formally interview a CARATs worker at High Down represented a lost opportunity to gather further and better information about the manner in which their son's Drug Intervention Records were completed. Unfortunately, although she was interviewed, the note was mislaid.)
4. On 1 September 2008, the investigator and my then Senior Family Liaison Officer met for the first time with the man's parents to invite them to raise any matters of concern about their son's time in prison and about the circumstances of his death. Further meetings took place on several occasions, most often in the company of their solicitor, to provide the family with up to date information about the progress of the investigation and to enable them to raise further matters of concern. Amongst their main concerns were:
 - The manner in which they were treated by one of the establishment's family liaison officers.
 - The delay in informing them of the events that occurred during the night of 22/23 August.
 - The extent to which staff at High Down managed their son's diagnosed condition of ADHD.
 - The discrepancies in timings recorded in his ACCT form during the night of 22/23 August 2008.
 - The effectiveness of the suicide prevention measures initiated for him.
 - The state of the Listener suite in which he hanged himself.
 - Whether he was bullied and how this was managed.

- The conduct of prison staff at the hospital.

HMP HIGH DOWN

5. Situated near Sutton in Surrey, High Down is a large local prison for adult and young men. (Local prisons serve Magistrates and Crown Courts in their area and hold prisoners detained before trial or shortly after conviction.) The establishment opened in September 1992. At the time of the investigation, it could hold up to 1,103 prisoners.
6. There are six main house blocks (residential units). House block 3 is the induction unit. House block 6 operates as the main detoxification unit whilst house block 4 is used as an overspill detoxification unit. There is also a segregation unit and a healthcare centre. Healthcare is provided by the local Primary Care Trust. The healthcare centre has beds for up to 23 in-patients.

Her Majesty's Inspectorate of Prisons

7. High Down was inspected by the former Her Majesty's Chief Inspector of Prisons in May 2006. In her report of that inspection, published the following August, she wrote:

“High Down, along with all local prisons, is under tremendous pressure as a result of the growth in the prisoner population. Despite this, the establishment had made considerable strides in a number of areas. However, it was failing to ensure the safety of all its prisoners and we and managers had serious concerns about the behaviour and attitudes of a small number of staff. As a result, High Down is not yet the healthy prison to which its Governor aspires. Nevertheless, it is moving in the right direction.”
8. Where safety was concerned, the report said:

“Reception, first night and induction arrangements were good in most respects as were arrangements for prisoners at risk of self-harm. Prisoners resident in the segregation unit were safe and were normally well treated. There were adequate arrangements for prisoners needing detoxification, and levels of discovered drug use were not particularly high. Suicide and self-harm prevention arrangements were satisfactory. The prison had a problem with bullying by prisoners and we received complaints of staff intimidation. There was an urgent need to improve the handling of prisoners' formal complaints about allegations of assault by staff. There had been a marked over-reliance on the use of force against prisoners and on the use of special cells, and despite some recent improvement this remained a serious concern. Systems for protecting vulnerable prisoners on normal location had failed and needed overhauling. The prison was not performing sufficiently well against this healthy prison test.”

The report made the following comments about the personal officer scheme:

“There was no effective personal officer scheme. Prisoners did not generally know if they had a personal officer or who he or she was. Wing files did not reflect the individual attention of a personal officer. The prison had re-evaluated the personal officer scheme with a view to focusing support on prisoners most in need. Linking personal officers to wings had not worked, since they were commonly re-deployed around the site because of under-staffing. Recent changes in working practices were partly designed to keep officers in their own house blocks as much as possible enabling more constructive relationships. It was hoped that the more needy prisoners - those most vulnerable, the self-harming, the dangerous - could be recognised and focused on as they arrived, or as the need emerged. The re-evaluation was to be welcomed, in that it recognised the value inherent in the personal officer scheme and sought to make High Down a safer place.”

9. Where suicide prevention was concerned, HM Chief Inspector recommended that checks by night staff on prisoners subject to Assessment, Care in Custody and Teamwork (ACCT) procedures should be frequent and unpredictable, and that case reviews should be attended by representatives of all departments that have regular dealings with the prisoner.

10. The prison underwent a further, follow-up inspection in May 2009, the report of which pointed to clear evidence of improvement. In the concluding paragraph of her introduction to the report, HM Chief Inspector wrote:

“In spite of its considerable expansion, High Down was a safer prison than at the time of the last inspection, thanks to considerable efforts to tackle violence and bullying. It was now performing reasonable well in all four of our key areas: safety, respect, purposeful activity and resettlement. Given the pressures of a busy and expanded local prison, this is a commendable achievement.”

11. Where safety was concerned, HM Chief Inspector wrote:

“Arrangements to deal with bullying and violence had improved considerably. A full time violence reduction coordinator managed the day-to-day operation of the over-arching violence reduction strategy. The monthly safer custody meeting focussed on relevant issues and had strong links to the security department. Information was analysed and used to inform interventions to reduce violence. Staff supported the use of peer supporters as anti-bullying representatives, and anti-bullying measures were well managed by the coordinator. Allegations of bullying were treated consistently and investigated promptly. The number of violent incidents recorded was not excessive for the size and composition of the population.

“There was a comprehensive suicide and self-harm prevention strategy. A full-time suicide prevention coordinator oversaw the protocols effectively, with input from residential managers and support from the safer custody committee. There had been an external review of procedures following three self-inflicted deaths since the last

inspection. The quality of self-harm monitoring documents was generally good. Care mapping was effective and case managers ensured that reviews were on time, although they should be more multi-disciplinary. The Listener scheme was properly supported and well advertised, and prisoner access was good.”

Independent Monitoring Board

12. In their report on High Down for the period 2006 - 2007, the Independent Monitoring Board (IMB) emphasised the increasing range and mix of prisoners in the establishment, some of whom they said were inappropriately placed in a local prison. The Board also commented on the difficulties caused by overcrowding and reduced funding. Despite this, they believed that High Down was well run, with the vast majority of staff committed to providing a secure, fair and decent regime for prisoners. The Board commented that there had been particular emphasis in building good relationships between staff and prisoners.
13. In their report on High Down for the following year, the Board drew further attention to their concerns about the holding of a large number of young offenders in the establishment. The Board expressed their view that the presence of so many young offenders created an imbalance. Time, energy and commitment had, in the Board’s view, been diverted from other areas which had suffered. Problems had been compounded by overcrowding, recruitment failures and consequential shortages of permanently based staff.
14. In the executive summary of their report, the Board wrote as follows:

“We consider that the prison is well managed, with a strong and consistent theme of providing a fair and humane regime for prisoners within a framework of security. The Board appreciates that difficult decisions over priorities have constantly to be made. There is determination on the part of management to target available funds and to do the best with what it has.”

Previous investigations at High Down

15. Before the death of the man, I had investigated the death of four other prisoners who had apparently died by their own hand at High Down. I understand from the Governor that follow-up action has been taken in respect of many of the issues I have raised in earlier reports.

The management of prisoners considered to be at risk of self-harm or suicide

16. The National Offender Management Service’s policies for the management of prisoners considered to be at risk of self-harm or suicide are set out in Prison Service Order (PSO) 2700. Governors and Directors of prisons are required to set out their local policies in keeping with the provisions of the PSO. Below is a brief summary of its key elements.

Assessment, Care in Custody and Teamwork (ACCT) procedures

17. ACCT procedures are pivotal in the management of at-risk prisoners. The ACCT document is the principal tool for assessing, monitoring and managing any prisoner thought to present a risk of self-harm or suicide. ACCT procedures can be initiated by any member of staff, irrespective of grade or discipline. The ACCT form itself contains instructions and guidance for its use.
18. If a member of staff has reason to believe that a prisoner is at risk of self-harm or suicide, he or she must open an ACCT form straightaway. The following further actions must follow:
 - A 'Concern and Keep Safe' form must be opened immediately. The purpose of this form is to determine the main issues causing the prisoner to be at risk of self-harm or suicide.
 - An immediate action plan must be compiled within one hour of the ACCT form being opened. The purpose of the immediate action plan is to consider and record the most appropriate environment and regime required to support the at-risk prisoner prior to the first case review. The plan should be drawn up within an hour of the ACCT form being opened.
 - An assessment interview must be conducted with the at-risk prisoner by a trained assessor within 24 hours of the ACCT form being opened. The purpose of this interview is to examine in depth the reasons behind the risk posed by the prisoner. The details of the assessment then inform the initial case review.
 - An initial case review must be conducted within 24 hours of the ACCT form being opened. The review panel must, in conjunction with the at-risk prisoner, agree a care and management plan - or 'care map' - setting out goals or the prisoner to achieve, with the help of staff, in order to reduce his risk.
 - Thereafter, regular multi-disciplinary case reviews must be convened, each involving the at-risk prisoner, so that his risk can be monitored and his care map updated.
19. The ACCT form can be closed once those involved in the prisoner's care, as well as the prisoner himself, are content that the risk has reduced to the point where formal monitoring procedures are no longer necessary. However, in such cases, a post-closure review, once again involving the prisoner and a multi-disciplinary panel, must be convened within an appropriate interval.

The Samaritans

20. Each prison is required to engage with a local branch of the Samaritans. Representatives of the local branch normally visit their establishments on a regular basis in order to see prisoners who wish to consult them, to attend safer custody or suicide prevention team meetings, and to see members of the Listener team.

The Listener scheme

21. Listeners are prisoners trained by the Samaritans to help and support those prisoners who are in distress or despair. Each prison is required to make use of an appropriate number of Listeners. They are accessible 24 hours a day and their interaction with prisoners is conducted in private on a confidential basis.
22. Central to the work of the Samaritans is the very strict principle of confidentiality which applies equally to prison work. Consequently, the details of any conversation between a Samaritan or Listener and a prisoner will remain completely confidential. Without this reassurance, prisoners may not feel able to approach Samaritans and talk freely about their feelings in an atmosphere of total trust. It is therefore important that telephone calls to Samaritans must not be monitored or overheard.
23. It is the Samaritans' policy that, when prisoners are considered to be seriously at risk of suicide, they will actively encourage them to seek further help. If the volunteer recognises that a prisoner does not wish, or is unable, to seek help on his own, then the volunteer will attempt to gain the prisoner's permission for staff to be alerted to the need for help. If the prisoner withholds consent, the volunteer will respect his wishes.

Peer support facilities

24. Annex 10C of Prison Service Order 2700 sets out the types of rooms that can be used by those prisoners who may require peer support. These include Listener Support Suites and Time Out Rooms. Although frequent references to Listener suites are made in this report, that specific term is not recognised in the PSO.

Violence reduction

25. Governors are required to have in place a local violence reduction strategy. At High Down, the strategy seeks to deal with mental and physical bullying, threats, fights and assaults. The Safer Custody Team, comprising key managers, monitors a series of indicators of the level of self-harm and bullying and meets regularly to deal with current issues and review the strategy. Wing managers and their staff are required to investigate instances of bullying, balancing the need both to protect victims and deal appropriately with perpetrators. The local strategy requires that a Bully Book should be opened in respect of any prisoner suspected of bullying. By this means, the behaviour of the prisoner concerned is monitored for an appropriate period and a record is kept of any sanctions imposed upon him.

KEY EVENTS

Background

Previous sentence

26. The man had already served two prison sentences at High Down before his arrest on 7 June 2008. The second of the two sentences was imposed on 10 April 2008 after he was found guilty at Magistrates Court of theft, battery and failure to surrender to bail. He was given a nine week sentence which expired on 9 May.

27. On 1 May, the following entry was made in his clinical record:

“Seen in houseblock 2 at the request of CARATs [Counselling, Assessment, Referral, Advice and Throughcare service]. On examination, patient appears to be very low in mood and tearful. Has a history of deliberate self-harm. Self-harmed when he was here in December 2007.

“Very polite, compliant, good eye contact. No symptoms of psychosis. Appears to be a bit depressed.

“States that he wants to end it as he has nothing to live for. Has been living on the streets for the past 2 years and will have nowhere to live when he leaves prison.

“Plan: 1. ACCT opened
2. To be moved to a sharing cell
3. To see GP as an emergency tomorrow
4. Dr to prescribe Nytol [a medication normally used to help patients sleep] for 3 days.”

28. The clinical record does not make clear if or when the ACCT form was closed. Neither the clinical record nor the core prison record was available to the reception staff at High Down when the man was received there for a third time on 9 June 2008. (No system was in place in the National Offender Management Service at the time of his death to allocate the same prison number to a prisoner at the outset of each new sentence. A new prison record was therefore opened every time a prisoner was received anew. However, a system known as p-NOMIS has since been introduced that allows for the allocation of the same prison number to each prisoner continuously.)

Arrest on 7 June 2008 and subsequent police detention

29. In the early hours of Saturday 7 June 2008, the man was arrested for being in possession of an offensive weapon - a broken glass bottle. He was detained at a police station where, at approximately 4.00pm that day, he was formally charged. He remained in police custody over the weekend.

30. A comment was made by the station sergeant on a risk assessment form to record that the man said he had a sore neck, suffered from epilepsy, and had ADHD, autism and asthma. He also said he had paranoid schizophrenia and was addicted to crack cocaine and heroin. He told the sergeant he had tried

to slit his wrists, hang himself, and had taken an overdose in the past. He was interviewed by a doctor for 15 minutes from 1.37am. The doctor recorded that he was under the influence of drugs and was not fit for interview, charge or transfer. He prescribed 30mg of Dihydrocodeine (an analgesic normally prescribed for moderate to severe pain) three times daily, and recommended that he should be subject to half hourly checks.

31. At 9.00am that day, the man was seen in the police cells by a doctor who noted,

“... hears voices, self harm never, sectioned, no delusions, some paranoia, sleepy, heroin yesterday, overdose hanging electrocution, sleepy, reassess at 10.30.”

The doctor recorded that he thought he presented a medium risk of self - harm. He, too, considered him to be unfit for interview. He saw him again at 10.50am. On this occasion, the doctor recorded that he was less drowsy and could cope with being interviewed. However, he thought his risk of self-harm was high.

32. The doctor saw the man yet again at 2.46pm and noted, “appears well, 2 bags heroin smoked a day, appears calm, declines dhc [Dihydrocodeine] see fme [forensic medical examiner] if unwell later”.

33. Another doctor assessed the man in the police cells at 2.17pm and noted:

“... was diagnosed with Schizophrenia, drugs abuser, DSH [deliberate self-harm] - old cuts and cigarette burns on left arm. Drinks alcohol heavy at times. Now complains of withdrawal from drugs.”

He deemed him to be fit for transfer and interview, and prescribed further dosages of Dihydrocodeine.

34. During the day, whilst in the custody suite, the man was assessed by a representative of the Croydon Branch of the Westminster Drug Programme who completed a Drug Intervention Record (DIR). He told the assessor that he suffered from paranoid schizophrenia, manic depression and Attention Deficit Hyperactivity Disorder (ADHD). He also reported that he used crack and heroin daily, having last done so the day before (6 June). The DIR was faxed to High Down prison on 11 June.

35. At 10.15pm, another police doctor saw the man and wrote in the Detained Person's Medical Form:

“Paranoid schizophrenic, seen for review as requested. See previous records. Reports to be epileptic/ADHD as well as heroin addict: £250 a day. Now suffering from stomach cramps, diarrhoea and vomiting. Also painful toes right foot from bus running over it 3 days ago - Thursday. Cold numb very tender right foot, 1st and 2nd toes. Discoloured: purple/red. Last had Dihydrocodeine 2x30mg at 18.23. Transfer to hospital for further management. Alert and orientated and co-operative.”

36. The man was transferred to hospital for treatment to his foot later that night and returned to the police station shortly after 2.00am the next day. The following note was made by a doctor in the Detained Person's Medical Form:

"The man is on 10mg of Temazepam [normally prescribed to help people sleep] and 30mg of Dihydrocodeine – quantity 2. This seems to have been prescribed following arrest as he was found to have a foot injury and was taken to hospital to have it looked at following arrest - no fractures, just soft tissue injuries."

Appearance in court

37. The man was taken from the police station to the Magistrates Court during the morning of 9 June. The Prisoner Escort Record (PER) covering the journey shows that he was thought to have a 'mental condition'. Also noted was that he presented a risk of escape, self-harm and substance misuse.
38. At court, he was remanded in custody and ordered to appear at the same court on 30 June. He left for HMP High Down shortly before 6.00pm. The PER for the journey does not indicate what time he arrived. The form contains comments about a risk of self-harm and escape. Other entries indicate that he was an epileptic and a paranoid schizophrenic.

HMP High Down: 9 June – 22 August

Reception health screen

39. As part of the normal reception procedures at High Down, the man underwent an initial health screen conducted by a bank nurse. He told her he had no fixed address and had not registered with a doctor. He said he had been in High Down earlier in 2008. He added that he had received no injuries during the previous few days but that, although he had not been prescribed any medication, he was using an asthma inhaler.
40. The man told the nurse he usually drank five large bottles of cider daily and the last time he had done so was on 6 June, the day before his arrest. He admitted he had taken heroin the same day and said he usually took heroin to the value of £250 daily. He added that he also used cocaine and crack and sometimes took drugs intravenously.
41. He said he had not received treatment or medication from a psychiatrist but had been diagnosed as a paranoid schizophrenic. He said he had self-harmed in January 2008 by cutting his arm but did not currently feel suicidal. The nurse decided to refer him to a doctor in relation to his substance misuse history.
42. My investigators attempted to interview the nurse on several occasions. However, each time an appointment was made, she failed to appear. Thus it has not been possible to check with her whether she had sight of the PER covering the man's journey from court to High Down. Neither did the investigation find any clear evidence to show whether the information contained in the Detained Person's Medical Form was available to her.

Reception interview

43. An officer interviewed the man in reception in his role as First Night in Prison officer. At interview, he explained that newly received prisoners would be interviewed initially by a reception officer who would sign the PER to show it had been seen. However, the investigation found that the PER was not signed by any member of staff at High Down. He told my investigators that he could not remember whether he saw the form.
44. During his interview with the officer, he said he had last harmed himself in January 2008. When asked how often he would self harm, he said, "every day for three years". In answer to the question, "Are there any triggers or reasons why you would self harm or commit suicide?", he said, "Being locked up with someone I don't like". However, he said he had no plan to take his own life. During his interview with the officer, my investigator asked him if he had any reason to believe he was at risk of suicide. The officer replied that had he felt he was at risk, he would have opened an ACCT plan, inferring that he did not judge that he was at risk when he met him.
45. The man told the officer he had been discharged from High Down six months earlier. (In fact, as I have said above, he was released from High Down on 9 May 2008, a month previously, at the end of a nine week sentence.)

Cell sharing risk assessment

46. The purpose of the cell sharing risk assessment is to measure what, if any, risk a prisoner presents of harming others if he were to share a cell. Another officer carried out the man's assessment in her role as a reception officer. A nurse, whose signature is illegible, conducted the healthcare element of the assessment. (The nurse was probably the bank nurse.)
47. At interview, the officer told my investigator she had not seen the PER form. However, she signed the cell sharing risk assessment form to confirm that she had received it. She also confirmed that she had not seen his Detained Person's Medical Form.
48. The officer noted on the cell sharing risk assessment form that the man told her he was 'detoxing' and wanted to be placed on a detoxification programme. He also said he wanted to be allocated to a single cell or to the segregation unit. He emphasised that he did not want to be allocated to a shared cell. She noted that he had a history of drug and alcohol misuse and was currently dependent on both. She recorded that he was not currently subject to ACCT procedures and there was no evidence that an ACCT form had been opened for him previously. (As his records relating to his previous period of imprisonment at High Down were not available to her or anyone else at that time, she would not have known that he had been subject to ACCT procedures during that sentence.) She concluded that he presented a low risk of harming others and therefore considered him suitable for sharing a cell.
49. The nurse who completed section three of the form concluded that he presented a low risk of harming others and that there were no concerns about

self-harm risk. The nurse wrote, "For houseblock 4 or houseblock 6 for detox. Fit for ordinary location." (House blocks 4 and 6 both operated as detoxification units.)

50. The man was allocated to house block 3 that evening. His record does not make clear whether he was put into a shared cell or a single cell. At the time of the investigation, house block 3 was the induction unit. The following morning, he was moved to a single cell in the detoxification unit in house block 6. During the induction process he was not thought to be at any risk of self-harm.

Appointment with a prison doctor

51. At approximately 9.00pm that day, a prison doctor saw the man as part of the reception procedures. At interview, she told my investigators:

"I wrote [in his clinical record] that the man was an 18 year old male. I documented that he told me he had last been in High Down a month previously and that time he had been in High Down for nine weeks. I asked him what treatment he'd had for substance misuse during that period and he said he hadn't had any treatment. He told me that over the previous four weeks he'd been taking heroin, 200 pounds a day which he was smoking and he'd last smoked it three days previously. I said that he'd had DF118s [another term for Dihydrocodeine] over the weekend, presumably that was in the police station. He told me that he used crack, £200 a day which he smoked and also alcohol. He consumed five three litre bottles of nine per cent cider a day. He'd last drunk alcohol three days previously. He told me that he started drinking on waking and that he drank all day. In his past medical history which I asked him about, he said he was asthmatic and he was treated with salbutamol and becotide 100 inhalers. In the psychiatric history I asked him about, he told me he was diagnosed with paranoid schizophrenia when he was ten years old but he'd had no treatment or follow up for it. I found his mental state to be appropriate with no sign of psychosis. He exhibited signs of opiate withdrawal and I also documented that he hadn't had any benzodiazepines [normally prescribed for symptoms of anxiety, sleep disorders, agitation, alcohol disorders] in the police cells. This is because if people were alcohol dependent and they were given benzodiazepine in the police cells for treatment of it, then they might not show signs of withdrawal when they came in and, as he hadn't had alcohol for three days, then I concluded that he wasn't using alcohol in a dependent manner. We did a urinary drugs screen and this was positive for morphine (that's heroin), positive for benzodiazepines, positive for cocaine, negative for methadone and negative for amphetamines. And we agreed that he would be prescribed a subutex regime which is treatment for substitution for heroin or other opiate addiction - withdrawal state."

52. She explained that, as she felt he was not withdrawing from alcohol, she believed he needed treatment only for his opiate dependency. She said:

"We have a standard regime we start with. Normally if people come in on heroin, we don't make long term plans in their treatment in reception. So I

start off a treatment plan and that would be reviewed by a key worker, by his nurse in the subsequent days.”

53. When asked where the treatment plan was documented, she replied,

“Well the initial one was for the subutex regime and the nurses in the following days would have seen him. I know there is some documentation but the plan would be in the notes. I know there aren’t many and I don’t know if a plan would have been made certainly verbally but whether it’s written down or not I don’t know because quite, not uncommonly we don’t have access to the IMRs [Inmate Medical Records]. It’s quite a big prison now and they go missing and we would write on continuation sheets if we can’t find them. So I don’t know if it wasn’t documented or if it wasn’t on the continuation sheet.”

54. When asked what the process would be following the reception health screen, she said:

“He’d be followed up by a nurse in liaison with a CARATs [Counselling, Assessment, Referral, Advice and Throughcare] worker and a treatment plan would be formulated, however simple or complex, and it would be presented to me to write a prescription if the nurse and CARATs worker was happy.”

55. The doctor said he made no mention of being on Ritalin or of suffering from ADHD for which Ritalin is sometimes prescribed. She could not remember whether he may have displayed signs of ADHD when she saw him. When asked whether a detoxification programme might have had an effect upon him if he was suffering from ADHD, she said she thought it might. However, she said if he had been displaying such signs, she would have discussed this with him and with the mental health in-reach team.

Appointment at Wellman clinic

56. Shortly after the man’s consultation with the doctor, he underwent a Wellman (a general health) assessment by a Healthcare Assistant (HCA). At interview, she described him as being “very pleasant to talk to” and “very chatty”. She explained that she was not conducting a mental health assessment of him, and said she had become involved in assessing him because he had been placed on a detoxification programme.

57. During the consultation, he told her he had been taking Ritalin prior to his imprisonment because he had ADHD. When asked whether she would normally refer to the mental health in-reach team any prisoner suffering from ADHD, she said:

“No, the reason I say that is because the mental health in-reach team really do specify that they deal purely with very severely psychotic symptoms. They don’t deal with depression or anything like that because they feel that if, for example, they have a substance misuse worker or a CARATs worker, the CARATs worker can deal with that but I wouldn’t refer someone with ADHD.”

58. My investigator asked the HCA what could be done to help and support prisoners with ADHD. She replied:

“Aside from the medication, I’d just make sure that there was always someone making other people aware but then it’s something that the nurses would have picked up on as well.”

59. She decided to refer the man to a doctor for his asthma. She could not remember whether, at the time of her consultation, he appeared to be under the influence of drugs or withdrawing from them. However, she was clear that she did not regard him as being subdued, emotional, depressed or suicidal.

Appointment with substance misuse lead nurse

60. The substance misuse lead nurse saw the man on 10 June in order to give him his medication for the day.

61. At interview, the nurse told my investigators he had met the man during his earlier sentence at High Down. He said he knew he had not been subject to any detoxification treatment in the community prior to his arrival at High Down on this occasion. He described him as a very quiet person who would give only short answers to any questions asked of him.

62. The nurse said 10 June would have been the second day of the man’s detoxification programme and explained that he would have been prescribed 8mg Subutex, a medication that had to be administered under supervision rather than being held in possession. The medication came in tablet form and was held under the tongue until it dissolved. According to the nurse, it was thus impossible for him to store the medication. He told my investigators that the first five days of the detoxification regime were normally used to stabilise the prisoner, during which period an initial 4mg dosage would be given. Thereafter, the dosage was increased daily by 2mg for five days. The nurse said that, during this period, the CARATs staff and those who ran Wellman clinics normally worked together with the prisoner. According to him, each prisoner was asked at the end of the five day period whether he wished to be placed on a maintenance programme or remain on a detoxification regime. He said the man chose the former.

63. My investigator asked the nurse to confirm whether individual entries were normally made in a prisoner’s clinical record on each occasion he was seen by a substance misuse nurse. He said that this would normally be the case. He acknowledged that no entries had been made in the man’s clinical record until 27 June.

Referral to Counselling, Assessment, Referral, Advice and Throughcare Service (CARATs)

64. At the time of the investigation the CARATs manager at High Down explained to my investigators that all CARATs clients were automatically seen by the CARATs team as part of the induction process. (The man had already been a client of this service in the community and was therefore an existing client. As noted at paragraph 35 above, a community based CARATs worker completed a Drug Intervention Record (DIR) in respect of him whilst he was in

police custody. This was forwarded to the prison on 11 June.) A member of the Substance Misuse Team at High Down at the time updated the DIR on 11 June. During this assessment, the man said he had taken an overdose of valium in February 2007 as a suicide attempt and had made six previous attempts at suicide. He also told him that his foster sister had died from a heroin overdose three weeks earlier.

65. The member of the Misuse Team asked him to sign a consent form allowing the information on the DIR to be shared with a range of internal and external agencies. A signature appears at the bottom of the consent form, indicating that he had given his consent. The initials 'CP' also appear in a number of boxes on the form listing which agencies could be given the DIR and which could not. The initials are written neatly, in a form of handwriting that seems different from that seen in his signature. This was a matter of concern to the man's family. My investigators asked the member of the Misuse Team if he, rather than the man, had entered the initials on the form. He confirmed that neither the dates / times nor the initials shown on the form were in his own handwriting. My investigators were satisfied that the man had entered his initials himself and that there was no evidence of any wrongdoing on the part of the Misuse Team member. However, the man's parents remain doubtful as to whether it is his signature.
66. On 16 June, the man was interviewed by his allocated CARATs worker at High Down, in order to complete a Comprehensive Substance Misuse Assessment. The purpose of this assessment was to identify what his substance misuse needs were and to draw up a care plan for him. At the conclusion of the assessment, he was asked to sign a consent form. The following words were written at the end:
- "I have been told by my worker that all the agencies listed above will respect the confidentiality of any information about me and that individuals will not share this information with their parent organisation except for the purpose of ensuring the continuity of my care."
67. Two signatures can be seen at the bottom of the consent form. One of the signatures is that of the CARATs worker. The other purports to be the man's signature. However, it differs from his signatures that appear elsewhere in his CARATs file. This, too, was of concern to his family. One of my investigators discussed this matter with the CARATs worker to check the authenticity of the signature. She confirmed that she entered his name in the box reserved for the prisoner's signature. She said she did so because, during her interview with him, he did not pay attention to what she was saying and behaved in an odd fashion. She told my investigator that such was her concern at his behaviour she wondered at one stage whether to terminate the interview. As with the DIR mentioned in paragraph 53 above, the initials 'CP' appear in a number of boxes on the form listing which agencies could be given information contained in the Comprehensive Substance Misuse Assessment form. She confirmed that she had entered them on his behalf after confirming his consent with him during the interview. My investigators were satisfied that there was no evidence of any wrongdoing on her part.

Substance misuse summary and care plan

68. At the conclusion of the man’s assessment form, the CARATs worker summarised his physical and mental health needs as follows:

“No concerns with physical issues. Client states that he does not wish to take medication connected with his mental health. Client states he wants to feel normal. He wants to feel and be in control of himself.

“Work required to explore relaxation techniques to attend and participate IDTS [Integrated Drug Treatment System] relaxation session.”

69. She agreed the following care plan with him:

Objective	How achieved will be measured	What work be done to achieve the objective?	Who will do work?	In what timescale?	Comments on completion/reason objective not achieved
Explore relaxation techniques	Feedback and discussion post group	Attend and participate in IDTS relaxation techniques	CARATs and [the man]	14 July 08	DNA (Did not attend)
Increase knowledge and awareness of healthy living and healthy balance	Feedback and discussion post group	Attend and participate in healthy living and health balanced classes	CARATs and man	14 July 08	DNA
Increase reinforcement motivation to change ambivalence	Increase motivation and movement through the stage of change	Attend and participate in IDTS MET [Motivation Enhancement Therapy]	CARATs and man	14 July 08	DNA
Explore issues around crack	Increase knowledge and awareness around crack use	Attend and participate in IDTS crack awareness sessions	CARATs and man	14 July 08	DNA
Explore relapse prevention strategies	Increase knowledge/ awareness of triggers/coping strategies	Attend and participate in IDTS relapse prevention session	CARATs and man	14 July 08	DNA

70. The CARATs manager told my investigators that, in order for the man to achieve the objectives listed in his care plan, he would have been required to attend a group session related directly to the subject matter described in each objective. When asked whether there were a number of group sessions that would have been programmed to take place by the target date set for him (14 July), she confirmed that within the IDTS programme there were 14 group sessions. Thus, within a 28 day period, each session would be run twice. She commented that, in relation to the IDTS relaxation group objective, he had two opportunities to attend. In fact, he attended neither.

71. The man's CARATs file contains his CARATs case history, a form on which entries can be made by individual CARATs team members to record specific details of significant events and interventions. My investigators noticed that a number of entries were made on his form, one of which on 27 June was, "Went and saw the man. No problems. Awaiting IDTS groups". The entry was initialled by the CARATs manager.

Seen by Nurse Adechi

72. On 27 June, a Registered Mental Nurse made the following entry:
- "The man is currently on 6mg of Buprenorphine tablet which seems to be quite sufficient for him. He however complained of being constipated and is being prescribed Lactulose commencing from 28 June 08."
73. At interview, the nurse explained that he appeared to be alright other than in respect of his constipation. She said:
- "He would have been definitely ok because things like that I pick up because I'm a mental nurse. Sometimes you don't need to see it at all. I can read body language, check their eyes ... I do call 'you appear not to be yourself today, is there anything going on?' But that day there was nothing at all that I could see was wrong."

Written warnings

74. On 20 June, an entry was made in the man's file by a nurse to record that he had been abusive by blowing cigarette smoke in his face. The nurse told him that a red entry, or written warning, had been made in his file. On 29 June he pressed his cell bell to demand that an officer ask his cell mate to light a cigarette for him. The officer refused to do so and told him he had been given a further red entry.
75. He was required to return to court on 30 June. Little is recorded in his prison file about this. Upon his return to High Down, he returned to the detoxification unit in house block 6.
76. The next day (1 July 2008), a Senior Officer (SO), the then manager of the detoxification unit, had cause to interview the man as he had received the two red entries described above. She told my investigators that, whenever a prisoner received two such warnings within 28 days of each other, the unit manager was required to interview him to decide what if any further action was required. She decided to warn him that, if he were to receive a further written warning within that period, he would be referred to an Incentives and Earned Privileges (IEP) Board at which his position on the IEP scheme would be reviewed. (The IEP scheme has three levels: basic, standard and enhanced. Prisoners' behaviour and attitude inform decisions made by officers and managers as to what level of the scheme they should be placed on. Each level attracts a different range of privileges such as access to television and entitlement to visits and letters. At this time, he was on the standard level.)

Seen by substance misuse key worker

77. That same day, a nurse made the following entry in the man's clinical record:

"Seen this afternoon. Has lots of anger issues and problems with authority. Have discussed attending groups to address these issues – reluctant at first but finally agreed. To have subutex increased to 8mg as from 3 July. Then review after court appearance. To return to group when up and running."

78. My investigators interviewed the nurse. She explained that she was a band 6 nurse with Registered General Nurse training. (The band relates to the level of responsibility defined in the job description and the pay level it attracts. A band 6 nurse is relatively senior.) She said she had been appointed as a key worker in the establishment's substance misuse team and explained that this role required her to act as a liaison point between her clients and the CARATs team. She told my investigators:

"We came round to the fact that he does have problems with people telling him what to do. He doesn't like being told what to do. So I just broached the subject and said there's a new group that will be up and running soon ... would you be happy to attend it because I think you would benefit from it. At first he didn't want to attend but by the time we'd finished our chat he was quite happy to try it."

She explained that the group she had mentioned to him was a community based psychotherapy group held in the prison each Tuesday.

79. When asked how he appeared when she saw him, she said:

"He was fine. I think he'd had a visit that day or the day before. His mood was ok. There was no cause for concern at all. We discussed his Subutex being increased and I said to him, once you've been to court we'll review it depending on your sentence, because I think he was looking at a quite a long sentence."

Alleged assault by another prisoner

80. At approximately 4.00pm on 4 July in cell 61B11 (i.e. house block 6, first landing, B spur cell 11) the man pressed his cell bell. When Officer A responded, he told her he had been attacked by another prisoner. He said the attack was related to a tobacco debt. He told the officer he had been punched on both sides of his head. She recorded in his file that she had seen red marks on both sides of his temple. Whenever a prisoner sustains an injury other than through self-harm, a form F213 must be completed. (Where the injury is caused by an act of self-harm, a form F213 SH must be raised.) The form should be completed by the member of staff who first discovers the injury. The investigation found no evidence that this form was completed on this occasion. At interview, the officer told my investigators she would ordinarily complete the form in such circumstances but was not certain that she had done so. Neither could she remember whether she told anyone about the assault.

81. The officer said:

“If he had open wounds or anything like that, I would automatically get Hotel Two to come and attend. [Hotel Two is the radio call sign used by whichever member of the healthcare team is responsible for providing the first response to a prisoner who may need medical attention.] In this case, because we have nurses based on our house block who deal solely with those people that are on detox, the likelihood is I would have asked one of those nurses to take a quick look at him. But I don’t remember which I did.”

82. When asked what the local anti-bullying policy required her to do, the officer said:

“We are supposed to go and inform the senior officer. We should make an observation book entry and he should be interviewed as to what’s happened. And if it’s found that there is what we think to be bullying going on, then the person who is alleged to have committed the assault would be placed on a Bully Book.”

83. My investigators were told that Bully Books were an important feature of the establishment’s anti-bullying strategy. Staff were required to open one whenever they had reason to believe that a prisoner was a victim of bullying. Bully Books were used to monitor prisoners’ behaviour and to ensure that appropriate measures were taken to safeguard victims and to tackle perpetrators. The investigation found no evidence that a Bully Book was opened on this occasion.

84. In interview, the officer offered the view that the man may not have ingratiated himself with other prisoners because he may have frequently asked others to give him items such as tobacco, sugar and tea bags.

Discovery of minor cut and improvised weapon

85. The officer made a further entry in the man’s prison file later that day. She wrote:

“At approx 19.20 hours he pressed his cell bell to tell staff he had a paper cut! Hotel two attended and put a plaster on it just to keep it clean. I then had a chat with him and he gave me an improvised weapon (a toothbrush with a melted head with one razor blade in it). He said it was purely to protect himself. He is worried he will now be labelled a grass.”

(The term ‘grass’ is prison slang for an informer.)

The man moved to a different house block

86. The following day (5 July), the man was moved to house block 4 after telling staff that other prisoners had threatened him. He offered no names of the individuals allegedly involved. Officer A explained that one of the spurs in house block 4 was for prisoners subject to a detoxification regime which was probably why it was chosen for him. This explanation was supported by an entry made in his prison file by another member of staff on the day he moved.

The officer, whose signature is illegible, wrote that 'meds' were the reason for him being moved there.

87. The officer told my investigators:

"From what I can remember there was another prisoner in the man's cell when he reported that somebody had assaulted him. He was trying to get the other lad to say that he'd seen it happen and that what he was saying was the truth. The other lad wasn't willing to say anything and he didn't want to get involved, even though the man had called him his cousin. Later, when he wasn't around, the other prisoner came to me and said, Can I have a word? I said of course. And he said the reason I didn't want to say anything was because that's not what happened."

88. When asked whether the prisoner told her what actually happened, the officer explained that he had told her it was the man who had entered another prisoner's cell and intimidated them. In turn, the other prisoner had felt it necessary to defend himself.

89. My investigators were presented with an extract from a staff observation book in which the following entry was made on 5 July:

"A Bully Book has been opened on this prisoner [name withheld]. His sanctions are not to enter other prisoners' cells and also stay on the 1st landing unless collecting medication or posting mail etc."

90. My investigators found no evidence to show whether the decision to move the man was the result of a formal investigation into his claims that he was being threatened. Neither were they able to clarify whether the decision to open a Bully Book in respect of the other prisoner took into account the possibility that the man, rather than he, may have been the aggressor.

91. My investigators asked the officer whether his behaviour was symptomatic of ADHD but she said she did not know.

Further written warning

92. On 9 July, he was issued a further written warning for misusing his cell bell.

Abuse of subutex

93. The man was supposed to report to the treatment room each day to collect his medication - Subutex - from a member of the detox team. On 13 July, Nurse A was on duty in the treatment room. When she realised he had not reported for his medication, she asked a colleague to collect him from his cell. He refused to attend. She therefore decided to see him in his cell. At interview, she said she asked him whether he had a problem or if he was ill. He told her that other prisoners were asking him to give his tablets to them. She told my investigators that it was possible for prisoners to hide their Subutex tablets in their mouth rather than swallowing them so that they could store them or pass them to other prisoners. However, the substance misuse lead nurse told my investigator that prisoners could not store subutex whenever a prison officer was in attendance with the nurse who was

administering the medication. (Although these tablets are dissolvable, my experience of other investigations has shown that prisoners can be innovative in finding methods of storing such medication for illicit use.) He told the nurse he had refused to go to the treatment room in order to avoid being compromised. She said she drew attention to this development at the weekly multi-disciplinary substance misuse team meeting.

94. According to the nurse, he did go to collect his medication the next day. She said he did not appear to be anxious on that occasion. She told my investigators:

“When he was in house block 4, he wasn’t really chatty, he kept himself to himself. But when I came up to house block 5 he was more open. We chatted and he told us about what he had been doing. He had formed a sort of friendship with another prisoner across from his cell, who sometimes when we go there to give him his medication he’s usually in the prisoner’s cell talking. So he was quite pleasant really and I remember the last day because I along with another nurse went to give him the final 0.4mgs of Subutex and he was saying ‘Oh miss, I’m so glad to be off this, drug free and alright’. And I did say to him that if there were any side effects or if he was having any ill effects from not having tablets, he should contact one of the nursing staff to get him a symptomatic treatment.”

95. The nurse told my investigators she was not aware that he may have been suffering from ADHD and did not know anything about the condition.

CARATs case history update

96. On 14 July, the CARATs worker made the following further entry in the man’s case file:

“Client is no longer IDTS. He stated that he has been moved to house block 4. Client is currently on 8mg subutex maintenance.”

Refusal to return to his cell

97. At about 7.25pm on 17 July, the man was required to return to his cell in time for the evening roll check (head count). Instead, he took hold of the railings on his landing and refused to let go. Consequently, he was forcibly removed by staff using authorised control and restraint (C&R) techniques. (C&R are authorised techniques designed to minimise the use of force necessary to prevent a prisoner from harming himself or others or to restore order. They involve the use of wrist and arm locks applied by teams of three trained officers.) He was taken to the segregation unit where he was placed on a disciplinary report for disobeying an order from a SO to return to his cell. He was issued with a notice of report telling him that his case would go before a disciplinary hearing on 19 July.
98. The use of force forms completed by staff on his arrival in the segregation unit show that he had been injured whilst being restrained. A Form F213 was completed by a staff nurse after examining him. The nurse recorded that he complained of pain in his right knee and that some swelling was evident. The nurse applied an ice pack to the affected area.

99. The nurse also completed a segregation safety algorithm, the purpose of which was to assess the man's ability to cope with being segregated. The nurse considered that he would be able to cope with a period of segregation. The duty governor countersigned the completed algorithm to confirm that he agreed with the assessment.

Disciplinary hearing

100. An entry made in the man's core prison record on 18 July refers to his relocation from house block 4 to a single cell in house block 5. The Governor later explained that he was allowed to calm down in the segregation unit that day before being located on house block 5 and then went from the house block to the segregation unit on 19 July for his adjudication (disciplinary hearing). The Governor believed that this was a good practice that ensured that prisoners were held in the segregation unit pending an adjudication only when there were good grounds for them not being held in a house block.
101. He appeared before the Governor on 19 July in regard to his refusal to return to his cell two days earlier. He pleaded guilty but, in responding to the charge, he told the Governor he had refused to return to his cell because another prisoner had accused him of being a "grass". He added that the prisoner told him that if he did not leave his cell he would be given "a good kicking". He said he tried to speak to the SO (whose order to return to his cell he had disobeyed) but the SO would not listen to him. When asked by the Governor how long the conflict with the other prisoner had lasted, he said, "Three or four days and on Thursday afternoon he said I'd get a kicking. It was about 4.30pm."
102. He was found guilty of the charge and given a punishment of 28 days stoppage of earnings and 21 days forfeiture of privileges, but both penalties were suspended for a month. This meant that the punishment would not be put into effect if he committed no further disciplinary offences during that period. It also meant he could return to a house block. My investigators were presented with no clear evidence to show whether his claims of being bullied were investigated, or whether the information he gave during the disciplinary hearing was communicated to staff in his house block.

Further appearance in court

103. On 21 July, the man appeared at Magistrates Court for a further hearing. He returned to High Down the same day. His record contains no information as to the outcome of his court appearance. The PER for the journey to court includes the comment, "Didn't want to go in a holding cell with others".

CARATs case history update

104. The man's CARATs case history form was further updated on 27 July with the following entry by the CARATs worker:

“Client states he wants to switch to methadone. This has been discussed with the detox team. Client is in contemplation stage in cycle of change. Referral made to MET [Motivation Enhancement Therapy] group. Activity form completed.”

Abusive to staff

105. On 4 August, the man swore at a nurse who was administering his Subutex medication. A note of the incident was made in his record.

Appearance in court

106. On 11 August, the man appeared at Magistrates Court. He was remanded in custody and ordered to appear before the court again on 26 August by video link. The remand warrant issued contains the following explanation:

“Remand after conviction for the purpose of enabling enquiries to be made or of determining the most suitable method of determining the case.”

He returned to High Down that evening.

The man moved for his own protection

107. An entry made in the man's prison file by a nurse on 14 August shows that the man had been threatened that day by a number of prisoners. A decision was made to move him to another part of the house block for his own protection. The next day, the following entry was made:

“Upon speaking to him today, he raised concerns regarding a previous incident with another inmate. He feels that now [name withheld] has been moved off the house block, we shouldn't be keeping him segregated from the rest of the house block. I explained we were doing this for his own safety. The SO will speak to him in the morning.”

108. At interview, the nurse explained that the man's segregation took the form of being kept in his cell except at meal times when he was allowed out on his own solely to collect his meals. She said whenever prisoners claimed they were being bullied, staff were required by the local anti-bullying policy to open a Bully Book in respect of the prisoner(s) found to be perpetrating the bullying and to monitor events. When asked why it was necessary to keep him segregated despite the fact that the alleged perpetrator had been moved to another house block, she said it was necessary to do so in case there were other prisoners involved in bullying him. She said he was 'fine with that'.
109. A note was also made to this effect in the man's security file but the following additional information was included:

"[The prisoner – name withheld] refused an order to move house blocks after threatening to assault him. [The prisoner – name withheld] was issued with an IEP 3 for his behaviour. When returning to his cell [the prisoner – name withheld] said, "I'm gonna do that c*** one way or another. I know where he lives on the out and I've got a lot of cousins on this spur who I will tell to beat him up as well, you watch and see gov." [The prisoner- name withheld] was moved to HB4 and placed on basic regime."

110. SO A was acting in the role of unit manager of house block 5 at the time. She spoke to the man on 16 August and made the following record of her conversation with him:

"I have spoken to him this morning and he does not want to move. He has stated he doesn't feel threatened on HB5. I have explained that staff have concerns for his safety, but he stated that he feels safer on HB5. I am confident I have explained the options available to him. He has signed to say he wants to stay on HB5."

111. At her interview, she was not clear about precisely what form his segregation took but thought that "in general terms" it probably meant he was "kept behind his door" (in other words kept in his cell).

112. When asked why he was keen to remain on house block 5, the SO said:

"We spoke about that. He spoke about where he had been previously and he didn't want to go back to sharing a cell. He was very keen to have a single cell and he was saying this was the safest he'd felt. He was looking around the room. I got the impression he felt that it was a secure place to be."

113. The Governor later explained that in his view house block 5 had the highest quality accommodation in the prison and was generally a sought after location. He added that the man may have declined an offer to move to house block 2 and that staff were flexible in listening to him before making a decision as to where he should be located.

114. The Governor also emphasised that in house block 5 the cells are fitted with privacy locks, which allow prisoners some control over when they can leave or enter their cell. The Governor explained that it would thus have been possible for the man to remain in his cell and to choose for himself when to leave it without staff having to unlock or lock his door.

115. When asked what anti-bullying measures should have been taken, the SO replied:

"It's quite comprehensive. It would require basically finding out who the perpetrators are. If we can't find out who the main perpetrators are, we look at the best way of resolving it. We would place them on Bully Books to monitor them. Oft times they would be relocated. We wouldn't as a practice relocate the victim because then it's not resolving anything. It's not showing the perpetrators are the people doing something wrong. I previously opened Bully Books on house block 5 on four people and managed to send each of them to different house blocks so that they

weren't together, because they'd been acting as a group. It's a little more difficult when you don't know the perpetrators to deal with and if the person who is alleged to have been bullied isn't willing to speak with you about it that makes it more difficult."

116. One of my investigators put to the SO that two prisoners had come forward either just before or just after the man's death to tell staff they thought he had been bullied. She said she could not remember this taking place but she did recall speaking to a Listener who saw him. She remembered him saying words to the effect: "The kid's off his head, I don't believe anything else he's telling me now".
117. My lead investigator wrote to both of the prisoners in order to ask them if they were willing to be interviewed. Neither responded.
118. However, my investigators were able to interview the Listener in the presence of the local Samaritans co-ordinator. He said he had been a Listener in house block 5 since the unit was opened about a year earlier. He first met the man when Officer B asked him to speak to him. He said the officer told him he was the only one who "could sort this out". He explained that the officer was concerned about what the man was telling him. He therefore spoke to him in private in his cell. (As noted earlier, the details of conversations between a Listener and his client are confidential. Thus, it was not possible for my investigators to ask him to disclose what was said when he saw the man. However, he told them he saw him on two further occasions as 'follow up' meetings.)

Referral to In-Reach team

119. On 17 August, the man told Officer B that his parents, child and partner had all died within the previous three years. My investigators interviewed the officer. He told them he had worked at High Down for just over four years. His job currently entailed working in B spur of house block 5 where the man was located. He said he got to know him quite well despite the fact that he was not his personal officer. He gave the following account of the events of 17 August:

"This was the second time I had met him. I was working on B spur. We were locking up or getting them out for exercise and it's exercise or bang up as we call it and people who don't want exercise get locked behind their doors. I noticed that his cell wasn't very clean so I started speaking to him with regards to cleaning his cell. Also his personal hygiene wasn't the greatest. So I was talking to him trying to get him to clean his cell so what I suggested was that while everybody was out on exercise I would get a cleaner to give him some cleaning materials to clean his cell out. I went back some time afterwards and he told me that he'd cleaned his cell but it still wasn't very good. So again I asked him to clean his cell out for his own personal hygiene. I left him to it and again sometime later I can't remember how long but some time later I went back again and it still wasn't very clean. So I took the mop myself and I showed him how to mop his cell out. I actually ended up mopping his entire cell whilst talking to him. And this is where he started to tell me about his parents. He initially told me his mum had died of cancer three years beforehand and

that his dad committed suicide a week later because of that, because of the stress and emotions. At this point, when he told me that his mum had died, I had an instant connection with him because I too have lost my mum through cancer. So because of that I sort of took him under my wing to keep an eye on him and try and help him out.

“I took him to get some clean bedding and clean clothing so he could chuck everything out of his cell and start afresh, a new clean cell, new clean clothing, new clean bedding. I was going to help him get a job. And it was when we were getting the bedding that he then proceeded to tell me that after his mum had died that he ended up living on the streets and met a girl who he got pregnant. He then told me that the baby was stillborn and two months after that his girlfriend committed suicide because of it. At that point, I asked him if he had ever had counselling and he told me he hadn't. So I told him I was going to try to get him some help in the form of bereavement counselling and that is why I referred him to in-reach.”

Minor act of self-harm

120. A nurse was called to house block 5 on 19 August as the man had reportedly scratched his wrist. The nurse made the following record:

“... made a slight scratch on the inside of this left wrist - very superficial. No action other than soap and water to clean the scratch. Claimed he had taken Ibruprofen 200mg x 12. Called Poisons Unit - well below toxic level but may experience some G.I (gastro-intestinal) disturbance. No action needed at this time.”

121. Despite the fact that PSO 2700 makes it clear that an ACCT plan must be opened whenever a prisoner harms himself, the nurse did not do so.

122. On the same day, SO A wrote in the man's record:

“A prisoner approached me and said he had some concerns about the man. This was related to the fact that he states he has lost his family, who have all passed away.

“I went to speak to him with an officer and he told us he did get upset during the night, thinking about his family who have died. He stated he had no current thoughts of suicide.”

ACCT opened

123. On the afternoon of the following day - 20 August – the SO did decide to open an ACCT form as she was concerned about the man. Whenever an ACCT plan is opened, staff are required to complete the following tasks:

- Complete a Concern and Keep Safe form as soon as possible after the risk has been identified.
- Complete an immediate action plan.
- Carry out an ACCT assessment interview.
- Conduct a first ACCT case review within 24 hours of the initial concern being raised.

- Draw up a care map.

Concern and Keep Safe form

124. The purpose of this form is to determine the main issues which are causing the prisoner to be at risk of self-harm. The form should be completed as soon as possible after the risk has been identified. The SO completed this form at 1.45pm on 20 August. Its full details are shown in the table below:

What are the concerns?		Ask the individual open questions to determine the main problems are. Then tick all the relevant boxes and give details in the open box below.
1. Suicide attempt or statement of intent to kill self		The man recently spoke to a Listener and an officer regarding feeling upset and sad. He also attempted to cut his arm resulting in a minor scratch. He has stated that his parents are both deceased and his girlfriend committed suicide. He also stated he lost his baby. He told me he made the cut on his arm because his back was hurting. I advised him to speak to the doctor and complete a medical application.
2. Self injury or statement of intent to self-harm.	Yes	
3. Unusual behaviour or talk		
4. Very low mood (e.g. without energy or slowed down).	Yes	
5. Problems related to drug/alcohol withdrawal		
6. Other concerns, including vulnerability to age or maturity		

Immediate action plan

125. The purpose of the immediate action plan is to consider and record the most appropriate environment and regime required to support the prisoner at risk prior to the first case review. The plan should be drawn up within an hour of the completion of the concern and keep safe form. Whilst interviewing the man, prior to completing the immediate action plan, Officer B told him that he was going to telephone his next of kin. He asked him who his next of kin was, because he had previously told him that his father was dead. He told the officer that his next of kin was his foster father and that the telephone number on the computer record was wrong.
126. The officer rang the telephone number on the man's computer record anyway and spoke to his father. According to information his father later contributed via his solicitor, he told the officer that his son was not telling the truth about his family circumstances, that he was a compulsive liar and that he suffered from ADHD. He told the officer that his son had received some assistance for his ADHD in the past, but that he needed more help. The officer told him that he had referred his son to the mental health in-reach team. However, he did not tell him that his son had self-harmed or that ACCT procedures had been initiated. In order to be able to disclose this information, the officer would have had to gain the man's formal consent to do so.
127. At interview, the officer told my investigator that he thought he had the man's implicit consent to ring his next of kin but he did not tell him why he wanted to make the call. The officer noted the details of his telephone conversation with the man's father in the ACCT plan but omitted to make any reference what his father had said about the diagnosis of ADHD.
128. In the light of the man's reported family circumstances, the officer decided to submit a referral form to the mental health in-reach team for him to be

assessed. However, the form was returned as it had not been properly completed. In line with the mental health in-reach team procedures, the form should not have merely been returned. Instead the administrative assistant should have telephoned or emailed the officer to obtain missing information. Regrettably, the returned form did not arrive back at source until after the man had died.

129. The SO and officer drew up the following immediate action plan for the man at 4.20pm on 20 August:

Immediate action required	Action	By whom	Completed
Location	Feels safe on HB5 in a cell.	The SO – needs to be approved by HC for single cell. (<i>This done on 21 August</i>)	
Frequency of staff support	3 conversations daily. Minimum of 3 obs night (NB this was entered on front cover of the ACCCT for all users to see.)	Spur staff	
Phone access	Samaritans phone offered	Officers	
Listener access	Has been using Listener	Facilitated by Listeners	
Other immediate interventions	Support for drug problem. Claims he used crack outside.	CARATs	

ACCT assessment interview

130. The assessment interview should take place within 24 hours of the initial concern being raised. The interview with the man was conducted at 3.15pm on 21 August by Officer C who recorded the following comments:

“He had back pain which was making him feel low. He feels alright now. He cut his left wrist several times (superficial). Attempted hanging about seven months ago. Attempted overdose 2 days ago. He has no suicidal thoughts or intentions. He doesn’t want to kill himself.

“He has boys of 2 years and 1 year six months. Gets on well with older sister. Really wants to work doing anything so can have time out of cell. Just wants a job to focus attention on. Needs to see a doctor about his back pain. Would be fine if he had a job and saw a doctor.”

131. At interview, the officer told my investigators that she did not know the details of the injury he inflicted upon himself that led to the opening of the ACCT plan the day before. She had not seen a Form 213SH (report of an injury sustained by a prisoner through self-harm). She said she was one of a number of trained ACCT assessors. She explained that she currently worked in the segregation unit. She said that on 21 August she was the duty assessor and was therefore required to interview him, although she hardly knew him. My investigators asked her to describe his approach to the assessment and she said he spent most of the time laughing. He gave her the strong impression that he did not take the interview seriously. She said she found it very difficult to help him focus on her questions and to believe the answers he gave. She said she was not aware of any attempt by him to

overdose on drugs two days earlier and could not verify whether he had attempted to hang himself seven months earlier.

132. My investigators asked the officer if she knew anything about ADHD. She said she was aware of the condition but did not know very much about the symptoms. My investigators gave her some examples of the symptoms and asked her if she thought he displayed any of them. She said some aspects of his behaviour were similar to those symptoms, such as not paying attention when being interviewed. She said that after the interview she spoke to SO A about what she had recorded.
133. My investigators put the same question to Officer B and he confirmed that he knew what ADHD was. When asked whether he thought the behaviours the man manifested may have been symptomatic of ADHD, he said he felt unable to pass judgement.

Initial ACCT case review

134. The purpose of the initial case review is to assess the risk of self-harm and to establish a care and management plan, or Care Map. It should take place within 24 hours of the initial concern being raised. The SO convened this review at 6.05pm on 21 August. An officer attended, as did the man. No member of the healthcare team was present. The review was summarised as follows:

“No thoughts of self harm at the moment. He states he is still in a lot of pain with his back and it is stopping him from sleeping at night. He has applied for employment. Advised to use the Samaritans phone if he needs support. Has been using Listeners.”

Care map

135. The following care map was agreed at the review:

Issues	Goals	Action required	By whom and when	Status of action
Back pain	Reduce pain	Medical application	The man	Done
Needs a job to occupy his mind	Find suitable employment	Complete application for employment	The man ASAP	
Has cut himself when upset	Stop cutting	Speak to spur staff Samaritans or Listeners	Spur staff as required	

136. The care map did not record that the man had been referred to the mental health in-reach team or the need for intervention by CARATs as identified in the immediate action plan.
137. The panel considered that the man’s risk of self-harm was low. The next case review was scheduled to take place on 28 August. The panel decided that staff should record three conversations with him each day and that he should be checked three times during each night. The record shows that these targets were met.
138. My investigators were given a copy of the following email sent on 20 August by a Samaritan to two Senior Officers about the man:

“While the local Samaritans coordinator was on HB 5, there was an incident involving a prisoner [the man]. It seems he has been misleading the Listeners who are getting fed up with him as he lies to them. He has alleged that his parents are dead. But apparently Officer B has spoken to them at home! Please could you get a message to Chaplaincy not to phone his home tomorrow as the officer has already done so. The officer, who is now on leave for 2 days, would like this prisoner referred to the In Reach Team as he obviously has mental health problems and needs help. I understand it has been agreed that he will be given the Samaritans phone instead of calling the Listeners out. Someone has seen him so I’m sure he will be able to let you know what exactly has been going on.”

139. At interview, one SO thought the sender of the email was the then Head of the local Samaritans branch. He confirmed that the decision to offer the Samaritans phone to the man as an alternative to speaking to a Listener was made by the Samaritans themselves.
140. The following entries were made in the ACCT ongoing record on 21 August at the times shown below. The signatures in the ACCT ongoing record against each entry are illegible.

9.45am:

“I have spoken to the man this morning. He said he has a bad back and that he is seeing a doctor next week. He also said he was feeling ok and had no other problems.”

12.20pm:

“He collected his lunch meal. He appears in reasonable spirits but mentioned his back again. I told him to see the doctor to get some pain killers. He said I am, Miss.”

2.20pm:

“At roll check all was well. He had started to clean his cell and told me he was feeling ‘fine and well’.”

7.00pm:

“Interacted well with the other prisoners on association. When spoken to at locking time he was happy and looking forward to watching the Olympics.”

Events during the night of 21/22 August

141. Officer D, who was the assistant night orderly officer during the night of 21/22 August, told my investigators that the man asked to speak to a Listener that night. He said an officer told him the man used to ask for a Listener every night and might have been abusing the system. The officer nevertheless went to his cell and opened the door. He asked him to confirm that he

wanted to speak to a Listener and he said he did. The officer discovered that his cell was extremely dirty and smelly. He therefore told him that he should clean his cell. Although he was a little rude to him, he agreed to do so. The officer said he then searched him and allowed him to see a Listener.

142. My investigator asked the officer whether, in view of the frequency with which the man had been asking to speak to Listeners, he was aware of any 'blanket' ban on his access to them. The officer told my investigator he was aware but believed he insisted that he should nevertheless be allowed access to a Listener.

Events on 22 August

143. On Friday 22 August, the following further entries were made in the ACCT ongoing record:

11.00am:

"Asked to see the man to fit him for a single cell. He states he has no thoughts of self-harm. He states he only cut his arm due to frustration with back pain. He now has medication and states he will not cut." (Nurse)

11.10 am:

"He asked if he could clean his cell as he needed something to do. I asked him how he was feeling. He stated all was well."

4.00pm:

"Interacted well with other prisoners whilst on association. Seemed in good mood and had good eye contact with me. No problems at this time."

Events during the night of 22/23 August

144. On duty in house block 5 during the night of 22/23 August were two Operational Support Grades (OSGs). OSGs are auxiliary staff who carry no responsibility for the direct management of prisoners. By night, they are required to be present in each house block to maintain the security of the prison. They are not normally permitted to unlock cells except in an emergency, when they can access a cell key kept in a sealed pouch attached to their uniform belt after being given authority by the night orderly officer. However, OSGs are required to conduct observations of any prisoner subject to ACCT procedures and to draw the attention of the night orderly officer to any concerns that might require a member of staff to enter a cell.
145. Whilst OSG A was a relatively experienced member of staff, having worked exclusively as a night patrol for the previous eight months, OSG B was deployed as a night patrol the first time at the beginning of that week.
146. In charge of the prison was the night orderly officer (NOO) – who had the radio call-sign Oscar 1. (The term 'call-sign' refers to the coded identification attributed to each member of staff using a UHF radio whilst on duty.) He was supported by the assistant night orderly officer, Officer D - call-sign Oscar 2.

A number of prison officers were also on duty, but deployed to a central area of the prison in case there was an incident or an emergency.

147. At interview, OSG A told my investigators that his shift began at 8.00pm. He said it was usual to have a discussion between the staff on the evening shift and the night staff about events of the day. The handover, he said, also included a check of the Staff Observation Book (in which staff can record details of issues relating to individual prisoners for their colleagues on other shifts to read). He said he saw the Staff Observation Book when he started his shift but there were no entries relating to the man. He initially said he could not remember whether he was subject to ACCT procedures. He told my investigators, "I just can't remember if he was on an ACCT because he was put on an ACCT that week so I can't remember what day it was." He was asked how he would know how often a prisoner subject to ACCT procedures had to be observed during the night. He explained that ACCT forms were kept in unit offices so that staff could easily identify them and ascertain, at the beginning of their shift, how often each prisoner had to be observed.
148. The front cover of the man's ACCT form clearly shows the requirement for him to be checked three times during each night. The investigation found that the OSG made three entries in his ACCT ongoing record during the night of 22/23 August.

OSG A's first entry in ACCT form – routine check of the man

149. The first entry was made against a time of 8.30pm. This read, "Checked, okay, no issues raised". The OSG confirmed at interview that before making this entry, he talked to the man and that he seemed perfectly alright.

OSG A's second entry in ACCT form –the man's request to speak to a Listener

150. OSG A's second entry was made against the time of midnight as follows: "Checked, ok. He pressed ECB [Emergency Call Bell]. Requesting Listeners". The OSG explained to my investigators that he had responded to the cell call alarm. (All that an OSG is permitted to do in such circumstances is to approach the cell door and talk through it to the occupant.) According to the OSG, the man said to him, "Gov, can I have a Listener?" The OSG said he passed this request on to the assistant night orderly officer by radio, saying words to the effect, "Oscar 2, for information, a Samaritans phone or a Listener required on house block 5." When asked if he saw a Listener, the OSG said the night staff (i.e. the assistant night orderly officer and officers who may have accompanied him) went to see him and he changed his mind.
151. My investigators interviewed Officer D, the assistant night orderly officer, and asked if he recalled being told that the man wanted to see a Listener that night. The officer said he thought he did make that request. He explained that it was a very busy night when a number of requests were made by prisoners to speak either to a Listener or to the Samaritans. He said that, in such circumstances, there was a need to prioritise the requests, taking into account factors such as whether the prisoners asking for the facility were young offenders or adults, and whether they were subject to ACCT

procedures. He said that he would normally give priority to those for whom an ACCT form had been opened. He also said:

“If my Listeners are out with someone else, I will say to the OSG, offer him the Samaritans phone or stay with him there and have a chat with him even if he’s swearing at you, just stay there.”

Request to speak to the Samaritans

152. Officer D told my investigators he was accompanied by another officer when he went to speak to the man in his cell. The officer remembered that he very quickly changed his mind about speaking to a Listener and instead asked to use the Samaritans phone. (This is a portable telephone, normally held on a wing office, and solely for use by distressed prisoners who wish to speak confidentially to the Samaritans.) He explained to him that he could not use the telephone straightaway because it was being used by another prisoner. The investigation found that this was indeed the case and that the other prisoner left the Listener suite a few moments before the man entered it.
153. The officer explained that when he entered the man’s cell he asked him if he wished to use the Samaritans telephone. He confirmed that he did. He then saw him pick up a cigarette and lighter from the floor. He told him he could not smoke in the Listener suite and he threw down the cigarette and lighter. He asked him if he had anything in his pockets and he said he did not. He described him as being “funny” with him when he gave him his reply. The officer told my investigators he was thinking of searching him but, as he thought he was a little angry, he did not want to be “too confrontational” and so decided against conducting a search.
154. The officer allowed him to leave his cell and, in the company of the other officer, escorted him to the Listener suite on the landing above. He walked behind him and the other officer walked in front of him.
155. Closed circuit television (CCTV) facilities are available in house block 5 as an aid to staff in monitoring the movement of prisoners, especially by night. A camera is located at one end of the landing on which the man was located and there is another on the landing above, near the unit office. My investigators were able to view the CCTV footage recorded on both cameras for the night of 22/23 August. Together, the two separate cameras showed him being released from his cell at 1.17am and arriving at the suite on the landing above about a minute later.
156. As the man reached the top of the stairway that leads to the upper landing, he folded his arms and stooped very slightly forwards. The CCTV footage shows a bulge in the left sleeve of his pullover as if there was something concealed there. The officer said he did not see anything to suggest he was hiding anything on his body. He also confirmed to my investigators that neither the man nor he engaged in any conversation as they approached the Listener suite. At that point, he fetched the Samaritans telephone from the nearby office, took it to him, and locked him in the room. It is not clear whether the CCTV monitor in the office was watched by anyone as the man came into view. Neither officers searched the Listener suite before allowing him to enter the room.

157. My investigator asked the officer whether at any stage he considered allowing the man to use the Samaritans telephone in his cell. He said he did not because he knew that the signal reception for the telephone in house block 5 was especially poor on one side of the building. He said that, as a result, the usual practice was to allow any prisoner located in that area of the building to call the Samaritans from the Listener suite where the signal was reliable. He also cited another reason for taking prisoners to the Listener suite. He said that some prisoners had been abusing the system by using the Samaritans phone in their cells to charge up their own mobile phone batteries or to call people other than the Samaritans. He explained that using the Listener suite had reduced the level of abuse as prisoners believed they would be monitored more closely.
158. After they had locked the man in the Listener suite, both officers left the house block in order to resume their other duties.

OSG A's third entry in ACCT form - discrepancy in timings

159. The man's ACCT form contains a further, final, entry by OSG A against the time of 2.00am on 23 August. He wrote, "Samaritans phone requested @ (sic) 0200". This comment was at odds with the timing shown on the CCTV footage which clearly showed that he was allowed out of his cell to use the phone at 1.17am, some 43 minutes earlier. At his initial interview, the OSG reiterated that it was 2.00am when the man was issued with the Samaritans phone. At that stage, my investigators had not studied the CCTV footage and so had no reason to question the timing of the OSG's entry. As a result, the timing described initially by him led them to believe that the man was only in the Listener suite for about ten minutes before he was found hanging. However, after viewing the footage at a later stage, my investigators recognised the significant discrepancy. They therefore re-interviewed the OSG.
160. At his second interview, the OSG was invited to view the CCTV footage so that he could see for himself the timings shown. He was then asked to account for the discrepancy and to explain why he recorded in the man's ACCT form that he asked for the Samaritans phone at 2.00am. The OSG replied that he believed 2.00am was the correct time because that was the time at which he started a pegging round. (Pegging is the term for an electronic record of the times when staff patrol their areas of responsibility as well as the route they take. See further explanation below.) He was adamant that the entry was made contemporaneously. When asked how sure he was that the man was only in the Listener suite for ten minutes before he was found hanging, he replied that he could not say. However, he remained of the view that the timings he recorded in the ACCT form were correct as he said they accurately reflected the times when he checked him. He told my investigator, "I am adamant that it was two o'clock" (when he asked for the phone).
161. In light of the evidence the OSG offered at his second interview, my investigators decided to re-interview Officer D. Prior to his second interview, the officer was invited to view the CCTV footage for himself. During his interview, he acknowledged the significant discrepancy between the time

recorded by the OSG and the times shown on the CCTV footage. He confirmed that he did not have a clear memory of the chronology of events but thought that the time the man was allowed out of his cell was likely to have been at about 1.00am. He acknowledged that the timings shown on the CCTV footage were highly unlikely to be wrong.

162. As a consequence of the officer's confirmation, my investigators decided to interview the OSG for a third time. They did so on 15 January 2009. On this occasion, they put to him that the evidence gained from interviews was not consistent with his evidence about the timings and offered him a final opportunity to account for the discrepancy. He said:

"I may or may not have put down the correct procedures in his [the man's] ACCT form because at that time in the morning I'm tired. I could have put him down at two o'clock as a genuine error. That's all I can say."

163. My investigators suggested to the OSG that the entry he made in the ACCT form was wrong. This time, he agreed. This removed any doubt about the fact that, as shown in the CCTV footage, the man left his cell for the Listener suite at 1.17am rather than at 2.00am. As he was thus in the Listener suite for far longer than originally thought (some 53 minutes rather than ten), my investigators were concerned to check with the OSG the extent to which he monitored him, especially whilst he was in the Listener suite.

164. At a fourth interview conducted on 12 March 2009, my investigators asked the OSG at what times he checked him. He replied as follows:

"The first was at 8.30pm on 22 August when I came on shift. I looked in his cell. He was awake and I spoke to him. He said he was ok. The second was at midnight, when he rang his cell bell and asked to speak to a Listener. I spoke to Officer D, the assistant night orderly officer that night. He said he would sort it out. The man seemed ok to me. My third and last check was going to take place at the end of his conversation with the Samaritans or at 3.00am. I like to do my ACCT checks when I do my pegging."

Pegging

165. During one of the interviews conducted with the OSG, he told my investigators he carried out his pegging rounds "on the hour, every hour". (In order to ensure that key areas of a prison are effectively patrolled throughout the night, a pegging system is utilised. This system is usually electronic and requires night staff to register at predefined intervals and locations throughout the prison. The system is auditable and forms a part of the final night state report.) He was asked whether he carried out any pegging on the lower floor of house block 5 between 1.17am and 2.10am on the night of 23 August 2008. He replied as follows:

"No. Pegging starts from approximately 1.00am and lasts for approximately 15 minutes. During this time, I have to peg throughout the entire unit [i.e. all six landings]. This policy is written down in local orders. We are given a copy of these when we start our shift. I pegged from approximately 1.00am that night to approximately 1.15am. I did the whole

house block. This included the landing on which the man was located as well as the landing on which the Listener suite is located. After I had finished, I answered a cell call alarm from him at about 1.17 am.”

166. The OSG could recall that the man was the only prisoner on B spur of house block 5 who was subject to ACCT monitoring that night.

The man found hanging

167. The OSG explained that at 2.00am, he began his pegging round again. He said:

“So at two o’clock, started my pegging. He [the man] was on the Samaritans phone that time. So I did my first site, A spur, probably takes seven minutes, do the [point] right at the end, A spur on the ones. Come up and do the one by the office on the twos and then go and do the threes on the threes landing right at the end. So I come back, speaking to the other OSG about, can’t remember what that was about. And then at eight minutes past, nine minutes past, walked past the Samaritans - Listener suite on B spur and I saw him hanging.”

168. The OSG could see through the window in the door that the ligature was made from a piece of torn bedsheet tied to a metal conduit (a pipe protecting material such as electric wiring) fixed to the ceiling. He used his radio to send a “code 1” alert to the Night Orderly Officer. (This code alerts staff to the discovery of a life threatening emergency without using distressing terms that might be overheard by other prisoners.) He also asked permission to break the seal on his pouch which contained his emergency keys, so that he could enter the room. Having been given permission to do so by the night orderly officer, he entered the room accompanied by the other OSG. He asked her to get her anti-ligature knife out. As she did so, he lifted the man up so that the other OSG could cut away the ligature. Together, they laid him on the floor inside the suite. He had urinated. The OSG said in interview that he checked him for signs of life. He told my investigators he checked the carotid pulse and found none. He said his eyes were fixed and “pointing up to the sky”. He described him as pale but warm. He said there were no signs of rigor mortis.

169. He asked the other OSG to fetch a first aid bag from the office (a matter of a few metres away from the Listener suite). He then began to administer cardiopulmonary resuscitation (CPR) to the man. He said that by the time he did so “all the other crew had turned up”. By this he meant the prison’s healthcare staff. He explained that during the brief time he was applying CPR on his own, he applied only chest compressions. He could not recall what rate of compressions he applied. He said that the speed at which the Ambu bag (used for the manual application of oxygen) was brought to the suite was “pretty quick”. When asked to confirm whether the application of mouth to mouth resuscitation might have been quicker, and to explain what the other OSG was doing while he was applying chest compressions, he said:

“I can’t remember. I know she was just standing there. I think she went off to have a – she went outside ‘cos the night staff went off, went to a different spur instead of coming to B spur.”

170. The OSG confirmed that, when he was joined by a member of the healthcare team, he initially continued with the chest compressions while his colleague used the Ambu bag, and then took over the Ambu bag himself. He said the man did not respond to these measures. He thought the nurse was the first member of the healthcare team to arrive at the Listener suite. He said he stayed in the Listener suite until the paramedic crew arrived about five minutes later. He thought the orderly officer would have given directions to the control room staff to call for the ambulance. (The control room log records a request for an ambulance at 2.10am and the arrival of an ambulance at 2.18am.)
171. During her interview, OSG B told my investigators she had been deployed to work for a week of night duties for the first time in house block 5 at the start of the week commencing Monday 18 August 2008. She did not think she had received adequate training for her duties, citing suicide prevention including ACCT procedures, opening a sealed emergency key pouch, using an anti-ligature knife, first aid, responding to cell bells and the use of Staff Observation Books as examples of subjects in which she had not been trained.
172. OSG B said she began her shift at 8.00pm. She said she played no part in any events involving the man prior to 2.10am when OSG A discovered him hanging in the Listener suite. She confirmed that he called out to her at that point, and asked her to use her anti-ligature knife to cut the man down while he took his weight. She thought that he may possibly have stood on a table or chair to tie the ligature to the conduit in the ceiling and then jumped off.
173. She confirmed that she helped her colleague to lower the man to the floor but that she did not help to administer first aid. She said:
- “Afterwards I thought and during, if I was first aid trained then I could have helped a bit more but obviously I wasn’t and I didn’t know what I was doing, so I didn’t want to hurt him any more.”
174. She also said that, although she would not have been able personally to check for signs of life, she thought she could see none in him. However, she also thought someone said there was a weak pulse. After about two minutes of entering the suite, she left to answer a telephone call in the office.
175. The members of the healthcare team who arrived at the Listener suite included an officer together with two nurses. My investigators interviewed the two nurses. They felt it unnecessary to interview the officer.
176. Nurse A said he was a registered mental nurse and had a degree in forensic mental health nursing. He said that, although he was an agency nurse, he had been working at High Down on a daily basis. On the night in question, he was working in the detox unit in house block 6. He said he heard the coded alarm call on the radio and went straight to house block 5. He did not take any emergency equipment with him because he was “waiting for [call sign] Hotel 2 to come along”. (Call sign Hotel 2 normally carries the responsibility for taking appropriate specialist medical equipment to the site of an emergency.) He said that when he arrived at the Listener suite he saw the man lying on the floor, with “two or three officers” near him. They included

OSG A, who was administering CPR, and Officer D who was at the head. He remembered seeing a ligature on the floor. He took over CPR and the officer applied oxygen through the ambubag. He said he and the OSG shared their CPR tasks until Nurse B arrived (on call sign Hotel 2).

177. At interview, Nurse B confirmed that he was in the healthcare centre when he received the coded alert call on his radio. He said he collected a first aid box and ran to house block 5, taking about three to five minutes to complete the short journey. He said that amongst the first aid equipment he took with him were “bandages, glycogen and medicine, blood pressure machine”. He explained that he did not take any oxygen with him because this was available in a “resusc bag” on each unit. He also said he took a defibrillator although he noticed that a “resusc trolley”, including such equipment, was already in place in the Listener suite when he arrived.
178. Nurse B told my investigators that when he arrived in the suite, he could see “somebody lying on the ground being attended by officers and then my colleague from the detox team”. He confirmed that the colleague to whom he was referring was Nurse A. He said he was concerned to check that an ambulance had been called and was told this had already been done. He then assisted with the administration of CPR. He could remember seeing two officers and Nurse A in attendance, helping with CPR.
179. Nurse B later made the following entry in the man’s medical record:

“Received a code red call to attend HB 5. The man was lying on the floor in the Listener suite on B spur. CPR was being carried out on him by officers and healthcare staff. Immediately asked for a call out for emergency service. He appears unconscious but had a weak and feeble pulse on examination. B/P 45/32 PI I5 [i.e, his pulse rate] sats 69 [i.e. his level of oxygen saturation - described as very low]. Defibrillator was immediately applied whilst CPR continues. Emergency service staff arrived and took over. He was taken to hospital. There was a mark round his neck. According to officers he was found hanged and feet above floor level in the Listener suite. He was making a call to the Samaritans.”
180. The nurse confirmed that he checked the man’s carotid pulse using a sphygmometer, an instrument that measures blood pressure. Having detected a weak pulse, he continued with CPR until the paramedics arrived. He also confirmed that the defibrillator advised not to shock.
181. Officer D also played a part in managing the emergency. At interview, he said he took about 20 seconds to reach the Listener suite in house block 5 once he had received the coded alert on his radio. Upon arrival, he saw OSG B outside the room and OSG A inside on the floor near the man who was lying face upwards. The officer described him as having wet trousers. He felt his pulse and told my investigators that OSG A did not seem sure about what he should do. He said the OSG was not administering CPR to the man when he first arrived. However, he said to him, “Come on, we can’t lose him.” Thereafter, according to the officer, the two of them began CPR. He said he asked the other officer to fetch an ambubag. He had difficulty recalling which of them used the ambubag but he confirmed that he applied chest compressions.

182. The officer thought that the time lapse between the OSG finding the man hanging and his own arrival at the Listener suite was about 30 seconds. He also thought that the time lapse between his arrival and the application of CPR was at most ten seconds. He guessed that it took Nurse A a minute or two to arrive and five to six minutes for Nurse B to reach the suite. He thought it may have taken the other officer a minute or two to fetch the ambubag.
183. One officer submitted the following statement to explain his actions in response to the emergency:
- “I took over from OSG A on the oxygen bag to release him from the scene. Approx 5 minutes after using the oxygen bag myself and another officer were released to escort the ambulance on to the scene. Paramedics then took over from staff and carried out further CPR and tests and took the man to hospital.”
184. The other officer confirmed in her statement that she checked the man’s left wrist to see if there was a pulse (although she does not mention whether she found one). She later left to escort the ambulance from the gate to the house block, accompanied by the other officer.
185. Further emergency first aid was applied by the paramedics in the Listener suite. At 2.48am, the man was taken to hospital.
186. The following extract from a statement by one of the paramedics concerned explains his response to the emergency:
- “At 0200hrs we received a call to HMP High Down. The time of the call is approximate as we recorded the arrival time at the prison front gate as 0218hrs, and the call was received when we were at Epsom Ambulance Station, so we had to drive to the location. On this occasion the information stated, ‘male hanging obviously dead’. On arrival at the front gate I wrote down the exact arrival on the patient clinical record. We waited for the gate to open and passed into holding cell area of the gate then through to the second gate into the court yard. The further gated areas were opened for us until we reached the parking area. We were then updated to say that CPR was being carried out, as we had queried why we were going to a ‘deceased’. Just as we got the call the female prison officer that had escorted us started to run. There were numerous officers around. I started to run with the one female and a colleague gathered more equipment. I arrived at the feet of the patient at 0225hrs. There were several prison officers around the door of the room and at least 2 to 3 people performing CPR on the male. We had a monitor so I put him onto that and I started to ask questions in relation to the incident. I had established no pulse and no respiration so CPR was continued. Assistance was sought from prison staff. The particular rhythm show meant that under our protocols we continued CPR and due to the time-critical nature a collar was put on him and he was taken to the ambulance. At 0245hrs we left in the ambulance from the place we had parked. We arrived at the hospital at 0258hrs. The CPR and care was continued throughout the journey and a prison guard was present and assisting

under my instruction. The patient was taken to the resuscitation room and we were met by hospital staff. Our role was now over as hospital staff were in charge of his care.”

187. The following table shows the timing of some of the significant events recorded on CCTV that night, together with explanatory comments:

Time	Event seen	Comment
01.15.59	Officer approaches The man's cell door.	In response to his cell Bell
01.16.29	Officer D joins the officer at cell door.	As above. Only Officer D has keys to cell door.
01.16.46	Officer D lets the man out of cell.	The man is escorted to end of landing to stairs leading to upper landing.
01.17.19	The man and above staff appear on upper landing. He has arms folded. Slight bulge can be seen in left sleeve of his jumper.	The man is let into Listener suite, out of view of camera. Bulge may conceal the ligature he used.
02.10.15	First sight of staff movement near Listener suite.	This is in response to the discovery of the man hanging.
02.10.52.	OSG B appears on landing looking towards Listener suite.	
02.10.55	The two officers and a third male officer seen moving towards Listener suite.	
02.11.09	Same male officer seen exiting from Listener suite.	
02.14.36	Black male officer seen exiting Listener suite looking distressed.	This is an officer.
02.14.43	Same officer returns to Listener suite	
02.26.22	Officer seen carrying emergency first aid equipment across landing to Listener suite.	The equipment is an ambu-bag and a portable chair .
02.33.04	One male officer and one female officer seen crossing landing toward stairs	They are two officers.
02.33.31	Same two officers seen entering the cell.	They enter cell to check for presence of any evidence indicating suicidal intent.
02.34.13	Same two officers leave cell.	They confirmed at interview that they realised they could touch nothing in cell so decided to leave.
02.34.50	Same two officers seen crossing upper landing, empty handed.	
02.36.36	Male officer seen inspecting document on	The document is the man's ACCT form. The officer is

	upper landing.	checking to see if there are any comments about risk. (NB The identity of this officer has not been confirmed and so his actions cannot be verified.)
02.29.30	The man is seen being removed from Listener suite on rescue chair.	
02.49.49	CCTV footage ends.	

188. The police later confirmed that no letter from the man explaining his intentions was found in his cell or in the Listener suite.
189. My investigators interviewed the Samaritans coordinator for High Down prison. They were keen to establish whether the man actually used the telephone to call the Samaritans before he hanged himself and, if possible, to discover whether he talked to them about killing himself. The co-ordinator kindly volunteered to make enquiries of his colleagues. He later confirmed that a call had been made to the Samaritans at approximately 1.17am and that the call had lasted for approximately 53 minutes. It had been diverted to the Brighton branch of the Samaritans. In keeping with the Samaritans' policy of confidentiality, neither the details of the contents of the conversation between the prisoner and the member of the Samaritans who took the call nor the identity of the caller could be disclosed. However, the co-ordinator gave my investigators a strong indication that the caller was likely to have been the man. The co-ordinator advised my investigators that, if an approach were to be made to the Coroner requesting disclosure of the transcript of the conversation between the man and the Samaritans, the Coroner might be disposed to issue a court order instructing the Samaritans to disclose. However, the Coroner has confirmed that this is not within his power. Furthermore, the Samaritans later clarified that no transcript of the conversation with them was made.
190. In the opinion of my investigators, taking into account the evidence presented by those who were first to arrive at the Listener suite after the man had been found hanging as well as that of the paramedic, he probably hanged himself shortly before he was found.

Contacting senior staff

191. The following table shows the sequence of events recorded by staff in the control room from the point when the man was discovered hanging:

Time	Occurrence
02.10	Code red HB5 – H72 acknowledged
02.10	Ambulance called
02.18	Contact Duty Governor no response
02.18	Ambulance arrives
02.19	Duty Governor.....unclear
02.22	Ambulance centre phoned for update?
02.27	V2 gate locked open
02.28	Tried to contact Governor ?????? no response
02.29	Tried to contact first Governor no response
02.30	Tried to contact second Governor no response
02.33	O1 requesting care team worker?
02.40	Tried to contact third Governor

02.41	Tried to contact fourth Governor
02.40	No response from any care team member / tried all numbers
02.43	Care team member reached – away from home.
02.45	O1 gives prisoner's details of the man
02.46	Calling care team member closer to home – no response
02.48	Ambulance at gate leaving for hospital
02.50	Care team member contacted and put through to Oscar 1
02.50	Tried to contact fifth Governor – no response
02.50	Tried to contact sixth Governor– no response
02.55	Tried to contact seventh Governor – no response
02.55	Re-trying to contact eighth Governor – no response
02.55	Trying a care team member – no response
02.58	Trying ???? – no response
03.00	Made contact with Officer ??? – no longer ???
03.00	Contact made with ?????
03.05	Contacted ???
03.08	Trying ????
03.10	IMB contacted, will be arriving at prison before 04.00am
03.15	Contact
03.25	Officer from NOU called requesting details for above incident. All k details passed on. Requires update before 07.00am. Call lasted ap 30mins.
03.40	Oscar 1 confirmed a Gov contacted and informed of incident.
03.50	Official arrived and escorted to HB5.
03.55	A Governor contacted again. Still no response.
04.07	The Governor finally contacted and put through to O1.
0400	IMB – in.
04.30	A Governor contacted.
04.45	Media relations called. 3 numbers tried and not getting through.
05.30	Police advised of bedwatch. CAD No: P308277587
06.20	Police arrive

192. The duty governor for that night had assumed that responsibility from the previous duty governor.
193. The local contingency plans for the management of a fatal incident at High Down require someone in the control room in the prison to inform the Duty Governor as soon as possible by using a pager, a mobile telephone or the home telephone number, details of which should be available to the control room staff.
194. The control room log shown above confirms that a code red message was received in the control room at 2.10am on 23 August. At 2.18am, an attempt was made to contact the previous duty governor, who was shown on the daily bulletin as being the duty governor. There was no response from him. The investigation found that the control room staff were not aware that he and the current duty governor had exchanged duties. As a consequence, the staff on duty in the control room then went through the list of managers available and telephoned them all. At 3.40am, the night orderly officer telephoned a senior manager, who was not on call to the prison, to tell her that the man had been found hanging and had been taken to hospital. This was the first time contact was established with a senior manager.
195. At interview, the senior manager said:
- “... We just sort of spoke through the process of who he [the night orderly officer] should contact. They said they'd had difficulties with the duty

governor. I was aware that the contingency plans had recently been updated with telephone numbers and asked were they looking in the right section. Whether they were or not I can't comment, but said you know check again because the contingency plans have had the new numbers put in."

196. At his interview, the duty governor confirmed that he was called at about 4.00am. (The control room log shows that contact was made with him at 4.07am.) When asked by my investigators whether he thought this was the first time anyone had tried to contact him, he said:

"It was, yes. I'd checked my pager. The lady that spoke to me said to me we've been trying to call you, we've been trying to call every governor in the establishment. We haven't been able to, so I asked her what phone number she'd had for me and she read a number. I didn't recognise it and I said to her I've got my mobile here, I've got my home phone here, my pager here, I said I haven't had any calls and she said well I had a list, I've now produced another list and that's where I've got your number from now."

197. When asked whether he thought the member of staff concerned had used the wrong number, he said, "Yes, as far as I am aware". He was also asked whether the two hour delay in contacting him could have had an impact on the management of the emergency. He replied:

"I don't believe in this case it did because the first thing I did was ask certain questions. For example, was the ambulance called, was CPR applied. I went through a series of questions and the answers I had to the questions were favourable in terms of the immediate care. But as far as I could ascertain immediate care seemed to have taken place appropriately, the ambulance came quickly, he'd left the establishment to go to hospital quickly."

Informing the man's family

198. The duty governor said he called the deputy Governor who, in the absence of the Governor, was in charge of the prison. He briefed him on what had happened. He then left for the prison, some 75 minutes' drive away. He said he arrived at about 5.45am.
199. The deputy Governor said at interview that he was contacted at 3.15am and that he later drove to the prison, arriving at about 4.30am, about ten minutes after the duty governor. However, these times are not consistent with those offered by the duty governor or with the control room log which records that he was contacted at 4.30am. My investigators found that the gate book – the register of entries and exits through the man prison gate – for that night shows that the gate was opened at 5.35am to let him into the prison. The book also shows that the gate was opened at 5.50am to allow the duty governor to enter. (No criticism of the deputy Governor is implied here. My investigator believed that, at interview, he did not recall the timings correctly.)
200. Upon arrival, the duty governor checked the man's core prison record for details of his next of kin. He told my investigators he had no difficulty

ascertaining who that was. He said that at about 6.40am he called the man's father. At interview, he described what happened next:

"I believe I said to him there's been an incident at the prison today or during the night involving his son and I believe I said that his son was found hanging in a room and that he's now gone to hospital. I advised him that I was intending to go into the hospital and I said that I would like to, I offered to meet him and we agreed that I would meet him at the hospital."

201. He told the man's father that his son was in a critical condition and was in the intensive care unit. When asked whether the man's father said anything about how he would get to the hospital or not wanting to drive because of his distress, he said, "No, although I never offered to get him a taxi which is a fair point".

202. During the duty governor interview, my investigators summarised the chronology of events. The interviewer reminded him that he had had a conversation with the control room just after 4.00am, had arrived at the prison at about 5.45am, and had contacted the man's father at about 6.40am. The investigators asked him if he could have done things more quickly in the circumstances. He replied:

"I think not really. I initially wanted to check all the details as much as I could because I was wary that they'd have questions and I had to speak to the Orderly Officer, I wanted to speak to the hospital themselves. So I think initially when we phoned the hospital there was slight difficulty getting through to the ward itself. We couldn't actually do that but then a PC phoned. I'm sure he phoned the establishment and spoke to the deputy Governor. So then I managed to get through to the hospital and I spoke to the PC briefly, got some information from him as to how things seemed at the time at the hospital. Then once I did that I raised the contact details for the family and made the phone call."

203. My investigators asked the duty governor about a comment made by the man's father during the course of the investigation. The man said he thought the officers from High Down in attendance at the hospital were insensitive to him in that they were allegedly "standing around as if to join up their story". In response, he said:

"There is no story to join really. I mean we were really there for support. I was certainly, I was wary that it's a personal time for the family. I felt particularly as we knew that the man was alive for a certain period of time. And I suppose I felt I should be there for when he was declared dead if that were to happen. Certainly it seemed as though he would be declared dead by the end of the night or certainly by some stage in the morning. And I felt it would have been completely inappropriate for the family to be given that news and to find that there was no-one there from the prison, certainly no-one there with any sort of management, you know, no managers there. I felt that was insensitive. So I suppose you know, in terms of the staff who were there, there was the officer there, an officer being relieved by another officer, and there was that officer, there was myself and the family liaison officer." (My investigators were later informed that the named officer was in fact another officer.)

204. The duty governor confirmed that at 11.30am on 23 August, hospital staff conducted brain activity tests on the man which showed he had no brain activity. He said that the hospital staff considered that he was therefore dead. According to him, they nevertheless indicated that they would conduct a further test after an hour. If this also indicated no brain activity, it would be confirmation that he had died. He said the further test was conducted as planned and this too showed no brain activity. As a result, a consultant declared the time of death as 11.30am (i.e the time at which the earlier test had been conducted with the same result). The man's father and mother were present when this declaration was made.

Appointment of a Senior Officer as initial family liaison officer

205. A SO was initially appointed as the establishment's family liaison officer (FLO). She had received no training for this role and was aware that unsuccessful attempts had been made to contact those prison staff who had been trained. She offered to perform the duties of FLO as she was experienced in the management of safer custody and because of the urgency with which an FLO was needed.
206. The SO decided to go to the hospital in order to make initial contact with the man's family. At interview, she confirmed she arrived around lunchtime. She said that when she arrived the duty governor and another officer, whose name she did not know, were present. She said the man's father was sitting at his son's bedside while other members of the family were in a separate family room. She confirmed that at this time the man was on a life support machine. She said she stayed at the hospital until about 2.30pm or 2.45pm. At interview, she explained:

“...The man's dad actually asked us to leave. He approached us after and asked if we were there because we had to be or because we were there for the family and we said well both really, you know we've done what we have to do. But we're here in case any questions need answering and he said oh in that case I'd prefer it if you left, so we said ok fine. And at that time we gave him telephone numbers and told him that someone would contact him.”

207. The SO then returned to the prison and completed her family liaison log. At interview she explained that she also attempted to discover which of the trained FLOs were likely to become available to take over from her. She said she was conscious of the fact that some of them were engaged with other cases and that it was important not to overload them. She knew that an officer had recently completed his FLO training and had not yet acted in the role. However, the officer was not due to return to work until the following Monday (25 August). On that day, a decision was made to appoint him as the FLO for the family.

Appointment of an officer as the next family liaison officer

208. The officer told my investigators he was appointed as FLO by the Deputy Head of Residence, but said he thought he was not appointed until Tuesday 26 August. He said his first task was to gather as much information as

possible regarding the man's death. To this end, he went to the Governor's office where the man's prison record had been stored and took notes from his history sheet and other documents.

209. The officer confirmed that he made an initial attempt at contacting the man's family by telephone at about 2.00pm on the day he was appointed as FLO. He said the man's father was not in. However, according to the man's father, the officer left a message on his answerphone saying he would ring him back. He also claimed that the officer did not leave a contact number.
210. The officer said he called the man's father back at about 4.00pm, some two hours later. (The log kept by the officer shows he made the call at 4.30pm.) This time, he answered the telephone. The officer explained to my investigators that the purpose of his call was to introduce himself as the new FLO and to let the family know what the job entailed. He also wanted to arrange to meet them. He said he apologised to the man's father for not getting back to him sooner and explained that he had been trying to gather as much information as possible. He said he then introduced the idea of arranging a face to face meeting with him. (The officer's log includes an entry implying that the man's father asked for a face to face meeting with him, Officer B and the duty governor.) However, the conversation did not result in any such arrangement being made as the man's father became deeply offended by some of the remarks allegedly made to him by the officer. He called the prison and spoke to a SO, the first FLO, about his concerns. He wanted to have a conversation with the duty governor but SO Price explained that he was not in the establishment. The SO reported his concerns to the Head of Residence who took it upon herself to ring him. Following their conversation, she decided to terminate the officer's appointment as FLO. Another SO, who was one of the prison's trained and experienced FLOs, was appointed in the officer's place.

Appointment of the SO as family liaison officer

211. On Wednesday 27 August, the SO telephoned the man's parents to introduce herself, offer them her condolences, and make an appointment to visit them at their home the next day in the company of the first FLO.
212. They visited them on 28 August as promised. During their visit, the man's father repeated his concerns about the officer's manner. The man's parents also asked a number of questions that neither member of staff felt able to answer. However, when asked about the timings surrounding the discovery of him hanging, the first FLO told them that their son had been placed in the Listener suite at 2.00am on 23 August. This was later to prove incorrect. The man's father also expressed his concern at the delay in informing him and his wife.
213. The new SO advised the parents that the Governor had offered to pay for the costs of the funeral.

Letter of condolence

214. The Governor wrote a letter of condolence to the man's parents in which their son's name was incorrectly spelt. As soon as this was noticed, the Governor

telephoned them to offer them his apologies. He followed this up with a fresh letter.

Cremation

215. The man was cremated on 8 September. The FLO attended on behalf of the Governor.
216. Two days later, the man's parents visited his cell and the Listener suite under arrangements made by the FLO. They also collected their son's belongings. The FLO maintained contact with them thereafter.

Prisoner support

217. The cases of all prisoners on ACCT forms on 23 August were reviewed that day. The reviews comprised one-to-one interviews in each unit. The first FLO arranged for the Samaritans to be available in the prison to any prisoner who might want to see them.

Staff support

218. The deputy Governor chaired an initial debrief of the staff who were involved in the emergency. Members of the prison's care team were made available.
219. At the time of the investigation a full debrief had still not taken place. My investigators were told that this was because no qualified debriefers were available.

ISSUES

220. Here I examine:

- Whether the man's physical and mental health needs were adequately met while he was in custody.
- Whether his risk of self-harm or suicide was properly identified, monitored and managed prior to the night of his death.
- Whether his risk was appropriately monitored during the night of his death.
- The design and use of the Listener suite.
- The standard of record keeping.
- Whether the response to the discovery of him hanging was prompt and appropriate.
- Whether he was bullied by anyone at High Down and, if so, whether appropriate measures were taken to deal with the bullies and maintain his safety.
- Whether appropriate courtesies were afforded to the family after he was discovered hanging and after his death at hospital.

Were the man's physical and mental health needs adequately met while he was in custody?

221. In this section, I rely heavily upon the findings of the clinical review conducted by the clinical reviewers. In some instances, I also make judgements of my own. I comment on the following issues:

- The man's reception health screen on 9 June and his general health assessment, or Wellman clinic, the next day.
- The management of his diagnosed condition of ADHD.
- The management of his substance misuse.
- The management of his self-harm and his risk of suicide.

Reception health screen and general health assessment

222. During his reception health screening interview at High Down on 9 June 2008, the man was not considered to be at risk of self-harm or suicide. He told the reception staff that, although he had a history of self-harm, he did not currently feel suicidal. ACCT procedures were not initiated at that time. However, the Prisoner Escort Record (PER) covering the journey between Magistrates Court and the prison that day carried a notation that he was at risk. The form was signed by the escort but not by anyone in the prison. The investigation found no concrete evidence to show whether the PER was seen by reception staff. Neither could the investigation show whether the information in the Detained Person's Medical Form completed at the police station prior to his appearance in court was available to the bank nurse or any other member of staff. As noted earlier, my investigator attempted to

interview the bank nurse on several occasions. However, each time an appointment was made she failed to appear. I cannot be certain that, had the comments on the PER and the Detained Person's Medical Form been taken into account, a different judgement about his risk would have been made. Nevertheless, it is of self-evident concern that such information seems either to have been unavailable or to have been ignored.

223. The following extracts from Prison Service Order (PSO) 1025 set out guidance for the use of the PER:

Paragraph 1.4

"Whenever a prisoner is received from the custody of others, during or on completion of a movement, the risk and vulnerabilities identified by the previous custodian should be noted and acted upon, to protect the prisoner and other prisoners, staff and the public."

Paragraph 3.1

"When taking receipt of a prisoner, reception staff must request the PER from the escort. Reception staff must sign the white top form at section 7 for receipt of the prisoner."

Paragraph 3.2

"Reception staff must alert appropriate staff in the prison to any risks identified on the PER, e.g healthcare and security staff/duty governor/orderly officer."

Recommendation 1

The Governor, should, in keeping with the provisions of PSO 1025, ensure systems are in place to guarantee that PERs are always seen and studied by reception staff, and that comments in PERs as to risk are taken into account by staff when judging how best to care for and support individual prisoners. Managers should carry out regular compliance checks.

224. On pages 8 and 9 of her report, the clinical reviewer summarises the reception screen and Wellman (general health assessment) as follows:

"The first reception screening suggests a current charge of possession of an offensive weapon. Again, the man denied being registered with a GP currently, but did disclose he had been seen in High Down earlier in 2008. He stated that he was not in receipt of any prescribed medication, had no physical difficulties apart from asthma, but under substance misuse he stated he was drinking cider up to five 3 litre bottles daily. He also stated he had been taking DF118 medication and that he drank cider from waking. In addition, he stated that he had been using heroin on a daily basis, up to £250 pounds worth daily. Also, he suggested he had been using crack cocaine. He suggested he had never had treatment from a psychiatrist outside prison but described himself as a paranoid schizophrenic. He stated that he was diagnosed but not treated for this illness and, when asked to disclose self-harm, said that in January 2008

he felt depressed and cut his arm. However, he was not experiencing any suicidal thoughts at that time (at the time of the health screen). Under the planned action, he was referred to the Substance Misuse Services by the bank nurse. In the subsequent Wellman health assessment that occurred on 10 June, he has recorded his concerns about sexual health and his requests for HIV or Hepatitis screening. When asked about medication prior to coming into prison, he stated that he had been taking Ritalin, antidepressants and epilepsy medication and gave the name of his General Practitioner. He requested a special diet avoiding anything with lemon or marmite. He was referred to the Medical Officer, the Hepatitis clinic and for blood tests by the HCA who completed that assessment.”

225. The investigation found that, although the man had been in High Down on two earlier occasions, his medical notes relating to those periods of imprisonment were not available to reception or healthcare staff on 9 June 2008. On pages 42 and 43 of her report, the clinical reviewer comments as follows:

“The man has had three admissions to HMP High Down over a relatively short period. It would be helpful for there to be a mechanism whereby Prison Health Services could obtain past medical records which may contain valuable background information to assist an individual’s care.”

The clinical reviewer recommends that there should be one unified health record within the prison and that this should contain information from health and substance misuse teams. She also says that the same record should continue during a period of custody and should be available during subsequent periods of custody. I endorse her recommendation and I repeat it immediately below paragraph 247 below, along with other recommendations I make.

226. At the consultation stage, the man’s parents expressed their concern about the fact that when the First Night Officer saw him on 9 June, he did not open an ACCT plan or refer him for a mental health review. I understand their concerns, especially in view of his disclosure that he had self harmed “every day for three years”. I nevertheless believe the officer’s decision not to open an ACCT plan was reasonable given his presentation and demeanour. I have decided not to make a formal recommendation on this matter, although with hindsight I suggest that the officer ought to have considered the option of referring him for a mental health assessment.

The management of the man’s diagnosed condition of ADHD

227. The man’s parents were especially concerned to learn whether medical and other staff at High Down were aware that he was suffering from ADHD. They also asked my investigators whether their son displayed any symptoms of ADHD in prison and whether any members of staff knew how to deal with those symptoms.
228. During the reception procedures on 9 June 2008, the man disclosed that he suffered from ADHD and a range of other conditions. However, when he was seen by the doctor the next day, he did not mention to her that he suffered from ADHD. (At this time, it would appear that neither his previous prison clinical records, nor his GP notes, nor the Detained Person’s Medical Forms,

were apparently available to the doctor.) In interview, the doctor could not remember whether he displayed any signs of ADHD when she saw him. However, she said if he had been displaying such signs she would have discussed them with him and with the mental health in-reach team. When asked whether a detox programme might have had an effect upon him if he was suffering from ADHD, she said she thought it might.

229. However, the man did disclose that he had ADHD when he was interviewed by the Healthcare Assistant for his Wellman assessment. When asked by my investigators what could be done to help and support prisoners with ADHD, she suggested that, aside from making others aware, she would normally expect healthcare staff to take follow-up action.
230. The discipline staff to whom the man disclosed that he had ADHD told my investigators at interview that, although they had heard of the condition, they felt unqualified to pass an opinion as to whether some aspects of his behaviour were symptomatic of ADHD.
231. In her clinical review, the reviewer confirms that the man was diagnosed with ADHD in August 2005 when he was 16 years old. He was initially prescribed Atomoxetine (a non-stimulant medication) which he took from April to October 2005. The prescription was then changed to Concerta, a slow release form of Methylphenidate, a commonly prescribed psycho-stimulant also known as Ritalin. He continued to take Ritalin until May 2006 when he reported the onset of seizures. A letter was therefore sent from the Adolescent Community Mental Health Team to the hospital asking for him to be assessed. Because of the likelihood that Methylphenidate could lower the seizure threshold, he was advised to discontinue the medication at that point. His case was closed by the Adolescent Mental Health Service in July 2006 after he had failed to keep his appointment and to attend group meetings. The clinical reviewer comments on page 40 of her report that, as far as it was possible to ascertain from the medical record, there was no suggestion that he had ongoing treatment with stimulant medication for ADHD following the discontinuation in 2006.
232. The clinical reviewer writes as follows on page 43 of her report:
- “Had contact been made with the man’s General Practitioner, it would have been possible to confirm that he indeed received a diagnosis of Attention Deficit Hyperactivity Disorder in his mid teens. It would have been clear that he had not taken medication for ADHD within the last [i.e. the previous] two years. His other self-disclosure of suffering from Paranoid Schizophrenia, Manic Depressive illness and Autism would also have been excluded. Had he been referred to Prison Mental Health In-reach Services, it is likely that these enquiries would have been made of his General Practitioner and his diagnosis would have been clearer to those managing him within the custodial setting. Unfortunately, the opportunity to arrange this assessment at Reception did not occur because of his non-disclosure of relevant information.”
233. On page 44 of her report, she concludes as follows:

“In terms of the management of the man’s Attention Deficit Hyperactivity Disorder, the natural course of ADHD shows a gradual reduction in symptoms with maturity and, although some individuals do go on to continue to suffer with symptoms of ADHD into adulthood, these are the minority. Most individuals with ADHD show a gradual resolution with approaching adulthood and those on medication will often be encouraged to discontinue medication for a number of weeks and months in order to see if the original symptoms have now attenuated. It would appear from the descriptions of him during his time in custody at HMP High Down that symptoms of physical over activity were not present. There remained some symptoms of Attention Deficit with poor concentration, distractibility and disorganisation, but these were not so severe that they caused those caring for him to consider asking for medical intervention.”

234. As a lay person, it seems to me that a possible cause of the untruthful claims the man made about his family history may have been his propensity to seek attention (a symptom of ADHD). His family made a specific request for my investigators to ascertain the extent to which healthcare and discipline staff were aware of the symptoms of ADHD. The clinical review addresses this issue as far as the healthcare staff are concerned. I imply no criticism of any member of the discipline staff who said they did not have any knowledge of the condition. In any event, Officer B did ask for medical intervention by referring him to the mental health In-reach team, given his concern at his behaviour (whatever its cause).
235. He was again referred to the mental health in-reach team on 21 August by the panel who conducted the initial ACCT case review the day after an ACCT form was opened for him. However, no appointment could materialise from the referral as he died two days later.
236. At the consultation stage, the man’s parents expressed their dissatisfaction that healthcare staff did not act upon the information he provided during his well man assessment. They cited the fact that during this assessment, he gave details of his GP and confirmed that he had previously been taking Ritalin, anti-depressants and epilepsy medication. They were also concerned that the CARATs team did not act on information in the Drug Intervention Record completed on 7 June 2008 while he was in police custody which recorded that he suffered from ADHD. In light of their comments, I have agreed to make the following additional recommendation:

Recommendation 2

Healthcare and CARATs staff must take appropriate action in response to information received relating to prisoners’ healthcare needs or ongoing health conditions. In addition, whenever a prisoner discloses details of medication they were receiving in the community or the name of their GP, such information must be communicated to healthcare staff who must take steps to verify that information as soon as possible. Such steps are necessary to ensure that provided with continuity of care.

237. The man’s parents also pointed out that he confirmed his diagnosis of ADHD during the Wellman and CARATs assessments at High Down and during his

time in police custody. They were therefore concerned that this information was not followed up.

The management of the man's substance misuse

238. **The investigation found that, as the man was an existing client of the CARATs service in the community (he had most recently been assessed by a community based CARATs worker on 7 June 2008 when he was in police custody), he was automatically seen by a member of the CARATs team at High Down shortly after his arrival there in June 2008.**

239. In her clinical review, the second clinical reviewer offers the following views about the man:

“It has been requested that I study the available documentation and provide an opinion particularly on the impact of the man's addiction and the treatment of his addiction.

“There is no record of drug or alcohol misuse in his general practice records, although his diagnosis of ADHD is fully documented. There is no corroborative evidence from any other source available to me of previous drug and alcohol misuse. However, on reception into custody he is recorded as stating that he had been drinking 25 units of alcohol daily for the previous 3 years and was using crack cocaine and cocaine powder to a daily cost of £2200. It is unlikely that his account of his alcohol consumption was accurate as he did not require an alcohol detoxification on entering custody and likely this stated level of consumption of heroin and cocaine was similarly exaggerated. There is no evidence of previous treatment of addiction prior to entering prison. It would be of interest to know if he had any previous period in custody and, if so, whether he required treatment for withdrawal from alcohol or opiates.

“He was treated with substitute opioid, Buprenorphine, at levels that are consistent with current national guidelines, to attenuate opiate withdrawal, as [this] was the withdrawal regime for opiate detoxification. As is documented, he initially requested and received a reducing detoxification regime, changed his mind and requested a maintenance dose which was prescribed, then again requested detoxification, his last dose being 16 August. He is recorded as being happy to be drug free and having completed his detoxification. However, there is no record of urinalysis results to confirm that he was abstinent from illicit drugs and a reference in the transcripts of selling a stereo to pay for ‘puff’ (sic). In a community setting, urinalysis would have been performed to monitor compliance with prescribed medication and abstinence from illicit substances.

Buprenorphine is taken by the sublingual route, that meaning that the tablet is placed beneath the tongue and is retained there until it dissolves. If swallowed it is inactive. It may take up to three minutes for the tablet to dissolve and the mouth should be inspected to ensure that it has been fully dissolved. The difficulties in supervision on the [house] block and the risk of diversion to another person are both noted in the documentation.”

240. My investigators were able to view the clinical records presented to them by the local PCT, which contain copies of the first reception health screens and

Wellman assessments for the man's two previous periods of custody at High Down. In neither record is there any evidence that he was treated for opiate or alcohol dependency at that time.

241. In her concluding remarks on page 49 of her report, the clinical reviewer comments as follows:

"In summary, I am clear that the man was opiate dependent but not alcohol dependent on reception into custody, [and] that the treatment he received for his opiate dependence was in line with national guidelines and was responsive to his requests for detoxification or maintenance. However, I am not clear whether he was using illicit substances as there are no recorded urinalysis results. This is not in line with national recommendations or guidelines. It is regrettable that action was not taken at his failure to attend CARAT treatment groups.

"However, withdrawal from opiates with a managed detoxification does not precipitate depressive disorder or suicidal ideation and there is no record of protracted withdrawal symptoms in him, such as severe insomnia, to support the hypothesis that his ADHD was so exacerbated."

Conclusions

242. On page 41 of her report, the clinical reviewer sets out her concluding remarks as follows:

"The man was seen by the General Practitioner on his admission to HMP High Down on 9 June and she found no evidence of him suffering from any current mental disorders, although she was aware of his disclosure of suffering from Schizophrenia in the past. Throughout his time in custody there were no specific concerns raised about his mental health until shortly before his death. There was mention at the end of July 2008 of him awaiting a mental health assessment, but during interviews with staff this appears to have been something he suggested was going to happen as part of the court proceedings. He was in fact referred to the Prison Mental Health In-reach Team following an episode of self-harm and concerns about his disclosures of bereavement very shortly before his death.

"At the time of his death, he was on an open ACCT document, and it would appear from interviews with staff that he had been in the habit of using both the Listener service and the Samaritans to support himself at night whilst in custody. His death occurred in the Listeners Room after he had been talking to the Samaritans.

"His substance misuse was managed with Subutex. He appears to have discontinued the use of Subutex in July and, at the time of his death, he was no longer on detoxification or maintenance medication. He did not require treatment for alcohol detoxification and it may well be that he over-estimated both his consumption of alcohol and illicit substances when disclosing his pattern of usage to staff.

“There was no evidence in the record that he, at the time of his death, was suffering from a depressive illness, nor any evidence of any other major disorder. Staff in their interviews have described him at times as being a quiet young man who gave limited responses to questions, but other times he is described as having poor concentration, a degree of disorganisation and perhaps some impulsivity. There did not appear to be physical over activity or significant sleep difficulties noted by staff.”

243. It is recognised that the man gave staff inconsistent and confusing information about his medical and psychiatric history in the early days of his sentence, but it should have been possible for his disclosures to be verified by reference to previous records. This systemic failure is too often revealed in the course of my investigations. I urge the National Offender Management Service to act upon the recommendations I and the clinical review team make in this regard.

244. The fact that the mental health in-reach team returned the man’s referral form for correction, rather than acting upon, it is of concern. However, the service manager for Surrey prisons who manages four prison mental health in-reach teams, has placed this issue in context. I quote him as follows:

“At the time of the referral, there was a clear procedure about the handling and management of referrals. In this instance, one of our administration workers did not follow the process because ordinarily we would telephone prison staff or email them if we needed more information. The original referral should have been kept by in-reach.

“Despite this error, the man already had assessment booked for 27 August with our Consultant Psychiatrist. When a referral is received for a patient who already has an assessment appointment booked, our main concern would be to ascertain whether the new referral suggests that more urgent action should be taken. Although our administration worker should have informed the referrer that an appointment had already been booked for him, there was nothing in the referral to suggest immediate risks or concerns about self-harm.

“The mental health in-reach team respond to routine referrals by offering an assessment where possible in 10 working days. From the date the referral was received, he was already booked to be seen within that timescale. Although it was not unusual for the mental health in-reach team to telephone referrers to get more information, we have to point out that this is often not practical. We accept that it would have been alarming for the officer who referred to mental health in-reach to find that the referral had been returned to him after his death. At the least our usual response would normally have been to inform the officer that an appointment had already been booked.”

245. In view of these comments, I make no formal recommendation about the manner in which Officer B’s referral of the man was handled. However, I urge the mental health in-reach team to do all they can to protect against a repetition.

Was the man's risk of self-harm or suicide properly identified, monitored and managed prior to the night of 22/23 August?

246. During the reception procedures conducted upon his arrival at High Down on 9 June 2008, the man admitted to a history of self-harm but said he did not currently feel suicidal. Thus, it was not considered necessary to initiate self-harm monitoring procedures at that point. Reception staff in all local prisons have little time to interview prisoners in depth or to make thorough assessments of the risks they may pose. It is not unusual for reception staff to conclude that a prisoner is not at risk of suicide if he tells them he is not feeling suicidal, even when comments contained within a PER suggest otherwise. I do not criticise the reception staff at High Down for not having initiated self-harm monitoring procedures for him at that point. It seems to me that their decision was reasonable in the circumstances. Although I make no formal recommendation, I urge the Governor and the PCT to remind reception and healthcare staff of the need to adhere to the provisions of Prison Service Order 500 (Reception).
247. However, I am concerned that those who assessed the man when he arrived at High Down seem not to have seen the PER which contained a notation that he was at risk of self-harm or suicide. Neither did they have access to his previous prison and medical records. As a result, they were unable to place his disclosures in context. The officer who conducted the cell sharing risk assessment for him during the reception procedures recorded that he was not currently subject to ACCT procedures and that there was no evidence that an ACCT form had been opened previously. The investigation found that during his previous term of imprisonment, which had come to an end only a matter of weeks earlier, he had in fact been subject to ACCT procedures.
248. Although there is no specific mention of any assessment of the man's risk of suicide in the record of the interview conducted by the doctor on 10 June, she commented that she felt his mental state was appropriate with no sign of psychosis. However, she too was disadvantaged by the fact that his previous prison and medical records were not available to her.
249. As I have said earlier, had the man's previous records been available during the reception procedures, it does not mean that a different conclusion would have been reached as to his current risk of self-harm or suicide. However, the absence of – or the ignoring of – such important information represents a significant failure (as I have commented at paragraphs 220 and 223 above).

Recommendation 3

The Governor should ensure that Reception staff are aware of the provisions of PSO 2700, especially in relation to the use and handling of Prisoner Escort Records (paragraphs 4.3 and 4.4 of that Order refer).

Recommendation 4

There should be one unified health record within the prison and this should contain information from health and substance misuse teams. The same record should continue during a period of custody and be available at

subsequent periods of custody. The National Offender Management Service should ensure that this record, as well as the core prison record relating to prisoners' previous periods of imprisonment, is available at, or very close to, the point of any subsequent admission to prison. When the unified health record or core prison record is received after the initial healthcare screening reports have been completed, the information in those reports should be verified against the details contained in the health and prison records. Staff should consider whether to take any action in response to any new information contained therein. Healthcare staff should request a copy of any medical records relating to the periods spent by prisoners in police custody, as well as relevant GP records, and should ensure that all the significant information is recorded in the prisoner's unified health record.

Recommendation 5

The National Offender Management Service should ensure that judgements as to risk of self-harm or suicide take into account historical information in prisoners' records.

250. Between his reception on 9 June and 19 August, the man reported two minor injuries. The first was on 4 July when he pressed his cell bell to tell officers that he had suffered a paper cut to his hand. At the same time, he produced an improvised weapon – a toothbrush with a melted down head containing a blade – claiming that he had fashioned it for his own protection. It was the judgement of the officer who spoke to him on that occasion that the injury was not the result of a deliberate act of self-harm. Rather, it was thought that he had accidentally cut himself on the blade of the weapon he had handed in.
251. The second injury was on 19 August when the man scratched his wrist. The nurse who examined him on that occasion concluded that the wound was so minor that it required nothing more than soap and water to clean it. But the same nurse recorded that he had also claimed to have taken 12 tablets of Ibruprofen. The nurse took the precaution of taking advice from a Poisons Unit. He was told that this number of tablets would be “well below toxic levels” but that he might experience gastro intestinal disturbance. Prior to 20 August, this was the only occasion when he manifested self-harm risk indications.
252. I am concerned that, following the incident on 19 August, no consideration seems to have been given to opening an ACCT plan. Annex 8G of Prison Service Order 2700 clearly states that an ACCT form must be opened whenever a prisoner is found to have self-harmed. I am disappointed that this was not done on this occasion. Although the impact was mitigated by the fact that formal self-harm monitoring procedures were invoked the very next day, staff should open an ACCT plan whenever a prisoner self-harms, no matter how minor the resultant injury.

Recommendation 6

The Governor and PCT should ensure that all staff are aware of and follow the provisions of Annex 8G of PSO 2700 which clearly states that an ACCT form must be opened whenever a prisoner is found to have self-harmed.

Assessment, Care in Custody and Teamwork (ACCT procedures)

253. An ACCT form was opened on 20 August after the man told a member of staff that he had suffered a series of bereavements in his family. It was also said he had spoken to a Listener and felt very sad.
254. PSO 2700 sets out the procedures to be followed whenever an ACCT form is opened. These include the timescales for each stage of the process. Those stages are repeated here for convenience:
- complete a concern and keep safe form
 - complete an immediate action plan
 - carry out an ACCT assessment interview
 - conduct a first ACCT case review
 - draw up a care and management plan (a care map).

Concern and Keep Safe form and Immediate Action Plan

255. SO A completed a Concern and Keep Safe form at 1.45pm on 20 August. Both she and Officer B then met with the man at 4.20pm to agree an immediate action plan. The plan should be drawn up within one hour of the risk being identified. The completion of his plan thus fell outside the prescribed timescale by two and a half hours. At first glance, this may seem to be an acceptable delay – understandable in any busy operational environment. However, this is the very period in which an at-risk prisoner may be at his or her most vulnerable. Whilst I make no formal recommendation on this point, I cannot overstate the importance I attach to meeting the provisions of PSO 2700 especially in respect of the timescales set out in Annex 8G. Whilst I recognise the demands placed upon prison staff in discharging their routine responsibilities, any tendency to let ACCT standards slip is greatly to be regretted.
256. The SO decided that the man's risk was such that staff should engage him in conversation three times during the day, and that he should be observed three times during the night. This requirement was recorded in the immediate action plan itself as well as on the front cover of the ACCT form for all staff to see. My investigators checked the extent to which this requirement was met. The entries in the ACCT ongoing record equalled the required nature of contact with, and observations of him, as well as the required frequency, between the opening of the ACCT and 4.00pm on 22 August. The level of his supervision during the night of 22/23 August is examined below.

ACCT case review

257. The first (and only) ACCT case review took place at 6.05pm on 21 August, the day after the form was opened. SO A chaired the review in the company of a unit officer and the man himself. The panel judged his risk of self-harm or suicide as low, but recorded that he should be the subject of a routine referral to the mental health in-reach team.
258. My investigators noticed that the two members of staff who attended the case review were both from house block 5. No other disciplines were represented. At the time of the review it was known that he had been upset and that he had

been in touch with a Listener on more than one occasion. It was also known that his claims of bereavement within his family had been tested by Officer B and found to be untrue. It was known that the officer had referred him to the mental health in-reach team. Finally, it was known that he had been the subject of a detoxification programme and that, on 16 August, he had asked for his medication to be changed. I am therefore surprised that no member of the healthcare team was invited to the case review. Another member of staff who could have been invited was the chaplain. Annex G of PSO 2700 gives the following guidance about the conduct of ACCT case reviews:

“The Unit Manager must chair the first Case Review and appoint a Case Manager (it may be the same person) (minimum grade of Senior Officer or Band 5 Nurse). Where the at-risk prisoner has severe mental health problems, the case manager can still be from the unit on which they are located. However in this event, the mental health professional must be invited to case reviews (and given as much notification as possible of the review time) and the Case Manager must seek their advice about how the individual is managed.

“When considering who to invite to the case review, the Unit or Case Manager ought not to be restricted by thinking only of staff who have met the prisoner; they should try to think of who else could positively contribute. It should also be attended by a member of staff who knows the prisoner well (such as personal officer or the officer who raised the initial concern). Where it is clear that there are mental health or drug/alcohol issues, an appropriate member of healthcare staff must be invited to make a contribution to the first review, in writing or by telephone if they are unable to attend at such short notice. The appropriate member of the Chaplaincy Team must also be invited to attend. Each case must be treated individually and attended by staff involved in the care of the prisoner, and where a provider of any specialist service (e.g. healthcare, mental health services, substance misuse, Probation, psychology, family advice, bereavement counselling) is referred to or otherwise involved in the care of a prisoner on an ACCT Plan, that specialist must be invited to contribute to the ACCT case reviews of that prisoner.”

Recommendation 7

The Governor should ensure that ACCT case reviews are conducted by multi-disciplinary panels in keeping with the provisions of Annex 8G of PSO 2700.

(I emphasise here that a similar recommendation was made by Her Majesty's Chief Inspector of Prisons in the report of her inspection of High Down, published in August 2006. She said that case reviews should be attended by representatives of all departments that have regular dealings with the prisoner. This recommendation was repeated at paragraph 2.59 in the report of the HMCIP inspection that took place in May 2009.)

259. Whilst I acknowledge Officer B's presence of mind in calling the man's parents on 20 August in order to verify the claims of bereavement he had made, I am concerned that neither he nor anyone else in the prison thought of consulting him as to whether he might give his consent for staff to inform his

parents that he had self-harmed and that the ACCT monitoring procedures had been initiated that day.

260. Paragraph 13.3.3 in Chapter 13 of PSO 2700 sets out the following guidance for contacting the family after a prisoner has self-harmed:

“After consultation with the prisoner, the nominated next of kin must be notified unless:

- there is a clinical reason not to, or
- if aged 18 or over, the prisoner does not consent (when asked, the prisoner’s response must be noted in the ACCT plan ...)
- the prisoner’s Care Map indicates otherwise.”

Recommendation 8

The Governor should remind his staff that, whenever a prisoner self-harms, the next of kin should be informed in keeping with the provisions of Chapter 13 of PSO 2700. The Governor should also remind his staff of the importance of ensuring that key information provided by the next of kin, especially that which may relate to a prisoner’s physical or mental health, should be recorded in the prisoner’s ACCT record (if there is one) and shared with healthcare staff as soon as possible.

Care map

261. The ACCT case review panel drew up a care map with the man’s agreement. A target was set for each of the three issues that were considered to be important for him to resolve: his back pain, his need to be employed and his tendency to cut himself when upset. However, the care map contains no reference to the earlier referral of him to the mental health in-reach team or to the support by CARATs that was considered necessary in the immediate action plan.

Further ACCT case reviews

262. The next ACCT case review was scheduled for 28 August. In the event, neither the appointment with the in-reach team nor the ACCT case review could take place. The ACCT form was still open when he died.

Was the man’s risk of self-harm or suicide appropriately monitored during the night of his death?

263. Two OSGs were the only members of staff on duty in house block 5 during the night of the incident. Whilst OSG A was a relatively experienced member of staff, having worked exclusively as a night patrol for the previous eight months, OSG B was deployed as a night patrol for the first time at the beginning of that week.
264. At interview, OSG A told my investigators his shift began at 8.00pm. He said it was usual for there to be a discussion between the staff on the evening shift and the night staff about events of the day. He said the handover also included a check of the Staff Observation Book. He said he saw the Staff

Observation Book when he started his shift but there were no entries in it relating to the man. He initially seemed unsure during interview as to whether he knew at the beginning of his shift that he was subject to ACCT procedures. However, he soon recognised that he had made entries in the ACCT form. He also admitted that his normal routine was to go through any open ACCT forms and ascertain the frequency of observations for each prisoner. He recalled that the man was the only prisoner in house block 5 subject to ACCT procedures that night.

265. The front cover of the man's ACCT form clearly shows the requirement for him to be checked three times during each night. As I have reported at paras 141-155 above, the investigation found that OSG A had made three entries in the ACCT ongoing record during the night. It may be helpful to repeat those entries here:

8.30pm – "Checked, okay. No issues raised." (the OSG confirmed at interview that, before making this entry, he had spoken to the man through the observation panel in his cell door and that he thought he seemed perfectly alright.

Midnight – "Checked, ok. He pressed ECB [Emergency Call Bell]. Requesting Listeners." (The OSG told my investigators that, on this occasion, he spoke to him through the observation panel and that he simply said, 'Gov, can I have a Listener?')

2.00am – "Samaritans phone requested." (During the course of the investigation, the OSG agreed with my investigators that the time of this entry was incorrect. The investigation proved that the man asked to speak to the Samaritans at approximately 1.17am and not at 2.00am.)

(At interview, the OSG told my investigators he intended to check him again at either 3.00am or at the termination of his telephone conversation with the Samaritans.)

266. As the OSG was not authorised to let the man out of his cell, he passed the request on to Officer D, the assistant night orderly officer. The officer told my investigators that, in ordinary circumstances, prisoners who asked to speak to the Samaritans would do so from their cell, using a portable telephone handed to them by staff. However, the signal on one side of the building was so poor that there was little or no reception. As a result, the practice was to allow any prisoner in that area of the building to call the Samaritans from the Listener suite where the signal was reliable. He also said that some prisoners had been abusing the system by using the Samaritans phone in their cells to charge up their own mobile phone batteries or to call relatives or friends rather than the Samaritans. He explained that the use of the Listener suite reduced the level of abuse, "as prisoners knew they would be monitored more closely there". (I need hardly add that the man was not in fact monitored at all during the 53 minutes he spent in the suite prior to being found hanging.)
267. The officer allowed the man to leave his cell and, in the company of another officer, escorted him to the Listener suite on the landing above.

268. Officer D admitted that he did not give the man a rub down search before allowing him out of his cell for fear that he would become angry if he was searched. The very act of letting a prisoner out of his cell at night, when staffing levels are at their minimum, could represent a threat to security and control. However, the Governor has pointed out that night staff are sometimes faced with operational circumstances that render rub down searching inappropriate. He takes the view that the officer's judgement not to search him was justified because, in the circumstances, it was more important both to his wellbeing and to the safety of the prison to avoid confrontation than to carry out a rub down search.
269. The investigation found that the man must already have manufactured the ligature with which he later hanged himself and carried it hidden to the Listener suite. A rub down search might possibly have led to discovery of the ligature. (When his parents viewed the CCTV footage, they noticed a bulge in the left sleeve of his pullover and came to the conclusion that this was probably where he concealed the ligature. Although no firm conclusions could be drawn in this regard, my investigators agreed that it was possible.)
270. At the consultation stage, the man's parents expressed their view that my report should highlight the fact that, in failing to search him before he left his cell, the officer did not comply with the local searching policy. His parents take the view that this was of extreme importance "in light of the probability that he had fashioned a ligature from a sheet in his cell and concealed this in the left sleeve of his pullover visible on the CCTV footage". They added that, had the officer searched him, it was likely that he would have discovered the ligature.
271. However, I believe that anything other than a strip search could not be guaranteed to reveal the presence of a ligature which a prisoner had hidden on their person. I agree with the views of the Governor that the officer's decision not to search the man was justified in these circumstances. However, I hope that the following recommendation will provide an appropriate safeguard against complacency.

Recommendation 9

The Governor should remind his staff of the need to rub down search any prisoner allowed to leave his cell at night unless, in the particular circumstances they face, it would be inappropriate to do so.

272. The CCTV footage showed that there was very little, if any, interaction between the two members of staff and the man during the brief journey to the suite. There was no evidence that either both officers asked him whether he was alright or offered him support beyond being allowed to speak to the Samaritans. His request to speak to a Listener and his subsequent request to speak to the Samaritans ought to have suggested the possibility that his risk of self-harm or suicide had increased. That suggestion is in keeping with the spirit, if not the letter, of the comments the Governor makes on page 31 of the local suicide prevention procedural document about the need for staff to be alert to the possible heightened risk to a prisoner when he asks to use the Samaritans phone.

Recommendation 10

The Governor should remind his staff of the importance of adhering to the provisions of paragraph 31 of his local suicide prevention strategy which requires them to be alert to the possible heightened risk to a prisoner when he asks to use the Samaritan's telephone.

273. In relation to this recommendation, the man's parents commented at the consultation stage that staff should attempt to speak to the prisoner and discuss his or her concerns to establish their state of mind and to enable an assessment of the prisoner's risk. They suggest that details of their conversations should be recorded in the ACCT plan. They said that staff should also consider the need to increase the frequency of observations of at-risk prisoners following any telephone conversations with a Samaritan.
274. Once the man had been locked in the Listener suite, he was left alone for approximately 53 minutes before he was found hanging. At the time, no clear general instructions were in place at High Down for the observation of prisoners during periods when they were locked in a Listener suite. Of course, in normal circumstances prisoners would not find themselves alone as the prime function of the suite is to enable a prisoner and a Listener to be in the room together. The Governor has made the comparison that had he been able to use the Samaritans telephone in his cell, there would have been no expectation that he would be supervised. Whilst I have some sympathy with that view, I wonder whether, had the provisions of paragraph 31 of the local suicide prevention strategy been applied, a decision might have been taken by the night staff to increase the level of observations of him had he remained in his cell.
275. The requisite number of checks to be carried out in respect of the man by night was three. By the time he reached the Listener suite, two of those checks had, according to OSG A, already been carried out. As has been pointed out above, the OSG said he intended to carry out another check either at 3.00am or when his conversation with the Samaritans came to an end. Thus there was no definite plan to observe him before 3.00am. My view is that, if the practice of allowing prisoners to use the Listener suite to telephone the Samaritans is to continue at High Down, they should be more closely monitored. It might be better if the practice is brought to an end.
276. I understand that, since the man's death, the Governor has introduced a system whereby a member of staff is stationed outside the Listener suite purely to observe any prisoner left alone in the suite to telephone the Samaritans. I support this decision.

ACCT observations and pegging

277. During one of the interviews conducted with OSG A, he told my investigators he carried out his pegging rounds "on the hour, every hour". He also said he preferred to carry out his ACCT checks while he did his pegging rounds. He was asked whether he carried out any pegging in house block 5 between 1.17am and 2.10am on the night of 23 August 2008. As I have reported in paragraph 163, he replied as follows:

“No. Pegging starts from approximately 1.00am and lasts for approximately 15 minutes. During this time, I have to peg throughout the entire unit. This policy is written down in local orders. We are given a copy of these when we start our shift. I pegged from approximately 1.00am that night to approximately 1.15am. I did the whole house block. This included the landing on which the man was located as well as the landing on which the Listener suite is located. After I had finished, I answered a cell call alarm from him at about 1.17 am.”

278. The CCTV footage made available to my investigators shows no picture of the OSG patrolling house block 5 at the times mentioned above. This is a matter of great concern to me.
279. My investigators examined Local Operating Procedure (LOP) 03/2006 – Night Procedures. The following are extracts from that document:
- “The night pegging system will be operational between 22.00 hours and 06.00 hours. The first walk must commence by 22.00 hours. Each subsequent walk must commence within 30 minutes of the completion of the previous walk.”
- “The patrolling Officer may miss two pegging walks for the purpose of taking meal breaks. Pegging will recommence 45 minutes after the previous pegging walk.”
280. The wording of the LOP makes no provision for pegging to be carried out “on the hour, every hour” as suggested by the OSG. If it was his practice to patrol in such a manner, he was in breach of local orders.

Recommendation 11

The Governor should ensure that the full provisions of his Local Operating Procedure for night procedures are both known and complied with by all those staff who are likely to be on duty in the prison by night. Special emphasis should be placed on pegging procedures.

Recommendation 12

The Governor should remind his staff of the importance of ensuring that checks of prisoners – especially those considered to be at risk of self-harm or suicide – are not carried out on a predictable basis.

Conclusions

281. Although credit should be given to SO A for opening an ACCT form on 20 August, the first and only case review held the next day was not conducted in accordance with the provisions of PSO 2700 which clearly state that the review panel should comprise a multi-disciplinary team, including a representative of the healthcare department.
282. When the man asked to speak to a Listener and then to the Samaritans during that particular night, no consideration was given to the heightened risk

of self harm or suicide he may have presented. This is contrary to the provisions of paragraph 31 of the local suicide prevention strategy.

283. OSG A seemed to be in ignorance of the local orders for the conduct of pegging and timing of pegging. Instead of following laid down procedures, he carried out his checks in a predictable manner. (I am also critical of the OSG in respect of the discrepancies between the timing of the entries he made in the man's ACCT ongoing record during the night and those shown on the CCTV footage.)

The design and use of the Listener suite

284. On the day the investigation was formally opened, my investigators examined the Listener suite where the man had been found hanging. They were told that the suite was in fact a multi-functional room that was often used for staff meetings and like purposes. Its size approximated to that of two cells joined together. The entrance to the suite comprised a low security door with a glass screen built into it and the adjacent wall. The room was L shaped, such that it was possible for someone left alone to be partially out of the sight of an observer outside. The room looked untidy. Inside were a table and some chairs, a bedcover, and a vacuum cleaner attached to a length of electric cable. It would have been possible for a prisoner to fashion a ligature from these materials, especially from the bedcover. There were numerous fittings on the ceiling and walls that could easily be used as ligature points.
285. Although the room was described by staff and managers as a Listener suite, that specific term is not used Prison Service Order 2700. At Annex 10c of that PSO, references are made, inter alia, to Listener Support Suites and Time Out Rooms.
286. According to the PSO, a Listener Support Suite provides joint accommodation for a prisoner requiring peer support and a Listener. The accommodation should normally comprise a double cell with separate areas for each prisoner to occupy.
287. A Time Out Room is a cell or room for a prisoner requiring peer support to meet with a Listener for a short period of time. The term Time Out Room best describes the design and function of the room in which the man hanged himself. The table below shows the guidance set out in Annex 10c of the PSO for the design and usage of Time Out Rooms:

Physical requirement	Single cell sized room. The room should appear less institutional than normal wing locations. The room should be furnished with soft chairs with a low, coffee type, table. The flooring should be vinyl. The windows can be curtained and tea/coffee making facilities should be provided. The cell/room door should be anti-barricade. Rooms should have a cell-call system, preferably auditable. Time out rooms are not to safer specifications.
Certified Normal Accommodation (CNA)	Time out rooms do not form part of the CNA count.
Location	Time out rooms can supplement or

	replace support suites. They should be provided in First Night Centres/ Induction Units. They can also be provided on normal wing locations.
Staffing requirements	Time out rooms operate with trained Samaritans/Listeners. There should be sufficient Listeners available to enable a time rotational relief pattern. Listeners will become fatigued where they have provided peer support for prolonged spells. Prison staff are required to bring a prisoner in need of peer support and the duty Listener to the time out room. Profiling/protocols should reflect all required transits to and in and out of the time out room.
Usage	A time out room provides an area that is less institutional for the provision of peer support. Listeners and those requiring peer support will be brought together. If prolonged support is required the duty Listener will need to be rotated with other Listeners. A time out room is not to a safer specification and therefore a prisoner requiring peer support must not be left unattended.
Prohibited usage	A prisoner requiring peer support should never be left alone in a time out room.

288. The room in house block 5 at High Down known as the Listener suite was not furnished in keeping with the above provisions, although it seemed to be used for the same purpose as a Time Out Room. The man was left alone in the room for approximately 53 minutes. He was placed in the room, not to benefit from peer support (i.e. to be with a Listener), but to enable him to speak confidentially to the Samaritans. In normal circumstances, it would not have been necessary for him to be placed in the room to speak to the Samaritans as the dedicated telephone would have been passed to him for use in his cell.
289. My investigators visited the Listener suites in some of the other house blocks at High Down. They were disappointed to find yet worse conditions in some cases. In one suite they found builders' rubble on the floor. However, the suite in the segregation unit stood out as a good example of how such a facility should be organised: it was furnished with soft chairs and did not look like a cell or an office.

Conclusions

290. I do not criticise the decision to allow the man to telephone the Samaritans from the Listener suite and I understand why he was left alone there. However, I believe the fact that the suite had been attributed the status of a multi-purpose room had the effect of eroding its role as a facility for the care of at-risk prisoners. In my view, insufficient attention was paid to furnishing the room for that purpose in keeping with the provisions described in PSO 2700 for Time Out Rooms. Moreover, the term Listener suite is unhelpful as it does not tally with terminology used in the PSO.

Recommendation 13

In conjunction with Prison Service Headquarters, the Governor should consider the merits of re-designating all Listener suites as Time Out Rooms.

At the consultation stage, the Prison Service rejected this recommendation. The following response was received:

“The Governor can designate his cells in whatever way he wishes and does not need the agreement of Safer Custody and Offender Policy Group or Prison Service Headquarters.”

Recommendation 14

The Governor should ensure that clear instructions for monitoring prisoners whilst they are in a Time Out Room are included in his local Suicide Prevention Procedural policy. This is especially important where prisoners subject to ACCT procedures are concerned.

At the consultation stage, the Prison Service rejected this recommendation. Instead steps have been taken to ensure that the room is no longer used by prisoners who are alone. The following response was received:

“High Down does not have Time Out rooms. The problem with the Samaritans phone signal/reception has been rectified by the installation of boosters. Prisoners do not now have to use a listening room to call the Samaritans. The room is only used when Listeners are present.”

Also at the consultation stage, the family solicitors commented as follows:

“The man’s parents are astonished that the PPO does not criticise the decision to allow him to call the Samaritans unsupervised from a room which was wholly unsuitable for this purpose and did not meet the Prison Service’s own safety standards.”

The standard of record keeping

291. The investigation found several instances of poor record keeping, some more significant than others. The following are examples.
292. Regular entries were not made in the man’s clinical record by substance misuse nurses after they had seen him. The substance misuse lead nurse told my investigators this was contrary to his expectations. It is important that information about a prisoner’s acceptance or rejection of detoxification medication is entered in his clinical record so that the complete picture of his healthcare is made visible to all healthcare staff.
293. Following a minor act of self-harm on 4 July, when the man told an officer he had been attacked by another prisoner red marks were visible on both sides of his head. Although the officer who noticed these marks recorded the fact in his prison record, she failed to complete a form F213 – the report of an injury sustained by a prisoner. Had she done so, he would have been

examined by a nurse or a doctor and an assessment of his treatment needs would have followed.

294. On another occasion, the same officer failed to raise the form after the man had reported that he had sustained what he described as a paper cut on his hand. Staff should complete the F213 form whenever a prisoner sustains an injury, however minor, not least because the record will reflect the frequency and nature of any injuries sustained. Medical and discipline staff will thus be better informed and able to decide what, if any, interventions are necessary in the process of discharging their duty of care to prisoners.
295. Although there was no evidence that any of these examples of poor record keeping related to the man's death, I must draw attention to the need for staff to follow the required procedures.

Recommendation 15

The Governor and the PCT should remind their staff of the importance of completing a form F213 or, if necessary, a form F213SH, whenever a prisoner sustains an injury, no matter how minor.

296. At the consultation stage, the man's parents reinforced their concern that he did not write his own initials on the Drug Intervention Record (DIR) completed on 11 June 2008 (see paragraphs 64-66 above.) Through their solicitor, they wrote:

“As is acknowledged the initials are neatly written in a form of handwriting that seem different from that seen in his signature. It is noted that the member of the substance misuse team denies he wrote the initials. It is possible, however, that the initials were completed by a third party and it is unclear whether any steps were taken to investigate who else has access to the DIR and whether the initials could have been written by someone else after completion of the form.”

297. My investigator had no reason to doubt either the member of the substance misuse team or the CARATs worker's explanation of this matter. Whilst I understand the parents' concerns, I am of the view that no further examination of the issues they raise in this connection is warranted.
298. On 21 July and 11 August, the man appeared at Magistrates Court, either by video link or in person. His record contains little, if any, detail of the outcome of either hearing. The importance of recording in prisoners' files details of decisions made at their court hearings, as well as of their reactions to those decisions, cannot be overstated. Prisoners often react badly to sentencing decisions or to a refusal by the court to grant bail.
299. Perhaps the most significant example of poor record keeping was that relating to the entry made by OSG A in the man's ACCT ongoing record at 2.00am on the night of the incident which proved to be grossly inaccurate (by 53 minutes). This was not just poor record keeping. It may fairly be described as an act of incompetence on the part of the OSG. (My investigators, who interviewed him three times so that he could account for the discrepancies,

concluded that, as serious as this error was, there was no evidence that he had lied about it.)

300. At consultation stage, the man's parents expressed their concerns that the CARATs team did not record any attempts to engage him in his care plan or to review his care plan. They were also concerned that his CARATs case record simply includes an entry which records 'client no longer ITDS [Integrated Drug Treatment System]' but gives no reason for this decision.

Recommendation 16

The PCT should instruct its substance misuse staff to make entries in prisoners' clinical files whenever they see prisoners, especially in relation to detoxification issues and events.

Recommendation 17

The Governor should remind staff of the importance of ensuring that contemporaneous, accurate and legible entries are made in prisoners' core files, especially in ACCT forms. Appropriate training should be available to those staff who may require it.

Was the response to the discovery of the man hanging prompt and effective?

Opinion offered by Back to Life Ltd

301. A company known as Back to Life Ltd was asked by the local PCT to provide responses to the following questions posed by my investigators:

- Was there an effective response from healthcare staff when the man was found hanging?
- What equipment was used and what was the level of training of the staff involved?
- Can the review comment on the fact that OSG B did not take part in the emergency first aid as she had not been trained? Was it correct for her to do nothing because of that?

Was there an effective response from healthcare staff when the man was found hanging?

302. Back to Life Ltd submitted the responses shown below:

"Based on the information provided, it is the opinion of the reviewer that there was an effective response by both healthcare workers and prison officers when the man was found hanging. It is appropriate that if there was doubt regarding a palpable pulse and the casualty was not showing signs of consciousness or breathing for the staff to continue CPR.

"Without being present at the arrest, it is not feasible to determine how effective the CPR was, but documentation supports the use of current guidelines by staff - being 30 compressions to 2 ventilations, the use of

adjuncts such as a bag valve mask and oxygen and the placing of a defibrillator/ECG onto him.”

What equipment was used and what was the level of training of the staff involved?

303. The company responded as follows:

“Radios were used to provide an emergency code 1 (or code red) message to other officers to gain swift assistance and alert the prison control room of an incident. An emergency key kept in the pouch of the officers was used to gain immediate access to the room. A ligature cutter in the possession of OSG B was used to cut the ligature when the man was lowered down. A bag valve mask with Oxygen 15 litres ... was administered to him on arrival of the red bag. A defibrillator or ECG was placed on his chest and left in position.

“A saturation monitor was used and recorded a saturation reading of 69% some time during the emergency procedure. [The company’s spokesperson later explained that a saturation monitor is used before or after a cardiac arrest. It is placed on a finger or ear lobe when the heart is beating. It is used to monitor a person’s oxygen saturation level in their blood. A normal reading of a healthy individual breathing room air would vary between 95% and 100% but may sometimes be lower, depending upon what they are doing. She said it is not usual for this equipment to be used during a cardiac arrest as the blood supply to the finger or ear lobe is usually insufficient to gain an accurate reading when the heart is not beating. It was their belief that if this reading was taken during the cardiac arrest, its accuracy was questionable and it should not have changed the management or decisions of the cardiac arrest team in any way.]

“A blood pressure cuff was placed on the man and a recording of 45 systolic over 32 diastolic blood pressure was documented. [The spokesperson later explained that a blood pressure reading is taken to measure how strong the heart is beating and how well the blood is circulating to the rest of the body. She said it is not usual for this equipment to be used during a cardiac arrest as the blood supply to the rest of the body is usually too poor to get an accurate and reliable reading when the heart is not beating. It was her belief that if this reading was taken during the cardiac arrest, its accuracy was also questionable and it should not have changed the management or decisions of the cardiac arrest team in any way.]

“A pulse rate of 115 was documented from the blood pressure machine (sphygmomanometer). [The spokesperson later explained that blood pressure machines may provide information about the pulse rate of a person with a normal heart beat. She said that they are not a reliable source of determining the strength of a person’s heart beat and they are not a reliable source of recording information in a cardiac arrest. Her opinion was that the only way to determine if a heart beat has returned, and the rate of the heart beat, is to feel for a pulse with your fingers whilst looking for signs of life, and counting the number of beats per minute whilst looking at a clock. She said that in the absence of the Ambulance

AS11 – the ambulance documentation sheet – she was unclear whether the heart beat had returned prior to the man’s departure from High Down to hospital.)

“Staff Nurse B took other equipment to the cell which included a blood glucose measuring machine.

“From the three interview transcripts provided to the reviewer, it appears that the level of training for staff involved was the following:

OSG B – No resuscitation training

OSG A – Unclear

Staff Nurse B – Unclear. He suggests that he attended a basic life support update or first aid training (which includes basic life support) in 2006 but later suggests he had done it in 2007. He states he is required to have an update yearly.

“The use or availability for use of all the equipment stated in the list above is appropriate in a peri-arrest (before or after a cardiac arrest when spontaneous circulation has returned, i.e. there are signs of life) and cardiac arrest scenario.

“Based on the information provided, but without reviewing the equipment personally, the reviewer believes that the prison appeared appropriately equipped to manage the emergency situation that arose from the man’s hanging. It is not possible without an in-depth audit to determine whether the type of equipment alluded to in this document was functioning effectively or met all the current standards in resuscitation.”

304. In a subsidiary report submitted on 7 August 2009, the spokesperson comments on the involvement of Nurse A. She offers the following conclusions as to his actions:

“Based on the information provided, it appears that the nurse took an active role in cardiac compressions and took over massage from the OSG to give him a rest. He also helped co-ordinate activities to minimise any delay of the arrival of the paramedics and provided referral paperwork to go with the man to hospital.

“It is the opinion of the reviewer that the information contained within this interview [i.e. that of Nurse A] suggests that the healthcare worker in this case appears to have provided an effective response.”

305. As for the equipment used by Nurse A and as to his training, the spokesperson comments as follows:

“With regards to Nurse A’s interview, he makes reference to the use during the resuscitation of the man of:

- an ambu bag
- a defibrillator

“He also comments that additional equipment was brought to the room, comprising:

- a blood pressure machine
- a BM machine (this measures blood glucose)
- a machine ‘that you place on the finger to record the oxygen’. (This is more commonly known as a ‘saturation monitor’.)

“Level of training of Nurse A – he states that he is CPR, Manual Handling and Health and Safety trained, although he does not say when.”

Conclusions

306. The spokesperson offers the following concluding comments:

“The equipment mentioned by Nurse A in his interview is all appropriate for use in a peri-arrest and during a resuscitation attempt.

“Aspects of all the training courses undertaken by the nurse can help to develop the skills to manage a resuscitation attempt. There is no documentation to inform the reviewer how recently any of these training course were undertaken.”

Can the review comment on the fact that OSG B did not take part in the emergency first aid as she had not been trained? Was it correct for her to do nothing because of that?

307. The spokesperson responded as follows:

“From the statements it appears that OSG B responded appropriately and swiftly to a call for assistance. She then assisted OSG A by cutting the ligature around the man’s neck and helping to lower him to the floor. Although from the documentation it appears she had not received any training in the cutting of a ligature and some comments suggest it may not have been done according to correct procedure, it appears that she did assist the other OSG in successfully lowering the man to the ground to the best of her ability in order to enable resuscitation attempts to begin.

“If as stated within the interview Officer D arrived within 20-30 seconds of the call, then it would suggest that only a few seconds passed once the man was placed on the floor before he arrived.

“OSG B comments in her interview that once they had lowered the man to the floor she heard the voices of other individuals responding to the emergency and called to help guide them to the location. OSG A and the officer then commenced resuscitation.

“It is unclear as to whether OSG B had been asked to get the first aid kit or decided to do this of her own volition. Someone without training may well believe that this would provide some equipment to help the situation. If she collected a basic first aid kit it should have contained a face shield or mask to provide staff with some protective barrier when performing mouth to mouth resuscitation. If she had mistakenly called it a first aid kit when it

was indeed the red resuscitation bag then this would have contained important equipment for the resuscitation attempt.

“As the resuscitation progressed she comments that she made phone calls and answered the phone in connection with the emergency.

“It is believed by the reviewer that on closer examination she contributed appropriately to the situation and provided important assistance to the man and members of staff during the resuscitation with little or no training in many of the procedures involved.”

308. Although any delay in commencing resuscitation is evidently dangerous, I do not believe that there should be any criticism of the actions of OSG B. Indeed, it is noteworthy that she encountered this tragedy in the first week of her new duties in a house block. If, as she claimed, she had received no first aid training of any kind, she did well to cope with the traumatic events she encountered.

309. The spokesperson reaches the following conclusions as to the overall effectiveness of the response when the man was discovered:

“Our review began at the point that OSG A saw him hanging in the Listeners’ room. Our remit was to review the clinical elements of the three questions raised by the Ombudsman as documented above.

“We conclude that based on the information provided, he was given swift and appropriate medical care. However, the incident reports were of a poor standard and provide limited accurate information. In particular, there were no time scales, which made the review difficult.

“The interviews provided more appropriate information. However, at times the transcript was confusing and missed words. The absence of a specialist in resuscitation at the interview led to many areas lacking important clarity and left a number of issues that would have provided invaluable information regarding the events that occurred that night unchallenged. It also led the reviewer to believe that staff lacked knowledge and understanding regarding some of the skills they were performing.”

The comments relating to the absence of a specialist during interviews are of course a matter for my office and the PCT rather than for the Governor of High Down in particular, or for the National Offender Management Service in general.

At the final consultation stage, the man’s parents expressed their view, through their solicitor, that the summary of the spokesperson’s advice on the adequacy of the treatment he received in prison was inaccurate or misleading. Their solicitor wrote as follows:

“The report confirms that the spokesperson believed the use or availability of all the equipment used to assist the man was ‘appropriate in a peri-arrest...and cardiac arrest situation’. However, earlier the report confirms her advice that the following equipment, used on him, was not appropriate during a cardiac arrest: saturation monitor, blood pressure cuff, blood pressure machine. In the event that

inappropriate equipment was used, his parents would have sought clarification of the possible negative consequences for his care. His parents remain confused by the advice and are disappointed that no steps have been taken to clarify this information in the report.

“The man’s parents also expressed concerns about the following issues:

1. The failure to provide the spokesperson with access to the Ambulance AS11 without which she was unable to confirm whether the man’s heartbeat had returned prior to his departure from the prison to the hospital.
2. The failure to provide her with staff training records. She has instead relied on information reported by staff to advise on the adequacy of the level of training of those involved in his care.
3. The failure to provide her with access to the equipment used to assist him, without which she confirmed that she was unable ‘to determine whether the type of equipment alluded to [by staff] was functioning effectively or met all the current standards in resuscitation’.
4. Her comments that OSG B may not have used the correct procedure to cut the ligature. The parents would have liked clarification of this comment, including details of any impact this may have had on their son’s situation.
5. The parents have confirmed that, above all, they remain concerned about the inadequacy of the information provided to the spokesperson and they contend that her findings may have been different had she been provided with access to appropriate records and equipment.”

310. The report makes the following recommendations:

- A full audit of resuscitation equipment, including the review of access to different levels of emergency equipment should be undertaken.
- An accurate database containing records of all emergency (first aid) training given to staff on site should be maintained.
- All staff should attend basic life support training including prison specific scenarios.
- In accordance with National Offender Management Service’s recommendations, ensure that Prison Officer Entry Level Training (POELT) courses not only include basic life support training but also a suicide scenario such as hanging.
- In accordance with the Department of Health’s publication ‘Toolkit for Health Care Needs Assessment in Prisons’, carry out a risk assessment to identify the level and number of people requiring specific training.
- Ensure an appropriate number of prison officers have first aid training.
- In accordance with the NHS Knowledge and Skills framework, ensure all qualified nursing staff can respond appropriately to emergency situations.
- In accordance with the Department of Health’s publication ‘An Education and Training Framework for Staff Providing Health Care in Prisons, dated October 2005’, there should be emergency response officers from either prison health care workers or prison officers who should be trained to UK Resuscitation Council Immediate Life Support (ILS) standard or equivalent. This framework also makes reference to Basic Life Support training in POELT.

- In accordance with the latest guidance from ‘National Health Service Litigation Authority (NHSLA) advice for Mental Health, May 2009’, it is advised not only for ILS training of appropriate staff in high risk areas but also regular emergency drills to take place to practice scenarios and adequately prepare scenarios and adequately prepare staff for such emergencies.
 - There should be training and education in how to document the events of a serious incident on an incident statement form.
 - It is also suggested that someone suitably qualified in resuscitation and in the management of medical emergencies is present at the interviews following this type of incident to ensure accuracy and clarity in the gathering of information pertaining to clinical incidents.
311. In a statement provided by one of the paramedics who treated the man, a reference is made to a remark that he was “obviously dead”. The remark was not attributed to any specific person. The investigation could not discover which, if any, member of staff at High Down used these words. Neither was there evidence that this statement had any adverse effect on the speed of response by the ambulance service. However, all staff who find themselves in the distressing position of having to respond to a life threatening emergency must take care to avoid the use of terms that may not be accurate. Whilst I make no formal recommendation, the Governor and the PCT may wish to bring the matter to the attention of their staff at High Down.
312. At the consultation stage, the man’s parents expressed their opinion that two officers should be criticised for entering his cell after he had been found hanging in the Listener Suite.
313. The Prison Service’s policy for the procedures to be followed when a death of a prisoner occurs in a prison is set out in Prison Service Order 2710. The following provisions are made at paragraph 2.6 of that Order:
- “Once a death has been verified by a qualified person, a member of staff must be posted to remain at the scene and keep a record of the names of all those entering the cell, which must be limited only to those directly involved in the incident. Pending the arrival of the police, all relevant evidence must be preserved, including unsent letters pending in outgoing post and pin-phone records of recent telephone calls.”
314. I am satisfied that the conduct of the officers in entering the cell was not in breach of these provisions. I say this because:
- He was declared dead at hospital and not at High Down,
 - he hanged himself in the Listener suite and not in his cell.
315. It is not clear why they decided to go into the cell. I surmise that Officer D, believing that the man was still alive, may have wished to satisfy himself as to whether there was anything in his cell which would shed light on his intentions. Whatever their motive, I believe both officers can both be forgiven if they believed that the area to be sealed for evidential reasons was the Listener Suite rather than his cell, however erroneous their perception may be judged in hindsight.

316. In any event, my investigation found that both members of staff recognised, within moments of entering the man's cell, that they were not permitted to disturb any of its contents and therefore left after a few moments. There is no evidence that their entry into the cell had any detrimental effect on the police investigation. I therefore make no criticisms of their conduct and make no recommendations in this connection.

Was the man bullied by anyone at High Down and if so, were appropriate measures taken to deal with the bullies and to maintain his safety?

317. The investigation found evidence that there were five occasions when there may have been some form of bullying related behaviour in which the man may have been either an aggressor or a victim. The first was on 4 July, when he told Officer A that he had been attacked by another prisoner. He said the attack was related to a tobacco debt. He told the officer he had been punched on both sides of his head. The officer recorded in his file that she had seen red marks on both sides of his temple. On this occasion, there was no evidence that the correct procedures for recording his injuries or for investigating his claims were followed.

318. The second occasion was the next day (5 July) when he told staff he had been threatened by other prisoners. Although he mentioned no names, another prisoner suggested to staff that he had not told the truth about what had happened. The prisoner suggested that he had gone to another prisoner's cell and had intimidated him in order to "get something out of him". Although the investigation found no evidence of any formal investigation into this event, an entry was made in the staff observation book recording that a Bully Book had been opened in respect of the other prisoner. Nevertheless, he was moved to another house block as a precautionary measure to afford him better safety.

319. The third occasion was on 13 July, when he failed to collect his detox medication. On this occasion, a nurse decided to see him. He told her that other prisoners had asked him to give them his medication. To avoid being compromised, he decided not to present himself at the treatment room where the medication was normally administered. My investigators found no evidence of any formal investigation into his claims.

320. The fourth occasion was on 19 July when, during the course of his disciplinary hearing for refusing to return to his cell two days earlier, he claimed his behaviour was due to threatening behaviour against him by other prisoners whom he did not name. The investigation found no evidence that any of his claims were fully investigated or whether the information he offered in his defence was communicated to staff in the house block to which he was sent.

321. The fifth and final occasion was on 14 August when he told staff he had again been threatened. On this occasion he mentioned the name of another prisoner who had threatened to arrange for him to be harmed once released from prison. The investigation found that specific measures were taken against the prisoner concerned and that he was kept isolated for a while in his cell until the other prisoner was transferred to another house block. A Bully

Book was opened on that prisoner. Save for my concern for the need to isolate bullies rather than their victims, I consider that the measures taken in respect of him were reasonable in the circumstances.

Conclusions

322. The fact that the man mentioned no names in respect of the first four instances of bullying described above would have significantly impaired the ability of staff to investigate his claims. This may explain why it appears no investigations were apparently carried out. However, although I make no formal recommendation, the Governor will wish to ensure there is no complacency on the part of staff in their management of unattributable claims of bullying by prisoners. The local violence reduction strategy seems to be a well constructed and effective statement of policy. Staff should be reminded of the importance of adhering to its provisions, as well as those of PSO 2750.

Were appropriate courtesies afforded to the man's family after he was discovered hanging and after his subsequent death at hospital?

323. Here, I examine:

- The actions of the officer in his role as Family Liaison Officer.
- The difficulties and delay in contacting the duty governor after the man had been found hanging.
- The consequent delay in informing the man's parents of his condition and admission to hospital.
- The conduct of the staff from High Down who attended the hospital.
- The level of support offered by the Governor and his representatives to the man's parents after his death.

The actions of the officer in his role as family liaison officer

324. The investigation found that, although trained as a family liaison officer, the officer had not previously carried out the role. At interview, my investigators asked him to explain how he thought he had conducted himself. He said that, having taken up his role on 26 August, his first priority was to go to the Governor's office where the man's files were stored and take notes from some of them. He said he thought his first telephone call to the family would have taken place at about 2.00pm that day. He told my investigators that the man's father "was not there". He therefore decided to call again later. He said he eventually got through to him at about 4.00pm. He explained to my investigators that the purpose of his call was to introduce himself as the FLO, to say what the job entailed and to arrange to meet the parents in person. At interview, the officer said he was keen to "help as part of the grieving process and to present the Prison Service in the best possible way".

325. The man's father has said that, when the officer called at 2.00pm, he left a message on his answerphone but failed to leave a contact number. The officer said he could not recall that failure.

326. The man's father has said that, in the same answerphone message, the officer said he would call again later but did not do so until prompted to do by the SO. The officer said he rang him back as soon as he "felt he would be

in". When asked how he would know when he would be in, the officer replied, "I think someone said to me that he'd been trying to contact me and I should call him. But I had in mind to call him back." He explained that, in the two hour period between making his unsuccessful call and getting through to him on his second attempt, he spent his time gathering more information about the man. My investigator put to him the suggestion that it might have been more appropriate to gather the information before making the first call. In response, he said that he was not aware of any guidance given to him about time limits during his FLO training.

327. The man's father has also said that the officer did not offer any condolences to the family. The officer said he could not remember doing so. When my investigators put to him that it might have been appropriate to say words to the effect, "I'm very sorry to hear of your son's death", he replied:

"When I was having the conversation over the telephone I wanted to portray that, I didn't want to portray sympathy that wasn't genuine and it was genuine. But I wanted my sympathy to be related to me wanting to see him as soon as I could, to being available at any time, which I told him I was and to let him know that I was trying to work as hard as possible and I was trying to work as quickly as possible with regard to getting his son's effects back to him.

"So I'd been in touch with various parties, the Coroner etc. In my mind I was trying to be empathic via those avenues, that I was working on your behalf, that I was really trying to do the best I can to try and resolve it. I wouldn't like to comment on my reasons. I feel, looking back now, that's what I was trying to achieve."

328. The man's father claimed that the officer "stalled, paused and stammered his way through the call". The officer told my investigators he was not aware that he did so. He said:

"I was aware that I felt very emotional and I was very aware of his emotions and I felt as though I was trying to be as impassive as possible and I was truly feeling the sadness of the whole situation."

329. The man's father claimed that during the telephone call, he told the officer he wanted to meet with a named member of staff but that the officer did not know who he was. The officer told my investigators he did not know straightaway, but by the end of the call he realised the member of staff concerned was the duty governor who had originally gone to meet the family at the hospital to which the man had been taken. When asked whether he was aware of this before he made the call to the man's father at 4.00pm, the officer said he was either told this by the SO or had read it in the FLO log.

330. My investigators checked the log and could find no reference to the duty governor prior to the officer's appointment as FLO. The log contains four entries made by the officer on 26 August, timed as follows:

1.55pm – telephone call made to the Coroner's officer
2.05pm – telephone call to the man's father
4.25pm – telephone call to the Coroner's officer

4.30pm – telephone call to the man’s father

331. The man’s father said that, in relation to his request for a meeting with the duty governor, the officer said, “I suppose this week would be nice?” The officer told my investigators he could not remember saying that and believed he would not have said it. When my investigators put to him that such a remark would probably have sounded flippant over the phone, he said:
- “It would depend on which way it was said. But I can’t remember. What I do remember saying is that ‘I want to meet you face to face as soon as possible’ and the Thursday we were talking in the morning, I was on a late shift and I was willing to come in my own time to meet him. That’s what I do remember.”
332. The man’s father said that the officer mentioned how busy he was and how his head “was all over the place”. The officer replied that he could not remember using that expression but could remember saying he was very busy and working on his (i.e. the man’s father’s) behalf.
333. The man’s father reported that when the officer said he was very busy, he – the man’s father- replied, “I feel really bad for you”. The officer said he could remember that being said and was surprised because he thought he was being sarcastic. The man’s father claimed that in response to this remark, the officer thanked him. The officer told my investigators he could not remember doing so.
334. The man’s father told my investigators that, at this stage, he activated the loudspeaker facility on his telephone so that a person who was in the room with him at the time could hear what was being said. He described this person as being “gobsmacked” by what he heard. The officer told my investigators he was not aware of that development and said he had no comments to make about it.
335. The officer told my investigators that at about 5.00pm that day, he was made aware of the fact that the man’s father had expressed his dissatisfaction with the manner in which he had expressed himself during the call and that, as a result, his role as FLO was terminated. When asked whether he would conduct himself differently if he had to perform the FLO task again, he said, “I feel I would have done. I feel as though I would have concentrated less on the fact gathering and more on the emotional.”

Conclusions

336. While I understand the pressure of the unfamiliar situation in which the officer found himself, it is very disappointing that this initial contact with the family went so badly. My investigators found that the two other FLOs – two Senior Officers - performed their role professionally, competently and, I believe, to the satisfaction of the family.

Recommendation 18

The Governor should consider the merits of requiring newly trained Family Liaison Officers (FLO) to shadow an experienced FLO prior to being given sole responsibility in that role for a family whose relative has died in custody.

The difficulties and delay in contacting the duty governor after the man had been found hanging

337. Governors are required to have in place contingency plans for the management of serious incidents that may occur by day or night. The plans must include arrangements for contacting senior managers as quickly as possible. Each prison has a duty governor rota system under which, in the event of a serious incident, a senior manager becomes the first point of contact for staff. The duty governor is responsible for ensuring that the contingency plans for the particular incident are fully and properly enacted. Details of contact numbers for duty governors and other senior managers should be available in the control room (or command centre) in each prison.
338. During the period Friday 22 August – Monday 25 August 2008, a deputy Governor was effectively in charge of High Down in lieu of the Governor, who was on leave. He was the nominated duty governor but another governor agreed to fulfil the responsibilities of duty governor in his stead.
339. The investigation found that staff in the control room were not aware that they had exchanged duties. At 2.18 am, eight minutes after the man had been found hanging, they telephoned the supposed duty governor's number and gained no response. They then systematically tried to contact the other senior managers on their list, again without success. At 3.40am, one and a half hours after the man had been found hanging, the night orderly officer managed to contact a senior manager who was not on call and told her that the man had been found hanging and had been taken to hospital. She was unable to drive to the prison. (In fact there was no requirement for her to do so as she was not on call.) Instead, she gave advice to the orderly officer as to what should be done.
340. At 4.07am, nearly two hours after the man was found hanging, the control room staff managed to contact the duty governor after at least one unsuccessful attempt.
341. During the course of the investigation, my investigators visited the control room and examined the quality of its organisation and the systems in place for the prompt and effective management of an emergency. My investigators also interviewed one of the Operational Support Grades on duty in the control room during the night of the incident.
342. The examination of the control room left my investigators with concerns about its efficiency. It was untidy and lacked organisation. A white board fixed to a wall in the room seemed to have been used to display information useful in an incident such as the contact numbers of senior managers. On the day of the examination it bore the wrong date. The board was positioned behind the control room staff so that they had to swivel their chairs to be able to view its contents.

343. My investigators also noticed that a number of folders were stored in an open cabinet near the point where the control room staff normally sat. Each of the folders contained separate contingency plans for different types of emergency. However, none of the folders was labelled. Thus, control room staff were unlikely to be able quickly to extract the correct folder for the particular emergency facing them.
344. My investigators were told that one such folder contained contact numbers. The responses given to my investigators during interviews suggested that some of the telephone numbers recorded in the control room folder may have been incorrect. The Operational Support Grade was unable to confirm that. She also told my investigators that training exercises in the management of serious incidents, which involved control room staff, were rarely carried out at High Down.

Conclusions

345. On the day of examination, the control room was untidy. There was no sense of ownership of the room. The effectiveness of its function as a key 'command centre' of the prison was impaired by its disorganisation.

Recommendation 19

The Governor should ensure that systems are in place in the control room for the recording and display of accurate and up to date contact details for all senior staff and that contingency planning exercises test this.

Recommendation 20

The Governor should consider the merits of including amongst the responsibilities of the duty governor that of visiting the control room every day in order to check the accuracy of the information recorded as well as its tidiness and organisation.

The consequent delay in informing the man's parents of his condition and admission to Epsom General Hospital

346. It fell to the duty governor to take responsibility for informing the man's parents that he had been found hanging and that he had been admitted to hospital. He did not do so until 6.40am that morning. He told my investigators that as soon as he had been contacted by the control room at 4.07am, he first called the deputy governor to brief him on events and then left for the prison, arriving at 5.50am. There was a further delay of 50 minutes before he called the family.
347. At interview, he explained that he spoke to the man's father and said that his son had been found hanging and was in a critical condition in the intensive care unit at hospital. He agreed to meet the family at the hospital. When asked whether the father said anything about how he would get to the hospital, or not wanting to drive because of his distress, he said he did not. In other investigations, I have found that prisons have offered to arrange taxis.

It might therefore have been appropriate for him to have offered to organise a taxi to take the father to the hospital at public expense.

Recommendation 21

The Governor should ensure that in any circumstances which lead to a prisoner's emergency admission in hospital, every effort is made to assist the prisoner's family to visit him. If necessary, the prison should consider providing a taxi for this purpose, paid for at public expense.

348. At interview, the duty governor said, "The only thing that I would say I would have done sooner, had I been contacted earlier, was notify the next of kin." He explained that the delay of about 55 minutes between arriving at the prison and telephoning the parents was because he was concerned to gather up to date information about events before making the call. He telephoned the hospital in order to get a briefing on the man's condition. He had difficulty getting through to the ward and only found out about his condition when he was telephoned by a police officer who was in attendance. He said he had no difficulty in ascertaining the parents' contact details.

Conclusions

349. I judge as unacceptable the two hour delay incurred by the confusion in the control room as to who was the duty governor and by the fact that contact details of some of the senior managers were inaccurate. This had the most unfortunate effect of incurring an equally unacceptable delay in informing the man's parents of his condition. I believe that the time taken by the duty governor to gather sufficient information before calling the family was reasonable in the circumstances. However, the combined effect of both these delays was the source of much pain for the family. This situation must not be allowed to recur.

Recommendation 22

The Governor should review his contingency plans for the management of a life threatening emergency involving a prisoner in order to ensure that arrangements are in place for informing the next of kin as a matter of extreme urgency.

The conduct of the staff from High Down who attended the hospital

350. The man's father told my family liaison officer he was concerned about the manner in which the staff who attended the hospital conducted themselves. He claimed the governors and officers "all stood together in a circle, huddled together". He said they were all holding different folders and he thought they were checking their notes and "getting their stories straight". He also questioned whether the SO felt uncomfortable about her attendance at the hospital in uniform.

351. In this connection, my investigators interviewed the duty governor and the SO, both of whom attended the hospital. In response to the father's comments, the duty governor said:

“There is no story to join really. We were really there for support. I was aware that it’s a very personal time for the family. I felt particularly as we knew that the man was still alive for a certain period of time and I suppose I felt that I should be there for when he was declared dead if that were to happen and certainly it seemed as though he would be declared dead by the end of the night or by some stage in the morning. And I felt it would have been completely inappropriate for the family to be given that news and to find that there was no-one there from the prison.”

352. At her interview, the SO said:

“I’d said to the family, I’m going to be in here for as long as you want me to be. If you’ve got any questions, just come and approach me and I’ll see what I can do.”

353. When asked what time she left the hospital, she said:

“I’m going to say about half two, quarter to three or something. The man’s dad actually asked us to leave. He approached us after and asked if we were there because we had to be or because we were there for the family. We said well both really, we’ve done what we have to but we’re here in case any questions need answering and he said oh in that case I’d prefer it if you left so we said ok, fine.”

354. My investigators put to the SO the question raised by the man’s father about her wearing uniform at the hospital. In response, she said:

“I don’t recall feeling uncomfortable about being in uniform. My main concern at that time was to get there and offer support to the family. Whilst on duty in the prison it is standard practice for me to wear uniform as it was also for the two police officers at the hospital. Had there been a Family Liaison Officer on duty, they also would have in uniform unless they had come from home.”

355. At the consultation stage, the man’s parents repeated their concern about the presence of uniformed officers in the hospital before and after their son died. They thought that this might have had the effect of “exciting the curiosity” of other members of the public who were present in the vicinity. They also felt that it was wholly inappropriate for staff to stand close to their son’s bed. They considered that the staff behaved insensitively.

Conclusions

356. The parents’ concerns are entirely understandable. In such tragic and distressing circumstances, it is clearly incumbent on Prison Service staff to draw the right balance between maintaining security and showing appropriate courtesies and sensitivities to the prisoner, his family, the hospital authorities and other members of the public. The man presented no threat to security and so it was arguable that the number of Prison Service staff in the ward could have been reduced to an absolute minimum. I recognise that uniformed staff were a particular source of embarrassment and distress to them, however the option of wearing civilian clothes was not available to them.

357. I believe that the Governor of High Down will appreciate the value of the feedback the man's parents have given and will wish to consider what specific measures can be added to his contingency plans to minimise the level of distress that the presence of uniformed prison staff can unintentionally cause.

The level of support offered by the Governor and his representatives to the man's parents after his death

358. The Governor wrote a letter of condolence to the man's parents shortly after his death. The letter carried an incorrect spelling of the man's name. This was most unfortunate, especially in light of the circumstances that had led to the replacement of the officer as FLO. However, as soon as the Governor realised the mistake, he telephoned them to offer his apologies.

359. The Governor offered to pay the full costs of the man's cremation, which took place on 8 September 2008. A FLO attended on the Governor's behalf.

360. Two days later, the man's parents visited his cell and the Listener suite under arrangements made by the FLO. They also collected his belongings.

Conclusions

361. The unfortunate matter of the letter aside, I believe the Governor and the FLO offered the man's parents appropriate support after their son's death.

PRINCIPAL CONCLUSIONS

362. This report includes a number of critical observations on High Down. Some of my recommendations repeat those made in earlier reports.

Healthcare

363. The authors of the Clinical Review raise no significant criticisms of the manner in which the man's healthcare needs were managed, making the point that there were no specific concerns raised about his mental health until shortly before his death. There was no evidence that, at the time of his death, he was suffering from a depressive illness nor any other major disorder. (At the consultation stage, his parents drew attention to their underlying concerns about their son's mental state in relation to his previous disclosures that he had attempted suicide and committed acts of self-harm. They believe that these concerns, together with his diagnosis of ADHD and the absence of medication to treat it, his use of the Samaritans and Listeners Scheme, his account of loss of parents and partner, along with the resulting referral to the Mental Health In-reach Team, meant that he did present a raised risk of suicide at the time of his death.)

364. It is recognised that the man gave staff inconsistent and confusing information about his medical and psychiatric history in the early days of his sentence, but it should have been possible for his disclosures to be verified by reference to previous records. This systemic failure is too often revealed in the course of my investigations. I urge the National Offender Management Service to act upon the recommendations I and the clinical review team make in this regard.

365. The fact that the mental health in-reach team returned the man's referral form for correction, rather than acting upon it, is a matter of concern. Although I make no formal recommendation on this matter, I urge the mental health in-reach team to do all they can to protect against a repetition.

Management of the man's risk of self harm and suicide

366. Although I give credit to SO A for opening an ACCT form on 20 August, the first and only case review held the next day was not conducted by a multi-disciplinary panel in accordance with the provisions of PSO 2700. The recommendation I make about this matter was made by Her Majesty's Chief Inspector of Prisons in two successive inspection reports.

367. When the man asked to speak to a Listener and then to the Samaritans during the night, no consideration was given to the heightened risk of self harm or suicide he may have presented. This is contrary to the provisions of paragraph 31 of the local suicide prevention strategy.

368. OSG A seemed oblivious of the local orders for the conduct of pegging and timing of pegging. Instead of following laid down procedures, he carried out his checks in a predictable manner.

369. I am also critical of him in respect of the discrepancies between the timing of the entries he made in the man's ACCT ongoing record during the night and those shown on the CCTV footage.

The design and use of the Listener suite

370. Although I do not criticise the decision to allow the man to telephone the Samaritans from the Listener suite, the fact that the suite had been attributed the status of a multi-purpose room had the effect of eroding its importance as a facility for the care of at-risk prisoners. In my view, insufficient attention was paid to furnishing the room for that purpose in keeping with the provisions described in PSO 2700 for Time Out Rooms. The term Listener suite is not unique to High Down, but it is unhelpful as it does not tally with terminology used in the PSO.

The standard of record keeping

371. The investigation found several instances of poor record keeping by substance misuse nurses and by discipline staff. Perhaps the most significant example was that relating to the entry made by OSG A in the man's ACCT ongoing record at 2.00am, which proved to be grossly inaccurate (by 53 minutes). I have drawn attention to examples of poor record keeping High Down in earlier investigation reports.

Effectiveness of the response to the discovery of the man hanging

372. The review conducted by Back to Life Ltd on behalf of the local PCT concluded that the man was given swift and appropriate medical care. However, the incident reports were of a poor standard and provided limited accurate information. In particular, there were no time scales mentioned in the reports.

Bullying related behaviour

373. The investigation found evidence that there were five occasions when there may have been some form of bullying related behaviour in which the man may have been either an aggressor or a victim. On four out of five occasions, he refused to name the alleged bullies. This may explain why no investigations were carried out. The local violence reduction strategy seems to be a well constructed and effective statement of policy. Staff should be reminded of the importance of adhering to its provisions, as well as those of PSO 2750.

The actions of the officer in his role as family liaison officer

374. I have criticised the officer's initial contact with the man's father, and believe that the decision to terminate his appointment as FLO was entirely appropriate. My investigators found that the two other FLOs - Senior Officers - performed their role professionally, competently and, I believe, to the satisfaction of the family.

The difficulties and delay in contacting the duty governor after the man had been found hanging

375. Because staff on duty in the control room at High Down on the night of the incident were not aware that the role of duty governor had passed from one senior manager to another, there was a two hour delay in contacting the correct person after the man was found hanging, and a further delay in informing his parents. The combined effect of both these delays was the source of much pain for the family. Such a situation must not recur.
376. An examination of the control room found it to be untidy. There was no sense of ownership of the room. The effectiveness of its function as a key 'command centre' of the prison was impaired by its disorganisation.

The conduct of the staff from High Down who attended the hospital

377. I believe that the Governor of High Down will appreciate the value of the feedback the man's parents have given and will wish to consider what specific measures can be added to his contingency plans to minimise the level of distress that the presence of uniformed prison staff can unintentionally cause.

The level of support offered by the Governor and his representatives to the man's parents after his death

378. The Governor wrote a letter of condolence to the man's parents shortly after his death. Very unfortunately, the letter included a misspelling of his name.
379. With that exception, I believe the Governor and the FLO offered them appropriate support after their son's death.

LIST OF RECOMMENDATIONS

To the National Offender Management Service

1. There should be one unified health record within the prison and this should contain information from health and substance misuse teams. The same record should continue during a period of custody and be available at subsequent periods of custody. The National Offender Management Service should ensure that this record, as well as the core prison record relating to prisoners' previous periods of imprisonment, is available at, or very close to, the point of any subsequent admission to prison. Where the unified health record or core prison record is received after initial healthcare screening reports have been completed, the information in those reports should be verified against the details contained in the health and prison records. Staff should consider whether to take any action in response to any new information contained therein. Healthcare staff should request a copy of any medical records relating to the periods spent by prisoners in police custody and should ensure that all significant information contained therein is recorded in the prisoner's unified health record.

The National Offender Management Service has accepted this recommendation and said,

"NHS Connecting for Health has a programme team in place to facilitate the national IT programme. TPP, system one aims to be rolled out in England by 2010 (gateway reference 11812) and will ensure a unified health record."

The Primary Care Trust commented as follows:

"There is already one unified health record used by substance misuse and healthcare. Previous records are kept in an archive room but locating previous records is dependent upon the accuracy of the information provided by prisoners, e.g. name/alias. TPP System One, an electronic record, is being deployed in all Surrey prisons commencing from February 2010. This record will be based on NHS numbers rather than on prison numbers. Continuity of care should therefore be greatly improved."

2. The National Offender Management Service should ensure that judgements as to risk of self-harm or suicide take into account historical information in prisoners' records.

The National Offender Management Service has not accepted this recommendation. The following response was received:

"PSO 2700 already requires staff to take account of all available information when assessing the level of risk presented by a prisoner at risk of suicide or self harm. Chapter 4.16 sets out the requirements for checking for risk in

previous custody and Chapter 4.17 deals with other sources of risk information or assistance concerning prisoners. ACCT Case Manager training includes specific modules on estimating and managing immediate risk of suicide, which covers levels of risk, mental health awareness and substance misuse. Before (or of need be after) undertaking an ACCT assessment, the Assessor is asked to collect risk pertinent information from the core record, wing file and healthcare staff.”

To the Governor and Primary Care Trust

3. The Governor and PCT should ensure that all staff are aware of and follow the provisions of Annex 8G of PSO 2700 which clearly states that an ACCT form must be opened whenever a prisoner is found to have self-harmed.

This recommendation has been accepted. The following response was received from the Prison Service:

“Safer Custody have delivered refresher ACCT awareness training for healthcare/In-reach staff. Aide memoires are provided for all staff receiving ACCT awareness training. National trainers recently provided a workshop for case managers and assessors. They have been invited back in the near future. ACCT awareness training is scheduled for training mornings as part of the prison training plan. The provisions of annex 8G are part of ACCT awareness training.”

The PCT responded as follows:

“This is already current policy. Staff will be reminded at clinical supervision and team meetings. All healthcare staff attend foundation ACCT training and this is reported by safer custody at the bi-monthly clinical governance meetings.

4. The Governor and the PCT should remind their staff of the importance of completing a form F213 or, if necessary, a form F213SH, whenever a prisoner sustains an injury, no matter how minor.

This recommendation has been accepted. The following response was received from the Prison Service:

“The suicide prevention coordinator investigates all incidents in the prison and highlights where F213/SH have not been completed. The deficiencies are passed to the Unit manager for rectification. The results of the investigations are fed into the Senior Management Team and Safer Custody Meetings. This system of raising awareness has improved the completion rate for 213s. To back this up a Governor’s Information Notice will be published informing staff of the requirement to complete F213/SH. The suicide prevention policy (available on the intranet in all staff accessible areas of the prison) also highlights the requirement to complete F213/SH. A self-harm incident pack has been produced and once the new incident reporting form has been printed, will be available in all areas of the prison.”

The PCT responded as follows:

“This is already current policy. Staff will be reminded at clinical supervision and team meetings.”

To the Primary Care Trust

5. The PCT should instruct its substance misuse staff to make entries in prisoners’ clinical files whenever they see prisoners, especially in relation to detoxification issues and events.

This recommendation has been accepted. The PCT responded as follows:

“It is the duty of all staff to comply with the NMC Code of Conduct of record keeping. Regular training sessions in record keeping have been in place for a number of years. Considerable improvement has already taken place in record keeping on the stabilisation unit. Audits within the last 6 months have demonstrated improvement.”

6. Healthcare and CARATs staff must take appropriate action in response to information received relating to prisoners’ healthcare needs or ongoing health conditions. In addition, whenever a prisoner discloses details of medication they were receiving in the community or the name of their GP, such information must be communicated to healthcare staff who must take steps to verify that information as soon as possible. Such steps are necessary to ensure that provided with continuity of care.

To the Governor

7. The Governor should, in keeping with the provisions of PSO 1025, ensure systems are in place to guarantee that PERS are always seen and studied by reception staff, and that comments in PERs as to risk are taken into account by staff when judging how best to care for and support individual prisoners. Managers should carry out regular compliance checks.

No response was received in relation to this recommendation.

8. The Governor should ensure that Reception staff are aware of the provisions of PSO 2700, especial in relation to the use and handling of Prisoner Escort Records (paragraphs 4.3 and 4.4 of that Order refer).

The Governor should ensure that ACCT case reviews are conducted by multi-disciplinary panels in keeping with the provisions of Annex 8G of PSO 2700.

This recommendation has been partially accepted. The following response was received:

“Every effort is made by the case managers to ensure that reviews are multi-disciplinary. This is not always achievable due to the size of the prison. If unable to attend, interested parties are invited to submit a written or emailed report. If required, the review will be adjourned for the staff to be phoned for further input.”

9. The Governor should remind his staff that, whenever a prisoner self-harms, the next of kin should be informed in keeping with the provisions of Chapter 13 of PSO 2700. The Governor should also remind his staff of the importance of ensuring that key information provided by the next of kin, especially that which may relate to a prisoner's physical or mental health, should be recorded in the prisoner's ACCT record if one has been opened and shared with healthcare staff as soon as possible.

This recommendation has been partially accepted. The following response was received:

"PSO 2700, chapter 13.3.3 states that next of kin should be informed unless the prisoner does not give consent or the caremap indicates otherwise. We will produce a form to be included within the ACCT document where a prisoner indicates his wishes."

10. The Governor should remind his staff of the need to rub-down search any prisoner allowed to leave his cell at night unless, in the particular circumstances they face, it would be inappropriate to do so.

This recommendation has been accepted. The following response was received:

"Staff currently adopt this approach. However, this is not reflected in the Local Security Strategy (LSS) or night orders. The Security manager is reviewing the LSS and this guidance will be included. The night orders will be amended accordingly. In the interim, the Head of Safer Custody will inform all night managers."

11. The Governor should remind his staff of the importance of adhering to the provisions of paragraph 31 of his local suicide prevention strategy which requires them to be alert to the possible heightened risk to a prisoner when he asks to use the Samaritan's telephone.

This recommendation has been accepted. The following response was received:

"We are unsure of the reference to paragraph or page 31. There is no reference to a heightened risk when asking for the Samaritans' phone. There is however a need to include this in the policy which will be updated."

12. The Governor should ensure that the full provisions of his Local Operating Procedure for night procedures are both known and complied with by all those staff who are likely to be on duty in the prison by night. Special emphasis should be placed on pegging procedures.

This recommendation has been accepted. The following response was received:

"Night staff sign for a copy of their night orders at the commencement of their shift. The Night Orderly Officer ensures compliance."

13. The Governor should remind his staff of the importance of ensuring that checks of prisoners – especially those considered to be at risk of self-harm or suicide – are not carried out on a predictable basis.

This recommendation has been accepted. The following response was received:

“This will now be included in case manager training and in the Suicide Prevention policy.”

14. In conjunction with Prison Service Headquarters, the Governor should consider the merits of re-designating all Listener suites as Time Out Rooms.

This recommendation has not been accepted. The following response was received:

“The Governor can designate his cells in whatever way he wishes and does not need the agreement of Safer Custody and Offender Policy Group or Prison Service Headquarters.”

15. The Governor should ensure that clear instructions for monitoring prisoners whilst they are in a Time Out Room are included in his local Suicide Prevention Procedural policy. This is especially important where prisoners subject to ACCT procedures are concerned.

This recommendation has not been accepted. The following response was received:

“High Down does not have Time Out rooms. The problem with the Samaritans phone signal/reception has been rectified by the installation of boosters. Prisoners do not now have to use a listening room to call the Samaritans. The room is only used when Listeners are present.”

16. The Governor should remind staff of the importance of ensuring that contemporaneous, accurate and legible entries are made in prisoners’ core files, especially in ACCT forms. Appropriate training should be available to those staff who may require it.

This recommendation has been accepted. The following response was received:

“Safer Custody team conduct ACCT management checks daily. Any deficiencies are highlighted to Unit managers for rectification. The findings are fed into the SMT and Safer Custody meetings for analysis and action. Houseblock managers also carry out quality checks of entries. This is also emphasised during refresher training.”

17. The Governor should consider the merits of requiring newly trained Family Liaison Officers (FLO) to shadow an experienced FLO prior to being given sole responsibility in that role for a family whose relative has died in custody.

18. The Governor should ensure that systems are in place in the control room for the recording and display of accurate and up to date contact details for all senior staff and that contingency planning exercises test this.

This recommendation has been accepted. The following response was received:

“Nothing currently in place. Every quarter commencing April, the Governor’s secretary will request current contact details for all senior staff, including pager numbers. This contact list will be shared with the control room. Security Governor to test contacting senior staff.”

19. The Governor should consider the merits of including amongst the responsibilities of the duty governor that of visiting the control room every day in order to check the accuracy of the information recorded as well as its tidiness and organisation.

In rejecting this recommendation, the prison explained that the responsibility for visiting the control room each day rests with the Security manager.

20. The Governor should ensure that in any circumstances which lead to a prisoner’s emergency admission in hospital, every effort is made to assist the prisoner’s family to visit him. If necessary, the prison should consider providing a taxi for this purpose, paid for at public expense.

This recommendation has been partially accepted. The following response was received:

“There is no requirement for the prison to provide transport for families to visit prisoners in hospital. If it is believed that the prisoner could die, or the family would find it difficult to attend the hospital, then the Duty Governor may offer assistance.”

21. The Governor should review his contingency plans for the management of a life threatening emergency involving a prisoner in order to ensure that arrangements are in place for informing the next of kin as a matter of extreme urgency.

This recommendation has been accepted. The following response was received:

“Contingency planning has already been set for 2010 to 2011. However, the Death in Custody contingency plan and Local Operating Procedure will be reviewed and updated.”

Recommendations made by the spokesperson of Back to Life as part of the clinical review

(The response from the PCT is shown below each recommendation)

- A full audit of resuscitation equipment, including the review of access to different levels of emergency equipment should be undertaken.

“Accepted. Surrey Ambulance Service recommended our resuscitation equipment and advice on updates of equipment. We will request they review our equipment again.”

- An accurate database containing records of all emergency (first aid) training given to personnel on site should be maintained.

No response was received for this recommendation.

- All personnel should attend basic life support training including prison specific scenarios.

“Accepted. All NHS staff attend basic life support as part of PCT induction. Annual updates are carried out as part of mandatory training schedule which is linked to KSF appraisal and Personal Development Plans.”

- In accordance with HM Prison Service’s recommendations, ensure that POELT (Prison Officer Entry Level Training) courses not only include basic life support training but also a suicide scenario such as hanging.

No response was received for this recommendation.

- In accordance with the Department of Health’s publication ‘Toolkit for Health Care Needs Assessment in Prisons’ carry out a risk assessment to identify the level and number of people requiring specific training. Ensure an appropriate number of Prison Officers have first aid training.

“Accepted with regard healthcare staff. The NHS is not responsible for first aid training for all officers. The Prison Service has its own training department. Basic life support and defibrillator training is provided for officers working in healthcare permanently or on the stabilisation unit in conjunction with the training for healthcare staff.”

- In accordance with the NHS Knowledge and Skills framework, ensure all qualified nursing staff can respond appropriately to emergency situations.

“Accepted. Each member of staff has KSF appraisal and a Personal Development Plan.”

- In accordance with the Department of Health’s publication ‘An Education and Training Framework for Staff Providing Health Care in Prisons, dated October 2005’, there should be Emergency Response Officers from either Prison Health Care workers or Prison Officers who should be trained to UK Resuscitation Council Immediate Life Support (ILS) standard or equivalent. This framework also makes reference to Basic Life Support training in POELT.

“Accepted. Hotel 2, which is the most senior nurse on duty, is emergency responder per shift. They coordinate the shift and respond to emergencies. If there happens to be more than one emergency at the same time, Hotel 2 will ask Comms via radio, to contact Hotel 1, the lead nurse in the inpatient department, to attend the second emergency.

“All staff are trained in basic life support.”

- In accordance with the latest guidance from ‘National Health Service Litigation Authority (NHSLA) advice for Mental Health, May 2009’ it is advised not only for ILS training of appropriate staff in high risk areas but also regular emergency drills to take place to practice scenarios and adequately prepare scenarios and adequately prepare staff for such emergencies.

“Accepted. The guidance which is based on the National Patient Safety Agency (NPSA) Rapid Response Report 2008/RRR010 states that training includes regular practices where feasible. There is a programme in place to learn from emergencies that happen on a daily basis in a local prison.”

- There should be training and education in how to document the events of a serious incident on an incident statement form.