

**Investigation into the circumstances surrounding
the death of a man at HMP Maidstone
in September 2008**

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

April 2010

This is the report of an investigation into the circumstances of the death of a man who was found hanging in his single cell in HMP Maidstone on the evening of Saturday 27 September 2008. He was 40 years of age.

I extend my sincere condolences to the man's family and friends for their loss. I also apologise for the slight delay in issuing this report.

The investigation was carried by one of my colleagues. A clinical review was carried out by West Kent Primary Care Trust. I should like to thank Maidstone's Governor and his staff for their co-operation.

The man had been at Maidstone for just two weeks at the time of his death. During his eight months in custody the man had harmed himself a number of times. Each time he was placed on special monitoring until deemed to be no longer at risk. He was subject to such monitoring at the time of his death, having harmed himself three days earlier. The man was very open about his reasons for harming himself. He said (although it was not confirmed) that he suffered from bi-polar disorder and that he would have suicidal thoughts during low periods.

Two brief notes were found in the man's cell after his death. In one, he sent his love to all his family and also apologised to his mother. In the other note he asked for his belongings to be given to another prisoner at Maidstone.

My report makes four recommendations of my own. Two are about first aid training for staff and another concerns contact with families following a death in custody. I also recommend that a member of staff be commended for his actions. Five recommendations are made by the clinical reviewer, all of which I endorse.

Stephen Shaw CBE
Prisons and Probation Ombudsman

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SUMMARY

The man, who was 40 years old, was found hanging in his single cell at HMP Maidstone on 27 September 2008. At the time of his death, the man was being monitored through the ACCT¹ process as he had been identified as at risk of self-harm or suicide.

The man was serving a five-year sentence and had been continuously in custody since 20 January 2008. He was remanded initially into HMP Belmarsh before later being transferred to HMP Blundeston (in Suffolk). He was then transferred to Maidstone where he arrived on 12 September.

The man had been receiving treatment for mental health problems for a number of years. He suffered from depression and, although the definitive diagnosis seems unclear, he certainly believed that he also suffered from bi-polar disorder. Whatever may have been the true diagnosis, the man reported consistently that he suffered from "highs and lows"; that he had no control over this fluctuation in mood, and that low periods would come on suddenly and without warning. The man would often harm himself when feeling low.

During the man's nine months in custody at these three establishments, ACCT forms were opened on five separate occasions after incidents of self-harm. The first such incident occurred in the community immediately prior to the offence that resulted in the man's arrest. All the other acts of self-harm occurred in custody: on one occasion he took an overdose of his in-possession medication and on three occasions he cut his neck (which is what he had done in the community). All of the cuts were superficial requiring minimal treatment, although on the final occasion at Maidstone he said that he had been looking for a vein and had intended to commit suicide.

The man's mother and aunt visited him on Friday 26 September, the day before his death, and staff noted in his ACCT form that he seemed in good spirits afterwards. The man telephoned his mother the next morning and told her that he was sending another visiting order for the following week. A good part of their conversation concerned a psychiatric consultation that the man was expecting on the following Monday. The man's mother was insistent that he should resist any further increase in the dose of his anti-depressant medication. He responded that he knew what he needed to help his symptoms but would see what the psychiatrist had to say.

At just before 9.00pm on Saturday 27 September, the man was checked and all was well. At the next check, an hour later, he was found hanging. Staff went into the cell, cut the ligature and attempted resuscitation. Ambulance paramedics attended and also attempted to resuscitate the man. Unfortunately, their efforts proved unsuccessful and the man was pronounced dead.

Following his death, two very brief notes were found in the man's cell. In one note he sent his love to all his family and said sorry to his mother. In the other he asked

¹ ACCT (Assessment, Care in Custody and Teamwork) is the process used for monitoring and supporting prisoners deemed at risk of self-harm or suicide.

for his possessions to be given to a fellow prisoner. Neither note contained an explanation for his actions.

Although the man was being monitored and supported through the ACCT process in the days leading up to his death, my investigation has found no reason for staff, nor anyone else, to suspect what he was about to do. Indeed, he had been making plans for the week ahead – it seems he was looking forward to meeting a psychiatrist who he was expecting on the Monday, he was planning to go to the gym, and his mother was to visit again.

The clinical reviewer has found that the man's clinical care and treatment was equivalent to that which he would have received had he been in the community.

THE INVESTIGATION PROCESS

1. The appointed investigator first visited HMP Maidstone on 2 October 2008 when he met the Head of Security and Operations, the Prison Officers' Association Chair and the Chair of the Independent Monitoring Board (IMB). The investigator had a lengthy discussion with one of Maidstone's Family Liaison Officers. The investigator also met a prisoner who became friends with the man in the brief time he was at Maidstone.
2. The investigator subsequently interviewed 14 members of staff. No other prisoners came forward in response to the notices about the man's death.
3. West Kent Primary Care Trust agreed to carry out a review of the man's clinical care and treatment.
4. One of my Family Liaison Officers (FLOs) contacted several different members of the man's family – his mother, his sister, his ex-wife and his partner.
5. The FLO and investigator subsequently visited the man's mother at her home. The man's sister and brother-in-law were also present. The man's mother said that her main concern was about the medication her son was being given. She said that he was being given a high dose of anti-depressant medication (chlorpromazine, also known as Largactil). She said that each time her son saw a psychiatrist his dose of medication was increased. She believed that the more medication he was given, the more depressed he became. The increased medication also caused him to become lethargic which led to him putting on weight which in turn caused him to become more depressed. She also wondered whether there was any interaction between the chlorpromazine and the other medications her son was being prescribed.
6. The man's sister questioned why her brother was not located in Maidstone's healthcare unit given that he had previously attempted to take his life.
7. An issue that was of concern to all of the man's family was that, despite cutting his neck and being made subject to special monitoring, he was allowed to keep his dressing gown cord. He was then able to use that cord as a ligature. I have addressed the family concerns later on in my report.

HMP MAIDSTONE

8. HMP Maidstone is an early 19th century category C training prison. It has four residential units (or houses) and holds just over 550 male adult prisoners. Maidstone's healthcare department is open only during day-time hours; it has no in-patient beds and no overnight nursing cover.

9. The last inspection of Maidstone by Her Majesty's Chief Inspector of Prisons was an announced inspection in February 2007. Matters discussed in the report included:

"The prison had used the assessment, care in custody and teamwork (ACCT) self-harm monitoring documentation for over a year ... Comments were of variable quality but the assessment interviews were good, even if subsequent care maps were not always of a consistently high standard."

"There were only eight Listeners² in post at the time of our inspection, half located on the vulnerable prisoner unit (Thanet). A training course for a further 11 prisoners was scheduled ... The Listeners with whom we spoke felt supported by most staff, although they said there was a small minority of officers ... who did not value their role, which made their task difficult at times ..."

10. The inspection found that all units apart from Kent House had a Listener room so one of HMCIP's recommendations was for a room to be installed there. This recommendation had been implemented by the time the man arrived at Maidstone.

11. In their report on Maidstone for the period 1 March 2007 to 29 February 2008, the prison's Independent Monitoring Board (IMB) commented on the operation of the ACCT process. The IMB reported that board members had regularly inspected ACCT booklets and found that the quality of entries had improved substantially since the previous year.

12. Since I took on the responsibility for the investigation of all deaths in prison custody in April 2004 there have been seven deaths at Maidstone, including that of the man. All of the other prisoners died from natural causes.

² Listeners are prisoners trained by the Samaritans to offer confidential support to their peers.

KEY FINDINGS

13. The man was born in 1968. He had one sibling, a sister. The man's parents separated when he was around 13, despite which he described his childhood as a happy one. After leaving school the man trained to be a bricklayer and it seems that he worked successfully in that trade for some years. During this time the man got married and had two sons. The man also reported though that he began to misuse alcohol which led to him losing his job in or around 2003. This, in turn, led to marital difficulties, separation and, eventually, divorce. The man subsequently lost access rights to see his children.
14. On 20 January 2008, the man went to Queen Elizabeth Hospital after deliberately cutting his neck with a disposable razor. He began swearing and kicking a vending machine while waiting to be seen. When a receptionist asked the man to stop he became verbally abusive and two security staff escorted him out of the hospital. Once outside the hospital, the man assaulted one of the security staff resulting in him being arrested and charged with assault occasioning actual bodily harm. The man remained in police custody until 22 January when he was taken to Woolwich Magistrates' Court. At court, the man pleaded guilty to the offences and was remanded into HMP Belmarsh while awaiting sentencing. This was not the man's first time in prison custody.
15. The standard prison reception process includes a cell-sharing risk assessment to determine each prisoner's suitability to share with others. During his assessment on arrival in Belmarsh, the man told the officer that anything could "set him off". He said that he would lose his temper very quickly. He was consequently assessed as presenting a high risk of assaulting any cell-mate.
16. The man had a first reception health screening assessment. He reported that he had recently been in a psychiatric hospital where he had been treated for psychosis and manic depression. He said that he was receiving prescribed anti-psychotic medication (chlorpromazine hydrochloride) as well as a sedative (diazepam). The man reported having tried to harm himself in the past although he had no current thoughts of harming himself. A doctor prescribed several medicines including diazepam and 350mg of chlorpromazine.
17. On the day following the man's arrival in Belmarsh, it was decided that he should be monitored under the ACCT system (used to monitor and support those prisoners deemed to be at risk of self-harm and suicide). An officer opened an ACCT form noting that staff were concerned because the man had tried to cut his throat on the day he went to Queen Elizabeth Hospital. The officer recorded the man as saying that he wanted to die as he did not like himself. The man also reported that he was a recovering alcoholic and had mental health problems.
18. The ACCT procedure includes setting an appropriate level of staff interactions with the prisoner – conversations and observations – while he or she remains at risk. In the man's case it was decided that staff should have three interactions with him during each of the three shifts through the day and night .

19. The ACCT form was closed after two days as the man reported that he was feeling more settled than when he first arrived in the prison and also said that he had no current thoughts of self-harm or suicide. The man explained that he first began to harm himself seven years earlier. He said that he was not sure why he did so, but that he hated himself because of his drinking and the effect that it had on his family. (As noted above, he was divorced and had no access rights to his children.)
20. Having already pleaded guilty, the man returned to court on 1 April 2008 when he was sentenced to five years and one day imprisonment.
21. On the early evening of 11 May, the man pressed his cell call bell and asked an officer to take his disposable razors from him. The officer told the man that he would have to call for more staff before unlocking the cell³. However, by the time the cell was unlocked the man had already cut his neck. It proved to be a superficial cut which was cleaned and dressed by one of the nurses (the nurse also referred the man to the mental health team). Another ACCT form was opened that evening and the man was moved to healthcare. The level of observations were set at one per hour through the night, pending an assessment interview by a trained ACCT assessor the following day.
22. The ACCT assessor's notes of the discussion with the man on 12 May included him saying that he could not explain his actions of the previous evening. He said that he had previously taken an overdose and had attempted to hang himself a number of times. The incidents were usually impulsive and alcohol related. The man told the assessor that he did not want to die but the assessor made a note indicating that he was not reassured by the denial. The assessor also noted that the man was anxious about the possibility of being moved from a single cell into a shared cell.
23. The prison psychiatrist reviewed the man on the morning of 13 May. The psychiatrist noted the man's reason for harming himself was because he felt "down and miserable". He had also said, however, that he was no longer suicidal and wanted to leave healthcare. The psychiatrist noted that the man's mood was stable with no sign of psychotic symptoms or that he was at risk of self-harm. The psychiatrist agreed that the man could leave healthcare and also that he should have a single cell. On the same morning, an ACCT case review panel altered the level of interactions with the man to a minimum of one "quality"⁴ interaction each day-time shift and three observations during the night.
24. The ACCT form was kept open for three weeks. During a case review on 19 May, the man said that he constantly thought about suicide and there was nothing staff could do to alleviate his feelings. He also said, though, that his medication helped. A week later, at his next ACCT review, the man said that

³ Prisons have protocols about the number of officers who should be present when a cell is unlocked at a time of day that cells are usually locked.

⁴ A "quality" interaction would be a worthwhile conversation (in contrast to an "observation" which would usually be a visual check that the prisoner appears well).

he felt okay at present, but “things can change in a second”. The ACCT form was closed at the next review on 2 June.

25. The man had been working as a cleaner for some weeks when an officer noted on 17 June, that he was unsuitable for the work as the strength of his medication caused him to be “zoned out”. This was the only such entry made by wing staff. Earlier entries about the man’s work as a cleaner had been very complimentary, but later entries indicated that he was becoming less willing to co-operate and comply with instructions.
26. On 20 June, the man was transferred to HMP Blundeston in Suffolk. (Belmarsh is primarily a local prison and most of its prisoners are transferred elsewhere after conviction and sentencing. By contrast, Blundeston is a training prison for convicted category C prisoners. In addition to training, Blundeston also provides other opportunities such as accredited offending behaviour courses.) During his induction interview at Blundeston, the man reported having harmed himself in the past but said that he had no current thoughts of doing so. When asked whether he had any concerns, he replied that he “must” receive medication to control his bi-polar condition. Following a cell-sharing risk assessment, an officer noted that the man was happy to be at Blundeston; that he had complex mental health needs requiring attention from healthcare; and that he was a high risk for cell sharing so should be in a single cell. The man was reviewed by one of Blundeston’s doctors three days later who referred him to the psychiatric in-reach team.
27. The man was allocated a training placement in the carpentry workshop, but on 10 July a report was made that he was not in a “fit state of mind” to work there due to his “heavy medication”. It was also noted that the man had threatened to harm either himself or others if he remained in the workshop.
28. The following day, the man was noted to have kicked a door. The officer making the report wrote that this was: “another indication of this prisoner’s state of mind and mood swing at the slightest thing”. The officer went on to note that the man’s behaviour was very unpredictable.
29. On the evening of 13 July, the man again used a disposable razor to cut his neck⁵. As at Belmarsh, the wounds were superficial and were cleaned and dressed by a nurse. An ACCT form was opened. The officer who opened the form noted that the man said he was bi-polar and suffered from severe depression. He said that he had been feeling fine 15 minutes before cutting himself and he felt fine afterwards. He added that he had no more thoughts of harming himself but that he never had any advance warning of when a depression would set in. The man was observed through the night at half hourly intervals.
30. The man had an ACCT assessment interview the following day. He told the assessor that cutting himself the day before was an attempt at suicide and that he had made numerous attempts in the past. He said that on each occasion he

⁵ Prisoners are issued with safety razors which they usually retain in their own possession.

felt fine one moment and then suicidal the next. He reported having no current suicidal thoughts but acknowledged not knowing when that situation might change. The man also told the assessor that he wished he was in a prison closer to London so that his family could visit him. The level of observations were reduced to one an hour. Later that day an ACCT case review was held and the level of interactions were set at one quality interaction each day-time shift with three observations through the night. The ACCT form was closed on 18 July.

31. Following the man's comment about wanting to move closer to London, Blundeston submitted a transfer request and, on 4 August, he was told that HMP Maidstone had agreed to take him when a space became available. The man was noted to be pleased at the news.
32. On the morning of 4 September, The man pressed his cell call bell. He reported that he had taken an overdose of his medication (this was medication that he was holding in his own possession). The officer took the man to healthcare where he was checked by a nurse. The nurse noted that the medication the man had taken did not present immediate life-threatening danger but could cause increased drowsiness depending on his tolerance levels. The nurse asked the man whether he had intended to commit suicide. He replied that he knew he was going to do something to himself that day, either cut his throat or take an overdose. He said his reason was that he was sick of being in Blundeston and desperate to transfer to Maidstone. The nurse judged that the fact that the man was planning for his future did not reflect the mindset of a person who truly wanted to end his life.
33. An ACCT form was opened in response to the overdose. At the ACCT assessment interview the following day, the man told the assessor of his desperation to get to Maidstone. The assessor told him that his transfer was scheduled for 12 September and the man then spoke about having visits from his family once in Maidstone. The assessor noted that the man promised that he would focus on his future. He agreed to write a focus sheet to go on his wall on which he would list positive factors such as the names of family and friends who he loved and his sentence release date. The assessor noted that he thought that the man was no longer at risk of self-harm and closed the ACCT form that day. (The man had been monitored through hourly observations while the form remained open.)
34. On 11 September, the man had a post closure review (part of the ACCT process). The man told the reviewer that he was "100% better" and that he was very happy about his transfer as he would be nearer to his family.
35. The man's transfer to Maidstone went ahead as planned on 12 September. During his healthcare reception screening he repeated that he had bi-polar disorder and a history of self-harm and suicide attempts. He also reported that he did not feel like hurting himself at that time and was expecting to receive visits and support from his family. During his cell-sharing risk assessment, the man was noted to be prone to acts of unpredictable and unexplained aggression. He was consequently deemed high risk for cell sharing.

36. At Maidstone, the man was seen by a prisoner who had the job of safer custody peer support worker. His responsibilities in that role include speaking to new prisoners arriving in reception about the support available in Maidstone. The support worker wrote a statement about his contact with the man on 12 September. The man had said that he had been on an ACCT form because he suffered from depression. The support worker told the man that there were prisoners at Maidstone who could help: both peer support workers and Listeners. The man said that he did not trust Listeners, but the support worker explained that the Listener scheme was completely confidential and that information disclosed to Listeners would not be passed on to others. The support worker wrote that after this explanation the man seemed more at ease about potentially using the service. He also said that he felt fine when the support worker asked that he would not “do anything silly”.
37. The man was visited by a Registered Mental Nurse (the first RMN) from the mental health in-reach team on 15 September. The first RMN noted brief details of the man’s mental health history as well as noting that he was presently being maintained on 500mg of chlorpromazine daily. The note went on to say that the man would be assessed fully on the following Friday (19 September).
38. Later on 15 September, the man was seen by one of Maidstone’s doctors who told the clinical reviewer that he only worked at Maidstone on an occasional, ad-hoc, basis. The doctor listed the medication that the man was receiving. The doctor noted that he was concerned about the medication and that the man should be referred to a psychiatrist as soon as possible. The doctor explained to the clinical reviewer that it was the dosages of chlorpromazine and diazepam that concerned him in particular and that he would have wanted this to be reviewed by a psychiatrist within a week or two.
39. The man was visited again by the first RMN on 19 September. The notes of the consultation include that the man had been known to psychiatric services for many years and that his mental health diagnoses included manic depression with symptoms of bi-polar disorder. The man mentioned his history of self harm and said he remained impulsive with a tendency to harm others. The first RMN told my investigator that he observed no signs that the man was suffering a psychotic episode nor were there any signs that the man was at risk of harming himself. The first RMN thought that the man was receiving too high a dose of chlorpromazine, although the man felt that he should be on an even higher dose as he thought the drug stopped him from becoming angry. Following the consultation, the in-reach team sent a fax to the man’s community psychiatrist seeking his views on his management. In the meantime, the man’s medication was continued at the same levels. Once the community psychiatrist had responded, the in-reach team would arrange for the man to be assessed by the psychiatrist from the mental health in-reach team.
40. Another prisoner at Maidstone whose cell was opposite to the man’s told my investigator that he went over to the man when he first arrived on the wing in order to introduce himself and to ask if he was okay. The man replied that he

suffered from depression and was receiving chlorpromazine for that condition. This prisoner said that the man's medication meant that he was very sedated, to the extent that he could not engage in a full and proper conversation. The prisoner introduced the man to some of his friends. The man would listen to the conversation but was too inarticulate because of his medication to join in properly. (Although this prisoner's view was that the man was very sedated, this was not the opinion of the staff to whom my investigator spoke. None of them thought that the man was drowsy or sedated, including the second RMN who worked closely with the man.)

41. On the morning of 24 September, one of the wing officers, the first officer, was carrying out fabric checks⁶ of the cells in Kent House where the man was located. The man stepped forward as his cell was unlocked and handed over two disposable safety razors saying that he had cut his neck. The first officer told my investigator that the cuts were superficial and there was very little blood. The first officer took the man to healthcare for treatment and as they walked he asked him his reasons for harming himself. The man replied that he was depressed and that this was a condition he had suffered in the past.
42. In healthcare, the man's injury was treated by the second RMN. The second RMN told my investigator that he had seen the man on almost a daily basis during his time in Maidstone. This would be both during medication dispensing rounds and when visiting other patients on the wings. He said that the man was always compliant with taking his medication. The second RMN told my investigator that the man's injuries on 24 September were superficial. The second RMN's impression was that the man had harmed himself because he was bored. The second RMN did not think that the act had been a suicide attempt. The second RMN was aware that the wing staff would be opening an ACCT form so after treating the man he spoke to wing staff about giving the man some work to keep him occupied pending the psychiatric assessment due to take place the following week. Talking in general about operation of the ACCT process, the second RMN said healthcare staff are consulted by the wing staff. Sometimes nurses attend ACCT case reviews or they are otherwise telephoned by wing staff for their input.
43. Once he had been treated in healthcare, the first officer brought the man back to the wing and opened an ACCT form. As an interim measure, the man was placed on hourly observations. In considering where the man should be located, the ACCT was noted to the effect that he should remain in a single cell as he was a high risk prisoner for cell sharing purposes.
44. Another wing officer, the second officer, saw the man that afternoon for an ACCT assessment interview. The man told the second officer that he suffered from bi-polar disorder and feelings of extreme low or extreme high came on suddenly with no obvious trigger. He had suicidal thoughts when he felt extremely low. The man also said that when he cut himself that morning he had been trying to find a vein with the intention of committing suicide. He said

⁶ Fabric checks are carried out on a daily basis. The checks are to ensure that prisoners have not compromised the security of the cell; for instance, by trying to work the window bars loose.

that he had tried to commit suicide on eight or nine occasions in the past and had tried a number of different ways: overdose, hanging, cutting. The man said that he still felt low, but was better than he had been in the morning and was no longer suicidal. He also said that, although he had no current intention of committing suicide, he regularly thought about methods for carrying out that act and had concluded that hanging would be the best way.

45. The second officer told my investigator that the man was very relaxed during the interview and did not seem particularly depressed. He spoke openly about his mental health history, his problems with alcohol, his problems of access to his children and his history of attempting suicide. When the second officer asked if there was anything that might help him cope, the man said that being behind a locked door for long periods during the day did not help as he had time to think which was a “bad thing”.
46. The man’s first case review was held that same afternoon. The first Senior Officer (SO) chaired the review and was joined by the second officer and one of the chaplains, the first chaplain. The first SO told my investigator that the man said that the earlier incident of self-harm had been a spur of the moment act which he now regretted. The man talked about his family problems, but spoke too about his hopes of gaining access to his children in the future. He also said that he had applied for an education placement to commence once he had completed his prison induction. The man said that he had been diagnosed with bi-polar disorder. The first SO told my investigator that healthcare were unable to confirm the diagnosis.
47. The first SO told my investigator that he was encouraged by the fact that the man was making plans for the future and so felt the earlier incident had not been a proper suicide attempt. The first SO consulted with the others at the meeting and decided the ACCT form should remain open.
48. Part of the ACCT process is the construction of a Care and Management Plan (CAREMAP). Staff are required to consider the needs of the individual and to devise a CAREMAP to address those needs. When the man mentioned being bored he was offered voluntary work as a cleaner, which he declined. However, in response to the man’s earlier comment to the second officer that being locked in his cell for long periods was unhelpful, it was agreed that his cell door would be left open whenever possible. This was noted in the CAREMAP.
49. The first chaplain told my investigator that he met the man when he first arrived in Maidstone. He said the chaplaincy team see all new arrivals and prisoners who have recently been on ACCT forms are prioritised. At that first meeting, the man mentioned that access to his children was his major concern and he spoke about it again at the review on 24 September. The first chaplain told my investigator that he had received ACCT assessor training and the man did not seem especially at risk. The man wanted help to arrange an appointment with the mental health in-reach team and in arranging work or training, and was assured that this would be provided.

50. The review panel decided that the appropriate level of interaction with the man was for staff to have one conversation with him each morning, afternoon and evening shift as well as random observations during the periods when he was locked in his cell. He would also be checked six times through the night.
51. Later that afternoon, the first SO told the man that healthcare had arranged for him to be seen by the mental health in-reach team the following Monday.
52. The third officer was responsible for several ACCT monitoring visits and made a number of entries in the man's ACCT form. The one substantial entry was at mid-morning on 25 September. The third officer told my investigator that he went into the man's cell that day and asked him how he was feeling. The man was very talkative. He spoke about his time in Belmarsh saying that he found it quieter than Maidstone. He said that he was thinking of asking for a transfer to Medway wing as that was quieter than Kent wing. He also mentioned that a place in education had been found and he would be starting in just over a week's time. The third officer told my investigator that he had previously seen the man around the wing before the ACCT form was opened. He described the man as a quiet and reserved individual who did not interact very much with other prisoners.
53. The second officer made an entry in the man's ACCT form at 3.00pm on 25 September:

“... I asked him how he was feeling today and he said that he was feeling a lot better than he did yesterday and he currently has no suicidal thoughts or intentions. I asked him if he felt any better with his door being open during the day and he said that it did help a lot. I reiterated ... that if he has any concerns or worries I am always approachable should he wish to talk.”
54. The man's next case review was mid-morning on Friday 26 September and was chaired by the second SO. Also present were an officer whose role was that of offender supervisor, and another of Maidstone's chaplains, the second chaplain.
55. The second SO told my investigator that this was the first time he had met the man following a very brief encounter on 24 September. The second SO said that the man was very open and talkative. He admitted to thinking about suicide during the previous few days which he explained was due to his bi-polar disorder, a condition that came with highs and lows. He said that this was a low period for him and that because of the illness he had been having suicidal thoughts on and off for many years.
56. The second SO asked the man whether he found it helpful being monitored on an ACCT and he replied that he could not have asked for any more of the staff. The second SO came to the conclusion that the man was not at immediate risk of suicide. The factors he took into account were the man's good interaction during the review, his denial that he had formed any actual plans for suicide, and that suicidal thoughts were something he had been living with over many years. Even so, the second SO decided that the level of observations should

be increased. He decided that there should be two observations each morning, afternoon and evening (in addition to the conversations that staff were having with him). For the night time, the second SO increased the observations from six to eight. The second SO checked with the others at the meeting and they all confirmed their agreement to the increased interactions with the man. Something else that the man mentioned at the review was that he had been due to see the mental health in-reach team that day, and was disappointed that the appointment had been cancelled. The second SO checked and told the man that the appointment was for the following Monday.

57. The officer whose role was offender supervisor told my investigator that in due course she would have dealt with arrangements for the man's sentence plan. She was on leave when the man arrived in Maidstone and 26 September was their first meeting. The offender supervisor said that when the man spoke about his bi-polar disorder he explained that he had no control over the condition. He talked about the illness coming upon him "from behind" and when that happened he had no concern for his family or anything else.
58. The second chaplain gave similar evidence about how open the man was about his psychiatric history, his history of self-harm, and that when he cut his neck two days previously he had been looking for a vein. The second chaplain said that he agreed with the second SO's decision about increasing the level of observations. The second chaplain also mentioned that he had not received any ACCT training.
59. The fourth officer told my investigator that, although she had no direct dealings with the man before the ACCT form was opened, she had seen him around the wing. He seemed to her to be a quiet person who did not speak to many other prisoners. Her first proper contact with him was on 26 September when she made three entries in his ACCT form. She said that initially the man was quite reserved and she had to make a lot of effort before he began to open up. In an entry made at lunchtime that day, the fourth officer noted the man saying that he had been receiving psychiatric treatment for 15 years and that he needed to see a psychiatrist to increase his medication. He told her that he had bouts of feeling low and needed medication to lift his mood.
60. The man's mother and aunt visited that afternoon. The man's mother told my staff when she met them that her son had spoken that day about coming out of prison the following January. She said that he was always very particular about his appearance and he asked her to bring him some clothes next time she visited. He told her that he would send a visiting order for the following week. The man's mother said that, although her son was smiling, he admitted that he was feeling depressed.
61. The fourth officer spoke to the man just after his visit and made the following entry in his ACCT form:

"Spoke ... about his visit. He said he had a good chat with his mum and auntie, who he referred to as being mad as a hatter and had a laugh. He

said he was going to have another visit next week and was expecting some kit from outside on next visit. He seemed in good spirits.”

62. The man telephoned his mother on the morning of Saturday 27 September⁷. Much of the conversation was about medication. The man told his mother that he was due to see a psychiatrist (from the mental health in-reach team) on the following Monday and she replied that she feared that that would result in a further increase in the dosage of his anti-depressant medication (chlorpromazine hydrochloride). She told him that she thought he was already on a high dose of this medication. Although they laughed she thought he had seemed a little depressed the previous day and said his medication could sometimes further fuel his depression. The man’s response was to say that he would see what the psychiatrist had to say, but he also indicated that he thought that this medication helped him. The man confirmed that he had sent her another visiting order for the following week and he reminded his mother that he wanted her to bring some of his belongings. He also asked if she could bring his niece but his mother told him she would be at school. The conversation ended with the man telling his mother that he would telephone her again on the Monday to tell her what the psychiatrist had said.
63. The fifth officer told my investigator that he did not usually work on Kent wing but did so on 27 September and met the man for the first time. The fifth officer made several entries in the man’s ACCT form about him doing such things as sweeping out his cell, collecting a meal and watching the television. The final entry was at 5.00pm when the man was rolling a cigarette. The fifth officer recorded the man saying “Goodnight, see you in the morning.” At interview, the fifth officer said that, while the man was not talkative, he seemed fine and gave no warning signs.
64. The second RMN saw the man that evening when dispensing the final medication round of the day. The second RMN told my investigator that there were no signs to indicate that the man might take his life later that evening. He also said that there were no indications that the level of ACCT contacts and observations for the man should have been set at a greater frequency.
65. At some time on 27 September, the man sent his mother another visiting order as he had mentioned he would do when they spoke by telephone. With the visiting order, he enclosed a note reminding his mother to bring him some clothes. Also that day, the man filled in his meal menu choices for the following week.
66. After the man had cut himself on 24 September, his prison friend asked him why he had done it. The man replied that he had attempted suicide on eight occasions in the past and that he would succeed one day. Despite the man’s actions in cutting himself, his friend saw no signs that he was about to do anything serious. For instance, he had mentioned that he was planning to start going to the gym from the following Monday and he was also arranging another visit from his mother.

⁷ My investigator listened to a recording of the call.

67. The man's prison friend talked to my investigator about the Listener scheme. He said that the scheme was not well advertised at Maidstone. Nor, he said, did the prison have a Listener suite.
68. Another officer had first met the man soon after his arrival in Maidstone when he asked about obtaining a television. The officer told my investigator that, when they went to collect one from stores he was able to get a brand new set which the man was very pleased about. The officer made two entries in the man's ACCT form on 27 September. The first was during the lunchtime lock-up period when the man was watching television, and the second was at 7.30pm after evening lock-up when he was listening to music. The officer said that there was nothing about either encounter to indicate any problems.
69. An Operational Support Grade (OSG)⁸ told my investigator that his usual job was working on the prison gate during the day dealing with staff and other visitors as they arrive and depart. However, on one week out of every six or seven he works nights on wing patrol. His role then includes ensuring that the wing is secure, responding to any prisoners who press their cell bells for assistance, and checking prisoners on open ACCT forms. The OSG said that when working nights, he carries a cell key in a sealed pouch (to be opened only in the case of an emergency) and an anti-ligature knife. He said that the gates allowing access off the wing are locked at night time and his key does not unlock that door.
70. The OSG confirmed to my investigator that at night time the ACCT process does not require close contact with the prisoner and only requires confirmation that the prisoner is well. The OSG said that the man understood how the ACCT process worked and when awake would lift his hand to acknowledge that he was well at the time of that check. When the OSG checked the man at just before 9.00pm on 27 September he was standing at the back of the cell. He said "Alright Gov" to the OSG, who was content that all seemed well.
71. When the OSG checked the man an hour later he saw him slumped on a chair at the back of the cell with a ligature around his neck tied to the window frame. The OSG radioed the control room to inform them that a prisoner was hanging and that he needed urgent assistance. He also asked for permission to enter the cell. Permission was granted so the OSG broke the seal to the key pouch and went into the cell. He lifted the man's body but that took all his strength and he was unable to reach out for his anti-ligature knife. The OSG continued to hold the man while waiting for other staff to arrive.
72. The Night Orderly Officer⁹ (NOO) on 27 September was based, as usual, in the Orderly Office along with other trained officers. From the Orderly Office, these staff are available to assist with any incidents in the prison. On receiving the OSG's radio message, the control room immediately contacted the Orderly

⁸ An OSG is a basic grade member of staff who will not have received the same level of training as a prison officer and he/she will have much less direct interaction with prisoners.

⁹ The Night Orderly Officer is the person in charge of a prison at night time.

Office and also called for an emergency ambulance and the duty doctor. The NOO, together with three other officers responded to the emergency call (and appear to have arrived at the cell within around two minutes). When they arrived, they cut the ligature and the man was placed on the bed. Some of the staff reported that the man's lips were blue in colour and his wrist was very cold. Staff checked for a pulse, but found none and so began to administer cardio pulmonary resuscitation (CPR) at a ratio of 15 chest compression to two rescue-breaths. Once some of the furniture had been removed from the cell, the man was moved to the floor and staff resumed their efforts at CPR. They continued until they were relieved by ambulance paramedics at around 10.15pm. The paramedics attempted CPR for around ten minutes before deciding to cease. Death was pronounced by the duty doctor.

73. After his death, a brief note was found in the cell in which the man sent his love to all of his family and said sorry to his mother. He also left another note indicating that he wished for his possessions to be given to his prison friend.
74. The man used his dressing gown cord as a ligature and my investigator spoke to two of Maidstone's governors, including the Duty Governor, about the prison's policy on confiscation of such items. The governors explained that each case is treated individually. In the case of a prisoner identified as being actively suicidal, the management plan might include confiscation of clothing including a dressing gown cord. However, even though the man needed the support of the ACCT process, there was no apparent reason to suggest that the risk was so high his clothing should be taken from him.

After the man's death

75. The Duty Governor told my investigator that he was on duty from Friday 26 September until the following Monday morning. He said that he was at home when the prison telephoned to inform him that there had been a death in custody. The Duty Governor went into the prison and went to Kent wing. The police were already present when he arrived, as was the Governing Governor.
76. The Duty Governor said that he tried to contact the prison's Family Liaison Officer (FLO), but she did not answer the telephone. Although the FLO had a deputy, she had only very recently passed the FLO course, and the Duty Governor did not think the task of telling a family about a death in custody should be allocated to a person without any actual experience. In order to prevent any delay in breaking the news, the Duty Governor thought that the best option would be to ask the police to make the visit. He remained in the prison through the night so that he would be available if the man's family telephoned to ask for more information.
77. The Duty Governor held a hot debrief that night. The first chaplain also came into the prison in his dual roles of chaplain and member of the care team. Staff were told that the care team would be available whenever needed. The OSG was told that he could go home but he chose to remain on duty.

78. The man's mother, sister, brother-in-law and two nieces, visited Maidstone on Sunday 28 September when they were given information about prison processes and procedures. The man's mother and sister returned three days later and visited the cell. They asked to meet the man's friend and he agreed to speak to them about their brief friendship. The family were also told that the prison would contribute to the funeral expenses.

ISSUES

Adherence to ACCT procedures at Blundeston

79. On 4 September, staff at Blundeston opened an ACCT form for the man after he took an overdose of his prescribed medication. He told staff that his reason for harming himself was because he was desperate to transfer to Maidstone so that he would be closer to his family. His transfer was confirmed for 12 September. The ACCT form was closed the following day when The man said that he would focus on his future. Part of the ACCT process includes that a 'post closure review' to take place within seven days of the closure of the ACCT form. The man's post closure review was held on 11 September. This contravened the instructions contained in Prison Service Order (PSO) 2700 which deals with suicide and self-harm prevention. PSO 2700 instructs that a post closure review should not be held within 72 hours of a known transfer.
80. The PSO also instructs that in the case of an ACCT form closed in the last month of a transfer to a new establishment, the closed ACCT form should accompany the prisoner to the new establishment. Blundeston were also in contravention of this instruction.
81. Blundeston recognised well before this investigation was completed that it had contravened PSO 2700 in the two respects mentioned above. Consequently, I make no recommendation.

The decision to allocate the man to a single cell

82. The standard prison reception process includes a cell-sharing risk assessment to determine whether or not it would be safe to locate the prisoner in shared accommodation. In the man's case, he had a history of acts of unpredictable aggression. In all three prisons where the man spent time during this sentence he was judged to be high risk for cell-sharing purposes and was allocated each time to a single cell. When the ACCT form was opened at Maidstone the form was noted that the man should remain in a single cell due to his risk assessment. This was the correct decision in his case.
83. I acknowledge that the man was also a prisoner who was recognised to be at potential risk of self-harm, but there are other processes, as will be discussed in the following section, to deal with this risk. It is recognised that some at-risk prisoners might find it helpful to have the company of a cell-mate, but no responsibility falls on that cell-mate for keeping safe the at-risk prisoner. That task remains the responsibility of the staff alone.

The management of the man's risk of suicide

84. By the time the man arrived in Maidstone he had been in custody for eight months and ACCT forms had been opened and closed on four separate occasions. Each form had been opened in response to an incident of self-harm. On three occasions he inflicted cuts to his neck and on one occasion he

took an overdose of his in-possession medication. None of these acts resulted in any significant injury.

85. Another ACCT form was opened on 24 September when the man reported to an officer that he had once again cut his neck. He had used a safety razor to make the cuts which, as on the previous occasions, caused only minor injury. The man was seen by an ACCT assessor that day and he attended two case reviews over the course of the following 48 hours. As always, the man was very frank in his discussions with staff. He told them that he had a diagnosis of bi-polar disorder and that he was receiving medication for the condition. He said that he had attempted suicide eight or nine times in the past, and that suicidal thoughts would come at times when he was feeling extremely low. He also explained that the extreme lows would come on without any warning.
86. Having opened an ACCT form, staff had to decide on an appropriate support plan. The man was offered the opportunity to do some voluntary cleaning work to help him combat boredom, but he declined that offer. Staff did, however, agree to his request that his cell door be left open during the day time as he had said that he found it difficult being locked-up all day. (This issue is further discussed in the following section.) Staff also had to decide on what should be an appropriate level of interaction with the man. The guidance contained in PSO 2700 about interactions and observations to help prevent self-harm or suicide does not give examples of situations where a particular level of interactions and observations should apply in any case. And nor is such guidance included in the ACCT training courses that all staff attend. The Prison Service's reasoning for avoiding specific guidance on the level of contact is the need to treat every prisoner as an individual. It is therefore for the review panel to decide each time, and on an individual basis, what it considers to be the appropriate level of contact with the prisoner at that time.
87. At the first case review, the level of staff interactions with the man was set at three conversations during the day time with six observations overnight and random observations during lock-up periods. At the second review on 26 September, the man mentioned that he had had suicidal thoughts in the previous few days, while denying having made any specific plans. He added that he had been having suicidal thoughts for several years. Based on the man's comment about having had some suicidal thoughts in recent days, the review panel decided that the level of observations should be increased to one worthwhile interaction and two observations per shift during the day. He would then be observed eight times overnight.
88. I do not believe that the level of interactions and observations set, was inappropriate. In reaching that conclusion I acknowledge that the man had harmed himself on a number of occasions during a fairly brief time in custody, and I note too his declarations to staff that suicidal thoughts were a feature of the low periods of his bi-polar disorder. However, I am also mindful of the fact that none of the staff who encountered the man thought him to be at significant risk. This included the second RMN who saw the man almost every day during his time in Maidstone. Indeed, the man had spoken to an officer after his visit on 26 September and said he would get a visit the following week and talked

about having some clothes brought in. On the day of his death, the man had sent out a visiting order, filled out his meal choices for the coming week and told a fellow prisoner that he might go to the gym. All of these activities can reasonably be seen to be those of someone who is looking forward to the week ahead.

89. During his interview with my investigator, the second chaplain said that he had not received ACCT training. I acknowledge that the second chaplain, both through his work at Maidstone but, perhaps more so, through his extensive pastoral experience in the priesthood, will be well equipped in understanding when a person might be in crisis. Nevertheless, I would remind the Governor that all staff who come into contact with prisoners must receive training in accordance with the requirements of PSO 2700.

The decision to leave the man's cell door open

90. During his ACCT assessment on the afternoon of 24 September, the man said that he found it unhelpful being alone in his cell all day as it gave him time to think. In response, staff agreed that they would leave the man's cell-door open during the periods that other prisoners were at work or at education. This decision was a sensible and pragmatic response to his comment about how he was affected by being locked away.

The decision to allow the man to keep his dressing gown cord

91. PSO 2700 provides extensive guidance on suicide and self-harm prevention and management. The PSO advises that removing personal belongings from a person who is feeling hopeless and depressed, especially items of clothing, belts or shoelaces, can increase feelings of distress and therefore increase the risk of suicide or self-harm. The PSO goes on to advise that items should not be removed as a matter of course and should only be removed for the briefest possible time. (For example, a high-risk prisoner might have items removed at night but allowed access to most items during the day.)
92. It was his dressing gown cord that the man used for a ligature. I understand fully why his family question the decision to allow him to retain the cord after the ACCT form was opened. However, in allowing the man to retain this item, the staff at Maidstone were adhering to the general principles set out in PSO 2700. Items might have been removed from the man's possession had he been considered at greater risk than was thought and in that case such items might have included his belt, his shoe laces and even, perhaps, his clothing. But even in that case, he still would have retained bedding material.
93. Bearing in mind all these factors, I do not criticise staff for allowing the man to retain the dressing gown cord.
94. In certain circumstances, prisoners might also be prevented from retaining a safety razor. They might then be allowed a razor in order to shave and then asked to hand back the razor immediately afterwards. Although the man used a razor to cut himself on several separate occasions, on no occasion did he

inflict a severe cut. Moreover, when he did so at Maidstone he did not smash the razor to expose the entire blade but instead cut himself with the blade still enclosed within the safety casing.

95. Compared to many others whose deaths I have investigated, the man was not someone I would classify as a prolific self-harmer and nor did he cause himself serious injury when he did resort to self-harm. I consider it entirely reasonable, therefore, that he was allowed to retain razors in his possession.

Continuity of psychiatric care

96. One of the concerns raised by the man's mother was about the fact that there was no single psychiatrist in charge of her son's care. Unfortunately, there is no realistic solution to such a problem. All prisons commission clinical care delivery from a local provider. The man spent time in three different prisons during his time in custody and each prison has a different provider of mental health services. I am pleased to note, however, that the mental health in-reach team made contact with the man's community psychiatrist seeking his views before deciding whether to make any changes in treatment.

The medication prescribed to the man

97. The man's mother's primary concern was about the amount of chlorpromazine that her son was prescribed, and its effect on him. She thought that the medication and its dose caused her son to be overly sedated. The man's mother also questioned the possibility of any adverse interaction between the chlorpromazine and the other medicines he was receiving.
98. When the man was brought into prison custody in January 2008, he was prescribed chlorpromazine at a dose of 350mg per day. The dose was later increased to 450mg per day, and on 11 July it was further increased to 500mg per day.
99. The clinical reviewer, had explained that chlorpromazine is normally used to treat schizophrenia and other psychoses. As a maintenance dose, up to 300mg can be prescribed daily, however a patient in psychosis can be given up to 1,000mg per day. The clinical reviewer has quoted the British National Formulary (BNF), a textbook on medicines, as explaining that chlorpromazine is useful for treating violent patients without causing stupor. One entry in the clinical records does report the man as saying that he was finding the chlorpromazine "too sedating", but he went on to say that he needed the medication as he was "psychotic". The clinical reviewer has pointed out that the dose prescribed to the man was well within the levels indicated in the BNF, and her view is that it was an appropriate dose to help the man deal with his impulsive and aggressive behaviour.
100. The man's prison friend told my investigator that he thought that the man was very sedated, but none of the officers to whom my investigator spoke agreed with that assessment. Consistently, their evidence was that the man was perfectly lucid showing no signs of sedation. (I should add that my investigator

concurred with the officers' views based upon the limited evidence of listening to a recording of the final telephone conversation between the man and his mother.)

101. The clinical reviewer has also considered the potential for adverse interactions between the various medications that were prescribed for the man. (These included diazepam and, intermittently, several different anti-depressants, including sertaline.) The clinical reviewer has mentioned two possible adverse interactions. One could have affected the man's blood clotting system, and another could have made him more prone to suffering epileptic fits. The man suffered neither of these adverse interactions however.

The discovery of the man's death

102. When the OSG Roberts checked the man at just after 10.00pm on Saturday 27 September, he saw him slumped on a chair and part suspended from a ligature. The OSG obtained permission to enter the cell without waiting for the arrival of the response team and he then supported the man's body until the arrival of his colleagues.

I recommend that the Governor commend the OSG for his determined efforts to go to the aid of the man without delay.

103. When additional staff arrived they cut the ligature and after checking the man for a pulse commenced CPR. One of the officers told my investigator that he delivered CPR at a ratio of 15 chest compressions to two rescue-breaths. My investigator advised him that current instructions were that CPR should be delivered at a ratio of 30 compressions to two rescue-breaths.

I recommend that the Governor ensures that staff who have been first aid trained are able to attend refresher training at appropriate intervals. I further suggest he reminds all staff of the currently advised ratio of compressions to breaths during CPR.

104. It would not appear that staff brought the prison defibrillator¹⁰ to help in the attempts to resuscitate the man. I understand that Maidstone had one defibrillator at the time the man was in the prison although more have now been obtained.

I recommend that the Governor ensures that a sufficient number of appropriate staff have been trained in the use of defibrillators and that they are always taken to the scene of an emergency.

The way in which the man's family were informed of his death

105. Prison Service Order (PSO) 2710 provides guidance and instruction on notification to families following a death in custody. The only mandatory

¹⁰ A defibrillator measures electrical activity in the heart and issues audible instructions about treating the patient including, when appropriate, delivery of an electric shock.

requirement is for the notification to be made as soon as possible and in a suitable manner, giving an accurate factual account of what has happened. In general, face to face notification by staff from the prison is the preferred option. Wherever possible, the visit should be made by a dedicated Family Liaison Officer working alongside a chaplain, or Governor or most senior individual available together with the chaplain. If a dedicated Family Liaison Officer is available, the Duty Governor can remain in charge at the prison.

106. The guidance acknowledges that asking the police to inform the family may sometimes be necessary, but the decision to do so should be based on an assessment of all relevant factors including availability of suitable staff members, the time of day or night and the need to inform the family in a timely manner.
107. The Duty Governor came into the prison after being telephoned at home. The Governing Governor also came into the prison. The Duty Governor attempted to telephone Maidstone's Family Liaison Officer (FLO), but had no success. Maidstone's other FLO had only recently been trained and so it was thought best to ask the police to make the visit so that the family could be informed without delay.
108. In a previous investigation into a death at Maidstone, the prison also asked for the notification to be made by the police. The reasoning behind the decision in that case was different to that that applied following this death. Nevertheless, I again point out that it is always best that the news of a death in custody is delivered by prison staff. This is what families and agencies that work closely with them say they prefer and expect, and it shows that the death is being taken seriously by the prison. In the absence of appropriately qualified or equipped FLOs, another option would include a governor grade member of staff accompanied by a chaplain.

The Governor should ensure that, where possible, the news of a death in custody is broken to the next-of-kin in person by a member of prison staff.

Clinical care

109. The clinical review has found that, while in prison custody the man had been seen regularly for his mental and physical health problems. Regarding the mental health perspective, the reviewer concludes that the man received appropriate assessment and treatment for his needs.
110. However, the reviewer is critical about some aspects of the clinical record keeping and she has made recommendations about this. She highlights, for instance, that doctors need to explain their rationale within the records when altering drug dosages and should also record the effects of the alteration. She has also pointed out that the records from Maidstone do not reflect the communication that took place between the nursing team at the prison and the mental health in-reach team. This might have led to the confusion on the part of both the man and prison wing staff about whether or not a psychiatrist was scheduled to visit him on the Friday before his death.

111. Another of the clinical reviewer's recommendations is for HMP Blundeston where the man took an overdose of prescribed medication that he had been allowed to hold in his own possession. It would not seem that this previous incident of self-harm led to any review into the man's suitability to continue to retain in-possession medication.

RECOMMENDATIONS

The following recommendations were made in the draft version of this report. The Prison Service's responses appear in italics following each recommendation.

1. I recommend that the Governor commend the OSG for his determined efforts to aid Tte man.

Recommendation accepted and implemented: the OSG received a Governor's commendation at the quarterly full staff meeting in July 2009.

2. I recommend that the Governor ensures that staff who have been first aid trained are able to attend refresher training at appropriate intervals. I further suggest he reminds all staff of the currently advised ratio of compressions to breaths during CPR.

Recommendation accepted: Maidstone have carried out first aid training for senior officers and further training for staff is contained within their training plan. A notice to staff will be issued in relation to the rate of compressions to breaths during CPR. Target date for completion is November 2009.

3. I recommend that the Governor ensures that a sufficient number of appropriate staff have been trained in the use of defibrillators and that they are always taken to the scene of an emergency.

Recommendation accepted: 22 members of staff attended a 3 hour foundation training course on the use of equipment on the 2 June 2009. Training is ongoing.

4. The Governor should ensure that, where possible, the news of a death in custody is broken to the next-of-kin in person by a member of prison staff.

Recommendation accepted and implemented: The procedure for use of the FLO is contained within the Death in Custody Duty Governors contingency plan.

(Further recommendations have been made by the clinical reviewer and are to be found on the final page of the clinical review).