

**Investigation into the circumstances surrounding the death of
a man at HMP Wakefield in December 2006**

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

January 2008

This is the report of an investigation into the death of a man at HMP Wakefield in December 2006. He was found hanging in his cell. He was 52 years of age and serving an indeterminate sentence for public protection.

My colleagues and I offer sincere condolences to the man's family and friends for their sad loss.

This investigation has been undertaken by my colleague. I would like to thank the Governor of HMP Wakefield and his staff for their participation. Particular thanks go to the Deputy Head of Offender Management.

A clinical reviewer undertook a review of the man's clinical care on behalf of the local Primary Care Trust (PCT). I also greatly appreciate his assistance.

The investigation was suspended until the beginning of April 2007 at the request of the police as their enquiries continued until that date.

It is clear from this report that the man struggled to come to terms with his offence (which was against his two daughters), and with his sentence, and was vulnerable. This vulnerability was identified initially by the Magistrates' Court when he first appeared in court in September 2005, and later at HMP Nottingham when he was placed on suicide and self harm monitoring and support procedures. However, there is no evidence that he confided in staff at Wakefield that he had any intention to harm himself. Although he illustrated a number of risk factors, I do not think the circumstances were such that staff could reasonably have predicted that he would attempt to take his own life.

The clinical review has raised some matters of concern. I am particularly surprised to learn that the man did not have a mental health assessment when he arrived at Wakefield, despite meeting the relevant criteria. I am also concerned that he complained of being bullied at Wakefield but the protocol for dealing with it was not followed in his case. I make three recommendations.

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

Stephen Shaw CBE
Prisons and Probation Ombudsman

December 2007

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SUMMARY

Following an appearance at Magistrates' Court on 7 September 2005, the man was detained in custody at HMP Nottingham. He was charged with the attempted murder of his two young daughters and had also tried to take his own life. He was placed on suicide and self harm monitoring and support procedures at Magistrates' Court. He said he had suicidal thoughts and had self-harmed in the past. On reception as a remand prisoner at HMP Nottingham, he was placed on an ACCT (Assessment, Care in Custody and Teamwork) form. (ACCT is the system used by HM Prison Service to monitor and support a person at risk of suicide or self-harm.) He was located in a safer cell in the healthcare centre on constant observation. (Constant observation is where the prisoner is observed by a designated member of staff who remains constantly in his or her presence.) The ACCT was closed on 5 October 2005 following improvement in his overall mood.

The man appeared at Crown Court on 19 December and was placed on an ACCT on his return to Nottingham as he appeared low in mood. He was given vulnerable prisoner status under prison Rule 45 on 23 December and he was appropriately located. He was concerned about contact with his wife and daughters. He was initially allowed to have contact with his wife but he was not permitted to have any contact with his daughters either by letter or telephone. On 17 January 2006, Social Services met with his wife. Following that meeting, he was told that he could receive letters from his daughters but could not send them letters, telephone them or have visits from them.

On 30 January, the man appeared at Crown Court and was given an indeterminate sentence of imprisonment for public protection (IPP). The minimum period he had to serve was five years before becoming eligible for parole. The sentence of imprisonment (or detention) for public protection (IPP) applies to offenders who are convicted of a serious offence (that is a specified sexual or violent offence carrying a maximum penalty of ten years imprisonment or more) and who are considered by the court to pose a "significant risk to members of the public of serious harm." The Parole Board makes a decision on release based on a demonstration of reduced risk. It is clear that he did not understand his sentence and was convinced that he would have to serve a full ten years, despite several members of staff attempting to explain his sentence to him.

On 6 February, the man was told he could not have any contact with his wife as she had apparently let their daughters talk to him during a telephone conversation with her. The ACCT which had been opened on 19 December was closed on 19 February 2006 as there were no current concerns. On 23 March, however, he was placed on an ACCT again as his cellmate was concerned that he was low in mood. He assured staff he did not need to be monitored and the ACCT was closed the next day.

On 28 June 2006, the man was transferred to HMP Wakefield. He was described by staff as being quiet and reserved. The prison was aware that he had been monitored under ACCT in Nottingham but he was not placed on an

ACCT at Wakefield. He started work in the kitchen on 14 August and appeared a lot more settled at that time.

On 19 August, Officer A completed a Security Information report (SIR) following a complaint that the man was being bullied by another prisoner. The officer spoke to him who confirmed that there had been problems. There is a note in the SIR that the wing manager, the SO, should give the other prisoner a verbal warning about his behaviour but he was not placed on anti-bullying procedures. The man did not approach staff again about this issue. He remained quiet and introverted.

The man did not have any other apparent concerns until 17 December when he spoke to his sister-in-law on the telephone. He told her that he had had an argument in the kitchen, and that he was worried about something, but he did not elaborate. He told his sister-in-law that he was going to stand up for himself. He said he was 'down' but did not threaten suicide.

The next afternoon the man was found hanging in his cell. Cardiopulmonary resuscitation (CPR) was attempted by staff but he was pronounced dead shortly thereafter.

THE INVESTIGATION PROCESS

1. My investigator studied all relevant prison records relating to the man. These included his main prison record, medical record and statements made by prison staff.
2. A clinical reviewer was asked to carry out a review of the man's clinical care. I am grateful for this review being undertaken in a timely manner. My investigator contacted Her Majesty's Coroner to inform him of the nature and scope of my investigation, and to request a copy of the Post Mortem report. Upon completion, this report will be sent to the Coroner to assist in his enquiries into the death.
3. The investigator and one of my Family Liaison Officers met with the man's wife. She raised a number of matters which are addressed in paragraph 49 below under 'family concerns'. I hope this report helps his family better understand what happened in the time leading up to his death.
4. My investigator discussed aspects of the man's treatment with staff at Wakefield and with the clinical reviewer. (Notices were issued to staff and prisoners telling them of the investigation and offering them the opportunity of contributing). During the course of the investigation 13 members of staff were interviewed. My investigator spoke too with the police in relation to their investigation. She also met with seven prisoners.
5. My investigation was suspended until the beginning of April 2007 at the request of the police as their enquiries were ongoing until that date. This was in line with my Memorandum of Understanding with the Association of Chief Police Officers (ACPO).

HMP WAKEFIELD

6. There has been a prison on the site of HMP Wakefield since 1595. In its current form, the prison dates back to 1845. All the cells are single occupancy and have integral sanitation, and the prison has recently undergone further refurbishment. The prison's healthcare centre is separate from the main residential areas.
7. Wakefield is a prison for men serving four years or over (including many life sentence prisoners) and forms part of the high security estate. It holds prisoners who potentially pose the greatest risk to the public.
8. The prison provides workshops and an education department offering both full and part time education. The programmes department offers a range of offending behaviour courses including FOCUS (drug programme), Sex Offender Treatment Programme (SOTP) and the Enhanced Thinking Skills (ETS) programme.
9. The most recent inspection by HM Chief Inspector of Prisons was in April 2005. Her report says:

“Our last inspection of Wakefield, eighteen months ago, reported significant concerns about the staff culture, and the access to activities at this high security prison. We described a lack of staff engagement with prisoners, an over-controlled atmosphere, and allegations of bullying and intimidation, particularly from older prisoners and in the segregation unit. We also noted that there was very little activity for prisoners: apart from the excellent offending behaviour courses. The inspection records some progress in relation to the prison's culture. A new governor and senior managers were making considerable efforts to move the prison forward. Managers were seeking to ensure that staff engaged more with prisoners on the wings. Suicide prevention and anti-bullying policies were improving. However, we still found far too many staff in offices while prisoners were out of their cells, an ineffective personal officer scheme and little support on the wings for prisoners involved in offending behaviour. Overall, Wakefield was clearly a prison on the move. But there was a great deal of movement still required in order to make it a fully effective prison, able to engage properly with the serious and difficult offenders that it holds.”

KEY EVENTS

10. On 7 September 2005, the man appeared at Magistrates' Court and was remanded in custody to HMP Nottingham. He was charged with two counts of attempted murder. He had been placed on suicide and self harm monitoring and support procedures at Magistrates' Court and that information was passed onto the prison via the Prisoner Escort Record (PER). He was interviewed in reception by a member of healthcare and said he had no drug or alcohol problems. He said he felt suicidal and had self-harmed in the past. He was described as being uncommunicative, quiet and withdrawn during the interview. The man was placed on an ACCT and was located in a safer cell in the healthcare centre on constant observation by staff. He was referred to the Mental Health Inreach Team (MHIRT) on 8 September. On 9 September, he was assessed by a Forensic Community Psychiatric Nurse (CPN). During that assessment, he was adamant he wanted to kill himself and admitted cutting his wrists as a teenager.
11. The man was still in the healthcare centre on 10 September and was refusing food and fluids. On 12 September, it was noted that he was more communicative and was eating. He was taken off constant observation. On 5 October, the ACCT was closed as he appeared to be a lot more settled. He had been transferred from the healthcare centre to B wing on 28 September.
12. On 1 December 2005, the man had a psychiatric assessment with a psychiatrist. The clinical reviewer notes:

“This detailed assessment identified that the man was able to give a clear account of himself with no evidence of any formal thought disorder or cognitive problem. He had full insight. It was noted that he had some ongoing suicidal ideation but no active planning or intent. The psychiatrist identified that there was no requirement for a psychiatric disposal. He identified that it was particularly important around the time of his trial to monitor regarding self harm and he should be reviewed by prison medical staff and the forensic inreach service. The psychiatrist did not believe that he was suffering a clinical depressive illness but that the need for psychotropic medication should be kept under review. In this interview he denied any previous self harm behaviour. Subsequent to this assessment he continued to be closely monitored in Nottingham.”
13. On 19 December, the man appeared at Crown Court. He returned to HMP Nottingham, and was remanded for sentencing on 30 January 2006. An ACCT was opened due to concerns on his return from court. He was very quiet and made little eye contact with staff. He was also worried that he would not be allowed to see his children.

14. On 20 December, an officer spoke to a probation officer about the man. She said that he had been authorised to contact his wife via her mobile telephone number, but he had told the officer that the number was inactive. The officer undertook to take the matter up with the PIN phone clerk. On 22 December, he was assaulted in his cell by another prisoner. He completed an application for vulnerable prisoner status on prison Rule 45. In the meantime (on 23 December 2005), he was located in the segregation unit for his own protection while he waited to be located on E4, the vulnerable prisoners' wing. On 29 December, he was located in cell E4-16 on Rule 45.
15. On 6 January 2006, the man was told by Social Services that he could not have contact with his children, either by telephone or by letter. On 10 January, his wife met with Social Services about his contact with their children.
16. On 17 January, the man was told by a Public Protection Coordinator that he could receive letters from his children but could not send letters, talk to his children or have visits from them. She noted that he seemed angry about that.
17. On 30 January, the man appeared at Crown Court and was given an indeterminate sentence for public protection (IPP). The minimum period he had to serve before becoming eligible for parole was five years.
18. The man was still on an ACCT but refused any healthcare interventions, including the anti-depressants prescribed for him. Another prisoner told staff that he was threatening to kill himself with a razor. His cell was searched but no blade was found. He told staff that he would not kill himself as he had his wife and children to think about.
19. On 6 February, the man had a visit from a probation officer who confirmed that he could no longer phone his wife as she had allegedly let him speak with his children during a telephone call with her. Her number was taken off his PIN account and was not to be reactivated. He was also told that his mail would now be monitored.
20. On 10 February, the man had an ACCT review. He said he was shocked at his tariff and was upset at not having access to his children, but there were indications that his wife would be supportive. On 19 February, the ACCT was closed. He was said to be more positive and going to work.
21. On 23 March, another ACCT was opened. His cellmate had told staff that he was low in mood. When he was interviewed he said he felt he could cope without extra support. The ACCT was closed the next day.
22. The man was transferred to Wakefield on 28 June 2006. He was seen by a nurse for the purpose of completing the First Reception Health Screen. (The form is used to gather medical information from the prisoner about his physical and mental health.)

23. The nurse noted that the man had been on an ACCT while in Nottingham and had declined medication for his mental health during that time. She described him as quiet and on the verge of tears. However, he said that he was alright, denied any suicidal intention and added that he did not need any medical input. She has noted in his continuous medical record that her assessment took place. Her entry is dated but not timed. He also had an assessment by the GP on duty. The doctor wrote that the man did not have a history of self harm or suicide. His blood pressure was on the high side of normal and the doctor identified the need to check his blood pressure in three weeks. She recommended that his mood should be observed. The assessment did not say who was to monitor his mood and there is no evidence that his blood pressure was in fact checked. The doctor's assessment is not timed or dated and she has not recorded in the continuous medical record that the assessment took place.
24. On the same day, an officer introduced himself as the man's personal officer. The man seemed a little nervous, but the officer reassured him that if he had any problems he could talk to staff. He told the officer that he wanted to start work as soon as possible. The officer explained to him that he would have to do induction first and he could then apply for a job.
25. On 2 July, another officer spoke to the man as his second personal officer. (A second personal officer covers when a prisoner's main personal officer is not on duty.) The first personal officer was on 18 days leave. The second personal officer noted that the man was very tearful about his offence and was worried about his wife. On 11 July, a probation officer seconded to work at the prison, spoke to the man as part of an induction interview. She told my investigator that he was emotional about his offence but assured her that he had no thoughts of suicide or self harm. He was concerned about engaging in group work as he felt more confident in a one to one situation. He told her that his wife was supportive and said his children wanted to have contact with him. She said that she encouraged him to break his sentence down into smaller parts to make it easier to cope with.
26. On 18 July, the first personal officer returned after his leave and the man told him he was fine and was just keeping himself to himself. On 1 August, the officer noted that the man was frustrated at not being able to work. (He started work in the kitchen on 14 August following the officer's intervention.) He was allocated another personal officer for the time he worked in the kitchen. The first officer was still his personal officer on the wing.
27. Officer A told my investigator that on 19 August, a prisoner spoke to him about another prisoner, Mr A, whom the prisoner said was pestering the man. The prisoner said to Officer A, "You need to do something about that predator." The officer spoke to the man and asked him whether he was having any problems with Mr A. The man told him he was a bit scared about showering when Mr A was around but did not want to talk

about it. The officer told my investigator that the man would not shower because of Mr A. The man told Officer A that Mr A had been telling him to shower with him and following him into the shower, saying that it was for his (the man's) own safety. The officer brought the issue up in a meeting and made a note of it in the wing observation book. He then observed Mr A. He told the man that if he had any problems he should let him know. He completed a security information report (SIR) about the matter and told my investigator that the man never approached him again about the issue. The SIR noted that the man complained about issues with Mr A. The outcome was that the wing manager, the SO, was to make Mr A aware, by way of a verbal warning, that his behaviour towards other prisoners was not acceptable. There is a note in the SIR by a member of the security department that the issue was raised at the residential (wing) meeting on 21 August and the wing manager (the SO) was aware of the issue. A Security Governor recommended that Mr A should possibly be placed on a behavioural compact but that did not happen.

28. On 20 August, the first personal officer noted that the man was feeling a bit low, although he told the officer that he would not do anything stupid. The officer recalled that he had been unable to speak to his wife which was getting him down. The man felt that he would never get out of prison. The officer told him to keep strong for his wife and children, and if he wanted to talk he could find him.
29. On 8 September, the first personal officer noted that the man was still quiet and reserved, and only associated with a couple of other prisoners on the wing. The officer further noted, on 21 September, that he was still feeling unsure how long his sentence would be and if he would ever get out of prison. He reassured him that if he did all he should he would not have to worry.
30. On 27 September, a chartered forensic psychologist saw the man about his Risk Assessment and Management (RAM) board report. (The purpose of RAM boards is to set individuals work and targets to address their offending behaviour.) She recalled that he did not find discussing his offending behaviour easy. She said he was cooperative but was tearful and upset throughout the interview. He said he regularly had thoughts of harming himself. She asked him if he was going to harm himself. He denied any such thought as he said his wife and family were standing by him. She noted that she would have concerns if that support ended. She explained to my investigator that RAM boards are usually chaired by the Principal Officer (PO) from the wing, and attended by another wing representative, normally the prisoner's personal officer, a representative from the Offender Management Unit, a member of the National Probation Directorate (a probation officer) working in the prison, and possibly an external member of the National Probation Directorate. She prepared a report about the man for the RAM board.
31. On 5 October, the man attended his RAM board and Officer B took the minutes of that meeting. She recalled that an external representative from

the National Probation Directorate attended, as well as the probation officer. It was recognised at that meeting that his physical and mental wellbeing would suffer if he lost the support of his wife and family. It was also apparent that he did not fully understand his sentence as an IPP prisoner. The record of the meeting states that the chair of the board clarified the position regarding his sentence.

32. On 23 October 2006, the probation officer wrote in the man's history sheet after she had received his post sentence report on 20 October. She noted that it said he would benefit from being monitored for low mood as he could be at risk of self harm. She concluded that the risk would be particularly high if his wife ended the relationship. There were no current concerns about self harm but she recommended that he should be watched for changes in mood.
33. On 8 November, the first personal officer noted that the man was worried about a letter that he thought had been sent to his wife by somebody from the National Probation Directorate. Allegedly, the letter said that he had no regrets over his crime. He felt he would never get out of prison if such things were being written by people who had never spoken to him. The officer told him that he should not worry as he had not completed any offending behaviour programme courses. He explained to him that his progress on such courses would ultimately help to determine his sentence plan. He told the officer that he would try not to worry so much.
34. On 21 November, the man had an Incentives and Earned Privileges (IEP) Board, and he remained on the highest level (enhanced). On 24 November, the first personal officer noted in the man's history sheet that he was working nights and would be on leave for three weeks after that so would not be able to make any entries in the history sheet.
35. On 17 December, the man telephoned his sister-in-law at 11.23am and 4.16pm. He told her he had had an argument in the kitchen with another prisoner and he was worried about something but he did not elaborate. He told her there could have been trouble but he had stood up for himself and just walked away. He said he was 'down' but did not threaten suicide. He told his sister-in-law he would try to call her during the coming week or the next weekend.

EVENTS ON 18 DECEMBER 2006

36. The man attended work in the kitchen as usual in the morning of 18 December. At around 11.20am, he was back on the wing and was seen by Officer C making a phone call before being locked in his cell around 11.45am. Prison records show that he made a telephone call to his sister-in-law but he did not get through. At around 1.20pm, two officers unlocked cells on C Wing, 3's landing, for movement to work, education, and other regime activities. Officer D unlocked the man's cell, C3-25, but did not open the door. Immediately after unlocking the cell, she left the wing to continue other duties elsewhere. At around 1.35pm, Officer E and Officer C started locking prisoners up on the 3's landing after movement. Shortly after, Officer C arrived at the man's cell and opened the cell door. He found him suspended from the window bars by a ligature made from a torn bed sheet.
37. Officer C shouted for assistance from Officer E. Officer C supported the man's body while Officer E left the cell to fetch something sharp to cut the ligature. At around 1.40pm, Officer E made an emergency call (code blue) over her radio, requesting healthcare assistance. Officer E went into the cell next door and asked a civilian workman who was working there if he had an implement to cut the ligature. Officer F responded to the emergency call and arrived at the cell at around 1.43pm as Officer E was going into the cell next door. As Officer F entered the cell, he saw Officer C standing on the radiator pipes trying to release the ligature. Officer F tried to assist Officer C by taking the man's weight. Officer E then returned with the civilian workman who entered the cell and cut the ligature with pliers. Officer C and Officer F then took the man's weight and placed him on his back on the bed. Officer C checked him for a pulse and removed the ligature from around his neck.
38. Nurse A arrived in the man's cell at around 1.53pm and saw him on the bed. She immediately took control of the situation and instructed Officer F and Officer C to move him onto the cell floor to commence CPR. She also ensured that emergency services had been called. The man did not appear conscious or show any signs of movement, and his head and extremities were very pale and discoloured. Nurse A checked for breathing and pulse. Neither was found and his body felt cold. Initially, she thought the ligature was still present as the marks and indentation on his neck were so pronounced. At around 1.56pm, Nurse B arrived with the emergency kit. Officer G arrived at the cell at the same time. Nurse A instructed Officer F and Officer G to put gloves on and start chest compressions while she put an airway in place and used the ambu bag and oxygen. (An ambu bag is a hand-held device used to provide ventilation to somebody who is not breathing or who is breathing inadequately.) Officer G and Officer F then took turns in providing chest compressions but there was no change in the man's condition. His pupils remained fixed, and there was no pulse or breathing. The Paramedic Rapid Responder then arrived at the cell, followed shortly after by the Prison GP. The paramedic attached a heart monitor but there were no

signs of life evident. The paramedic, in conjunction with the GP, pronounced him dead at 2.06pm.

39. On 18 December, Officer A completed a Security Information Report (SIR). A second prisoner had told him (after the man's death) that he was aware that another prisoner had been pestering him for sexual favours and asking to shower with him. The information was passed to the police liaison officer at the prison to assist the police with their investigation into the death. The prisoner told my investigator that he did not know the man personally, but after his death he heard that another prisoner had pestered him to go to the shower with him. He said that the other prisoner had been moved from C wing.
40. On 18 December, a SO completed a SIR after the man's death when a third prisoner told him that the man had been pestered for sexual favours in the showers. The prisoner intimated that this pressure had reached the point where the man was scared to shower. Again, the information was passed to the police liaison officer at the prison to help the police with their investigation into the death. The prisoner told my investigator that he met the man in Wakefield and was introduced to him by another prisoner. He said that before 18 December the man appeared a bit down but did not show signs of being suicidal. He said there were other prisoners on the wing the man could have spoken to, and also trained Listeners if he had been feeling depressed. He explained that another prisoner was 'stalking' the man as described by others and he felt that must have added to his worries.
41. A fourth prisoner worked in the kitchen with the man and informed my investigator that he had told him several times that he was going to kill himself. The prisoner did not pass that information onto staff. He was aware that another prisoner had been 'bothering' the man as described already in paragraphs 41 and 42. He last saw him during the morning of 18 December when they were both working in the kitchen. He said that he seemed alright and was a quiet man who got on with his work with little distraction.
42. A fifth prisoner transferred from Nottingham to Wakefield at the same time as the man. He told my investigator that the man had always been low in mood from the time he knew him in Nottingham. He said that he was always talking about committing suicide. He was aware that he had been on an ACCT at Nottingham but was not put on one at Wakefield. The prisoner said that the man regularly came to his cell to talk. He said that his thoughts were dominated by his sentence, his children and committing suicide. The prisoner believed that staff would not really have had any indication of the man's desperation as he was good at hiding his true feelings. He said that the man's mood was often 'up and down'. He spoke to him on 17 December and the conversation focused on whether the man should send money to his son who was also in prison custody. The prisoner said that, on reflection, he should have known something was wrong with him as he did not see anything in his eyes. In hindsight,

he wished he could have done more. He heard that the man might have been having trouble with another prisoner in the kitchen. He was also aware of the apparent pressure the man was experiencing from the other prisoner mentioned in paragraphs 41 and 42 above.

43. A sixth prisoner was located in the cell directly opposite the man. He told my investigator that the man visited him in his cell a lot to talk about his problems. He told him that he had sent some money to his daughter from his first marriage, and his current wife was not happy about it. The prisoner told him to send a letter to his wife explaining why he had sent the money. He said the man received a letter back from his wife to say things between them were going well. The prisoner spoke to the man the evening before he died. He said that he seemed alright but had 'a wild animal look in his eyes.' It was the same look as somebody else he knew who had hung himself. He said he should have picked up on how the man was feeling. The prisoner said he had heard that somebody in the kitchen was telling the man he would never get out of prison, but he did not know who that person was. He saw him the evening before he died and said he did not seem like a person who was serious about killing himself.
44. A seventh prisoner was located in Nottingham at the same time as the man and after transfer to Wakefield he worked in the kitchen with him. He told my investigator that the man often talked about feeling suicidal but he did not think he was serious about taking his own life. The prisoner said that the man was very worried about the length of his sentence and thought he was never going to get out. He did not witness any bullying of the man in the kitchen, even though he told him he was being bullied. He also said that the man told him he was being harassed by another prisoner as already mentioned in paragraphs 41 and 42.
45. There is no evidence that any of these prisoners spoke to a member of staff either about the man's talk of suicide or the bullying allegations.

ISSUES

Family concerns

46. At the meeting held with my investigator and family liaison officer, the man's wife said she was concerned because two prisoners had told her that he had been bullied. She also thought that an incident had taken place in the kitchen the day before his death. She felt strongly that the only reason he would have taken his own life was because he could no longer cope with the bullying. (The issue of bullying is addressed in a later section of this report.)
47. The man's wife said that, when his property was returned to her, she only received a few of the letters and cards she believed he had received while in prison. She was aware that he had kept more cards and letters and even some photographs. My investigator has checked with the prison, the police and the Coroner's office but none of them has any letters, cards or photographs. The seventh prisoner told my investigator of hearing that the man had destroyed some letters and cards.
48. The man's wife asked whether he had been taken to hospital about two weeks before his death, remaining there for a week. She said that he told her this had happened. There is no evidence in his medical record that he had been feeling unwell, or indeed that he had been taken to hospital around two weeks before his death. Such an event would have been recorded in his medical record and a Prisoner Escort Record (PER) would have been completed to accompany him from the prison to hospital.
49. The man's wife also questioned why he was in a cell with obvious ligature points such as the window bars. However, this is true of virtually all the cells at Wakefield. Moreover, there was no indication that he was at special risk as a result of being located in an ordinary cell. An appropriate cell sharing risk assessment was completed and he was then properly located in a shared cell on C wing.
50. The man's wife said she had noticed extensive bruising on the right hand side of his body when she saw him at the funeral directors. The funeral director apparently told her that the bruising was consistent with him having been beaten. The Deputy Head of Offender Management spoke to the Coroner's officer who explained that the bruising was post mortem staining. The Governor subsequently wrote to the funeral director to complain that his communication with the man's wife had been inappropriate. The Governor advised the funeral director that if he had any concerns they should be reported to the Coroner.
51. The man's wife mentioned that he had a good relationship with his personal officer. She also spoke very highly of the help and support she received from the prison's liaison officer and the chaplain after his death. She said she was able to visit his cell and meet some of the prisoners who

had known him. She found this to be of great comfort. The prison also contributed towards the funeral costs.

Clinical review

52. During the man's first reception healthscreen at Wakefield, it was known from the ACCT that had been opened at Nottingham that he had made threats of suicide whilst in custody there. His attempted murder of his two children also included a suicide attempt, and records detailing this were also available. The referral protocol for the Prison Mental Health Inreach Team at HMP Wakefield identifies clear reasons for referral if a prisoner meets any of the following criteria:

- A current diagnosis of a severe and enduring mental illness.
- Evidence of complex mental health needs/problems, past or present.
- History of suicide attempts or deliberate self harm.
- Requiring the input of more than one member of the mental health team at that time.
- Requiring a more complex assessment of mental health needs/risk assessment.
- Currently under the care or requiring the care of a psychiatrist.

53. The clinical reviewer concludes that the man should therefore have been referred to the Mental Health Inreach Team which would have initiated an assessment by a Registered Mental Health Nurse (RMN).

The Healthcare Manager must ensure that staff are aware of the referral protocol for the Prison Mental Health Inreach Team and refer prisoners as appropriate for assessment by a RMN.

54. The man also had an assessment by the GP on duty. The GP identified the need to check his blood pressure in three weeks and recommended that his mood should be observed. She documented this information on the assessment form but did not record it in his continuous medical record. She told the clinical reviewer that she asked the man to request a review of his blood pressure in three weeks' time. She explained that the emphasis is to make prisoners take responsibility for their own health. There is no record that he ever subsequently requested healthcare input to check his blood pressure. The GP did not identify who was to observe his mood.

The Healthcare Manager must ensure that any action regarding a patient's care is taken forward appropriately and in a timely fashion to provide a more holistic approach to care to ensure all the patient's needs are met.

The Healthcare Manager must remind staff of the need to complete medical notes appropriately and in accordance with the guidelines of the professional bodies for doctors and nurses with regard for the expected standards of records and record keeping.

55. The clinical reviewer concludes that the response after the man was found was appropriate and timely. The first nurse on the scene was an

experienced Registered General Nurse (RGN) with an extensive background in emergency care. She immediately took control of the situation, and the officers present commented on her calm approach and guidance she gave them. I agree with the clinical reviewer that she should be commended for her professional approach. I am concerned, however, that a workman was asked to cut the ligature as the officers were not carrying anti-ligature knives. Again I agree with the clinical reviewer that this is not a situation that should ever be repeated. I understand that all officers now carry anti-ligature knives.

Bullying

56. A Security Information Report (SIR) was completed by Officer A on 19 August when the man complained that he was being bullied. The Anti-Bullying Strategy training emphasises to staff that all suspicions or observations of bullying behaviour must be reported on an SIR and an Anti-bullying referral made. The Anti-Bullying strategy states:

“Prisoners are encouraged to report bullying by reassuring them through strategic advertising that those experiencing victimisation will be dealt with in confidence and that reported incidents are thoroughly investigated.

Safer Custody Officers will conduct a thorough investigation on every reported incident or suspected incident of bullying. The inquiries will be conducted sensitively and will maintain, where possible, the anonymity of victims, witnesses and informants.

The information collected will be used to decide what action must be taken against the prisoner who is bullying and what action must be taken to support the prisoner who is experiencing victimisation.”

57. The strategy set out above was not followed in the man’s case. The Safer Custody Manager told my investigator that the content of the Security Information Report was not reported to the Safer Custody Department and therefore not investigated by them. She told my investigator that there are now systems in place between Safer Custody Department and the Security Department. When a SIR is submitted that contains bullying implications it is referred to the Safer Custody Department by means of a proforma. I welcome this change which ensures all incidents are fully investigated.

58. On 17 December 2006, the man telephoned his sister-in-law. During that telephone conversation, he mentioned he had experienced some trouble from another prisoner while working in the kitchen that morning. However, there is no evidence that this was reported to any member of staff and no other evidence that he had been experiencing any problems in the kitchen. Another prisoner who worked in the kitchen with him, the seventh prisoner, said that he told him he was being bullied in the kitchen. Nevertheless, the prisoner did not see any sign that the man was being bullied and is adamant that the man enjoyed working in the kitchen.

RECOMMENDATIONS

The Healthcare Manager must ensure that staff are aware of the referral protocol for the Prison Mental Health Inreach Team and refer prisoners as appropriate for assessment by a RMN.

The Healthcare Manager must ensure that any action regarding a patient's care is taken forward appropriately and in a timely fashion to provide a more holistic approach to care to ensure all the patient's needs are met.

The Healthcare Manager must remind staff of the need to complete medical notes appropriately and in accordance with the guidelines of the professional bodies for doctors and nurses with regard for the expected standards of records and record keeping.