

**Circumstances surrounding the death of a man
at HMP The Weare on 3 June 2005**

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

March 2006

This is the report of an investigation into the circumstances surrounding the death of a man, apparently at his own hand, at HMP The Weare on 3 June 2005. The man was 27 years of age and serving a sentence of two years. He had been at The Weare for a little over a week.

The man was found hanging from a shower fitting in his cell. A bed sheet had been fashioned into a noose and was wrapped tightly around his neck. The man had given no indication that he might take his own life. He left no letter.

A post mortem examination performed on 7 June 2005 found that the cause of death was hanging.

I offer my sincere sympathy and condolences to the man's family, who have suffered the tragic loss of a much loved member of their family. I know that staff and prisoners at The Weare shared those sentiments.

The investigation was carried out on my behalf by Mr Ron Tasker. As part of his investigation he commissioned an independent review into the clinical management of the man. I am grateful to the doctor who carried out a long and comprehensive review on behalf of the South West Dorset Primary Care Trust.

My thanks also go to the Governor and all staff at The Weare, whose work in liaising with my investigators enabled the investigation to be thorough and to be completed in a timely fashion.

I make six recommendations for improvement and identify two areas of good practice.

Stephen Shaw CBE
Prisons and Probation Ombudsman

March 2006

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SUMMARY

The man was born in London and brought up there. At the time of his death, the man intended to return to London and to live on release from prison with his mother, her partner, and his sister and brother. Although only 27, the man had five children of his own and one stepson, and he had been married. He also had had a recent relationship with another woman. From her point of view, that relationship had finished. The man could not accept that their friendship had ended.

The man had not previously served a prison sentence. At the time of his death, he had served most of his sentence in an open prison in Sussex. He was released early on 28 February 2005, under an electronic monitoring scheme. During the monitoring period, he cut off his tag and gave himself up at a police station. The man still had about four months left to serve on his sentence. He was taken to HM Prison Pentonville and stayed there for about two months. With just seven weeks left before his release, he was transferred to HMP Weare, 150 miles away in Dorset, in order to free up space for new prisoners in London.

A post mortem examination found that the cause of death was hanging. A toxicological examination found drug screens negative for amphetamines, benzodiazepines, cocaine metabolites, cannabinoids, methadone and barbiturates. Amitriptyline was present at 0.03 milligrams per litre of blood, and nortriptyline was present at 0.08 milligrams per litre. Both were within the therapeutic range of up to 0.3 milligrams per litre. These findings are significant in that the man was prescribed Trazodone at Pentonville and he took it intermittently between 6 and 22 May. However, Trazodone does not break down into amitriptyline or nortriptyline. Yet the man did not see a doctor at The Weare, where he transferred on 24 May some two weeks before his death. He could not, therefore, have been prescribed either amitriptyline or nortriptyline whilst in prison and it is not known how he came by these drugs. Amitriptyline is prescribed widely for depression and breaks down into nortriptyline, which is eliminated more slowly from the body than is amitriptyline. It is possible that the man accessed this drug illegally in prison, perhaps to help him sleep.

At Pentonville, the man was clinically depressed and was diagnosed as such. After missing two psychiatrist's appointments, he eventually saw a psychiatrist who prescribed Trazodone. The man also missed several appointments for the administration of his treatment at Pentonville. The reasons he missed the initial psychiatrist appointments and failed to take regular treatment are not known. Clinical administration at Pentonville is not good, and my investigation could not establish what had gone wrong. I make a recommendation in respect of this.

Pentonville did not make known details of the man's condition to staff at The Weare, when he transferred there. The man saw a nurse on the day he arrived, but it is not known whether he asked to see a doctor. It is probable that he did. In any event, the reception nurse decided the man should see a doctor. He did not. Clinical administrative records were not good at The Weare and it remains unclear whether or not an appointment was made. The Weare has now closed. Nevertheless, I make a recommendation in respect of

the health care arrangements there, particularly as medical records were poor for prisoners who may still be serving sentences elsewhere. Significantly, my report of July 2004 in respect of an investigation into the death of another prisoner at The Weare also found poor record keeping in the health care centre.

In the few days before his death, the man spent much of his time trying to revive his failed relationship. He telephoned the woman who had ended it many times, and he talked extensively to his cellmate who gave my investigator comprehensive and helpful information as to the man's state of mind. The man gave no indication, however, that he was contemplating suicide or self-harm.

It is not possible to say what was in the man's mind when he wrapped the bed sheet around his neck. The information given by his cell mate, and the transcripts of his last telephone calls, together paint a picture of an unhappy man who had lost hope of finding a settled life on discharge from prison.

INVESTIGATION METHODOLOGY

The investigation was opened on 8 June when my colleague, met with the Governor, Safer Custody Manager, and other staff at The Weare. He was given a full and very helpful briefing by the Governor on the events leading up to and after the man's death. Ombudsman's notices, identifying the scope and methodology of the investigation, were issued to staff and prisoners. The notices also made clear that staff or prisoners who wished to see the investigator should make themselves known by either contacting the liaison officer at the prison, or by contacting my office direct. Staff and prisoners in key positions or locations were identified and invited for interview. All responded willingly. The local branch of the Prison Officers' Association (POA) was briefed. They were helpful and offered constructive comment and advice. During a follow-up visit, my investigator interviewed four members of staff and one prisoner. The man's cellmate gave a first hand account of the problems the man had faced in his personal life.

My investigator met with the Chair and one other member of the prison's Independent Monitoring Board (IMB). Their contribution was valuable especially that from the member of the Board who was in the prison at the time the man died. The IMB provided a helpful perspective on the prison. The prison chaplain gave my investigator a full and insightful account of life at The Weare.

My investigator met local police, who shared freely all their information and interview records, as did the coroner's officer.

My investigator commissioned an independent clinical review. This was conducted by a doctor on behalf of South West Dorset Primary Care Trust. This was a long and painstaking review, and the doctor went to great lengths at two prisons, in order to try to piece together the quality of the man's treatment. He also analysed and commented on the findings in the toxicological report.

My investigator, together with one of my family liaison officers, met the man's mother, father, sister and brother at their home, together with his mother's partner. They were made to feel very welcome and learned much about both the man's life and his state of mind at the time he was sent back to prison.

HMP PENTONVILLE

Pentonville was built in 1840 as a city prison accommodating short-term local prisoners, a role it fulfils to the present day. The prison holds 1,200 prisoners and is always full. It receives prisoners from local courts and holds them until either they are liberated or moved to less crowded prisons in order to free up places for new prisoners. It is against this backdrop that Pentonville's involvement in the man's life needs to be seen.

The man was referred to a psychiatrist at Pentonville. He missed two appointments, but on a third appointment he was diagnosed as being depressed and he was prescribed Trazodone, an anti-depressant drug. The psychiatrist recorded that he wanted to see the man in seven days time, and an appointment was made. The man missed that appointment, and he took his treatment only intermittently during the three weeks prior to his transfer to The Weare. Pentonville does not appear to have attempted to establish the reasons for the missed appointments and treatments.

HMP WEARE

The Weare, now closed, was a unique prison. Built as floating accommodation in Sweden and used later by British forces in the Falklands war, the ship was then sold to the US Government who used it as a prison. It was purchased by the Prison Service in 1997, as a temporary measure to ease population pressures. The ship was towed to Portland harbour and opened as a prison on 11 June 1997. It had an intended life of three years. In May 1999, its projected use was extended by three years, and, following a further extension, it remained in use as a prison until it closed on 12 August 2005.

When fully occupied, The Weare held 400 prisoners. At the time of my investigation in June and July 2005 there were fewer than 200 prisoners, as decommissioning work was well under way.

Her Majesty's Chief Inspector of Prisons, in her inspection report dated August 2004, described The Weare as unfit for purpose. However, her report recognised good relationships between prisoners and staff, and prisoners particularly commended reception and health care arrangements.

At the time of my investigation, The Weare had become further dilapidated and did not provide decent or tolerable conditions for prisoners. The ship was cramped, in bad repair and the outside exercise area on the upper deck had long been out of use, giving prisoners virtually no opportunity to spend time outside of the ship's claustrophobic confines. There was insufficient opportunity for prisoners to spend an active day. The whole prison had a weary, resigned feeling, consistent with the prospect of its imminent closure. Many staff had already transferred to new postings, and those who remained faced either transfer, or in some cases an uncertain future. Non-uniformed staff were particularly vulnerable, with the prospect of redundancy looming for some of them.

Nevertheless, staff were working hard under poor conditions. My investigator saw that staff and prisoner relationships were exceptionally good. There was an atmosphere of politeness throughout, and prisoners were easy in their conversations with all staff. I think this is particularly important, as later on in this report I criticise the medical care at The Weare and I am left wondering why the man did not feel able to take the initiative in the face of what I believe to be significant shortcomings by health care staff. Certainly, nothing in the ethos of the prison should have led to the man being unable to ask questions or receive reasonable answers, had he decided to challenge the quality of his health care.

The suicide and self-harm committee met bi-monthly under the chairmanship of a full time Safer Custody Manager. Meetings were well attended by staff and prisoners, and the suicide prevention policy had been reviewed and revised in January 2004. Notices in respect of suicide, self harm, bullying and means of accessing Samaritans were displayed clearly and in good measure throughout the prison. A 'buddy' scheme, where prisoners were trained to listen and help other prisoners through difficult times, was active, and well-run by an enthusiastic chaplain.

Mandatory drug testing showed low levels of drug abuse, and results from random sampling of prisoners were at the low end of the scale for all prisons, and well inside Prison Service targets.

KEY FINDINGS

Pentonville

The man saw a doctor at Pentonville on 31 March and said he was depressed. He asked to see a psychiatrist. He was asked specifically about his thoughts on self-harm or suicide and said he had no intention of hurting himself. The doctor arranged for the man to see the prison's visiting psychiatrist. The man did not keep two appointments, but on 5 May he was seen by a psychiatrist who prescribed a sedative antidepressant, noting at the same time that in view of the short period he had left to serve in prison, it would not be possible to arrange counselling. The psychiatrist noted that he would like to see the man again in seven days. The man missed that appointment and did not see the psychiatrist again.

The man collected his prescribed treatment daily from 6-11 May, and on 14, 20 and 22 May. He did not appear for treatment on other days although it was available. The clinical reviewer tried to establish the reasons for the man not attending the missed psychiatrist appointments, not collecting his medication, and not seeing the psychiatrist seven days after the consultation on 5 May. He asked if attempts were made to track the man down as he had not presented himself for either an appointment or his regular treatment. The gist of the answers was that the administration of the health care centre at Pentonville has been problematic, but has now improved. It is unlikely that clinical staff queried why the man had not attended for appointments or for treatment.

On 22 May, Pentonville received instructions to arrange an 'overcrowding draft' to HMP Weare. 'Overcrowding draft' is a technical prison term. In simple language, it means that when a prison is full and needs to create headroom in order to admit new prisoners, it may be given relief by arranging the transfer of prisoners from that prison to another which has spaces. City prisons are generally always full. Their routine business is to receive prisoners from court and if possible arrange their onward transfer to training prisons. There are reasons this may not be possible. Prisoners often arrive and have further court appearances pending, either because they have been remanded by a local court for a further appearance in the near future, or because they are appearing daily at court and need lodging for the night. Some other prisoners may need to stay pending their appeal. Given that the prison population is currently at record levels, it is unsurprising that Pentonville is one of the prisons needing relief and must find it wherever it is available. Often a city prison may be arranging a number of overcrowding drafts simultaneously, with a handful of prison places being available in a number of training prisons. A consequence will usually be that prisoners are sent to prisons a considerable distance from home. The man's parents were not happy that he was moved to Dorset. I entirely share the view that, wherever possible, prisoners should serve their sentences within a striking distance of home. However, in the circumstances and given that Pentonville had to make space for new prisoners, they had little choice but identify the man as one of many candidates for transfer. However, Pentonville should have established that The Weare could provide for the man's medical needs prior to the transfer.

The Weare was offering six prisoner places for the overcrowding draft. The criteria for selecting the prisoners were simple. They had to be medium to low (category C) prisoners, and their release from prison dates had to be before the end of July 2005. This date was significant as The Weare was due to close by the end of July (in fact, it closed on 12 August). These selection criteria for transfer produced a limited field. My investigator spoke by telephone to the Governor and later to the compliance manager at Pentonville who told him that the man was self-selecting, as he exactly matched the criteria.

My investigator asked the Governor of Pentonville to comment on his father's belief that the man's argument with a member of staff had led to his transfer. The Governor made enquiries and in a telephone call to my investigator, later supported by written entries in the man's prison record, identified that the man had been treated sympathetically by staff who had tried to help him find his way through his personal problem with his girlfriend - on one occasion telephoning her on his behalf. There was no record of the man having argued with a member of staff.

From Pentonville's point of view it was inevitable that the man, by virtue of an exact match to the criteria in a limited field, should transfer to The Weare. It is likely, given poor health care administrative arrangements, that staff arranging the transfer did not know of the man's medical considerations. The work to complete details of the overcrowding draft was completed on 23 May. The man transferred the following day.

The Weare

At The Weare, on the day of his reception (24 May), the man saw a nurse. An entry in the Receptions Record Book says '4MO'. I understand that at The Weare this was shorthand for 'for Medical Officer' and means that the man's name was put on a list to see a doctor the following day. It is not recorded whether or not he asked to see a doctor, or if his name was put on the list on the initiative of the reception nurse. There were nine new prisoners at The Weare that day. Four of them, including the man, had '4MO' beside their names, and five had 'Decline MO' written against theirs. The man did not see a doctor, nor did the other three prisoners. Of the nine prisoners who arrived on 24 May, only one had a medical record completed at The Weare.

It is possible that an appointment may have been made for the man to see a doctor on 25 May. The man's electronic medical record was accessed by a member of the health care staff at 11.50am. The health care manager suggested to the clinical reviewer that the record was accessed either in readiness for the man's appointment, or to establish that he was still at The Weare. The record was closed a minute later. No entry was made on it. When the clinical reviewer asked the doctor at The Weare what was done to establish why the man had not appeared for his appointment, the doctor said that patients missed appointments for a wide variety of reasons and to attempt to establish reasons was not practicable. In the clinical reviewer's words, '... the lack of records in this [The man's] case does not inspire confidence.' The clinical reviewer draws also on his wider experience of prison deaths, and comments that the issue of missed appointments is a

major problem within the prison estate as it is in the whole NHS. He recommends an audit and a new initiative in order to improve matters.

On 25 May, the man saw the duty governor on a routine induction interview and confirmed details of his home address, giving his mother's name to be used in case of emergency. He was told about rules at The Weare. The only entry of note in the man's record is an encircled comment, 'coping ok' made by the duty governor.

The man was allocated a cell, but learned quickly that a prisoner with whom he had shared a cell at Pentonville, and with whom he had struck up a friendship, had also moved to The Weare. By mutual consent, and with the permission of wing staff, they moved in together.

On Saturday 28 May, the man's mother, together with his youngest child and her mother visited him. The visit went well. The man's mother told my investigator that they had all been happy and that she had written a long letter to him following the visit. So did his little girl's mother who believed that she and the man were to settle down together following his release from prison. To all outward appearances, everything was all right. His mother knew of the man's attachment to another woman, but following the visit she felt that he might have taken the decision to make a go of it with his young daughter and her mother. Nobody, except perhaps the man's cellmate, knew the true extent to which the man was becoming increasingly out of control with his inner feelings.

On 29 May, the man's personal officer wrote, 'Arrived at The Weare on 24/5/05, appears to have settled in well and adheres to wing regime; no problems to note'.

Meanwhile, the man was telephoning the woman who had ended their relationship at every opportunity. My investigator retrieved transcripts of the calls which show him making long and impassioned pleas and she, in turn, politely but firmly telling him it was over and asking him to let her get on with her own life.

On Wednesday night (1 June), the man and his cellmate sat up until 3am on the Thursday morning. The conversation was about the woman who had, in the man's view, abandoned him. The man went over and over again that if she would only give him another chance, everything would be fine. His cellmate tried to impress upon him that he might have to accept it was all over, and that there was a good chance he could make a life with his young daughter and her mother. The man varied between seeing this as realistic, and then saying he would give up everything if he could resume his other relationship.

On Thursday 2 June, the man had an uneventful day, and he played pool all evening. Later, he and his cellmate watched a film and went to sleep at about midnight. It was the cellmate's impression that the worst was over. He told my investigator, "The man said he was ok. He said that being totally honest he had been depressed, stopped eating and couldn't sleep. He said he felt better now. He thought his blood sugar must have dropped. He had a bar of chocolate and started eating, and said he was feeling much

better. He had been full of despair on Wednesday night, but by Friday morning 3 June he seemed all right in himself”.

The man’s cellmate went to work on Friday morning, leaving the man - who had not yet been allocated work - alone in their shared cell. He had no anxiety about the man, considering him to be over the worst and looking forward to release from prison in a few weeks.

During the morning, the man’s cell was unlocked. Between 10am and 11am, he made four telephone calls, two of short duration to the mother of his young daughter, and two totalling nearly 50 minutes to the woman who had discontinued their relationship. It is clear from the transcripts of these long calls that the man was imploring the woman to resume their relationship, and that she was resolute in her decision that she would not. The man was agitated and his feeling of hopelessness comes through. Following the calls, the man returned to his cell.

Events following The man’s death

At about 11.35am, the man’s cellmate returned from work. He thought the man was in the cell. His tobacco was on the table and the toilet door was closed. He knocked on the door and called the man, but got no answer. He began to think something was wrong. He went into the toilet and saw the man hanging from the shower fitting. He immediately called for assistance by shouting along the landing and by pressing a general alarm button. A second prisoner responded and between them they moved the man. Staff were quickly on the scene and they started resuscitation. Nurses arrived quickly; an emergency ambulance was called and arrived at 11.52am. Paramedics took over the care of the man. Sadly their efforts were in vain and they pronounced him dead at 12.07pm. A local GP, who provides a medical service to the prison, confirmed their diagnosis at 12.50pm.

The Weare’s action plan for the death of a prisoner was followed meticulously. The coroner’s officer attended, as did local police. Staff and prisoners were interviewed. They were saddened and shocked but together they supported each other in the immediate aftermath of the sad event of the man’s death.

The Governor telephoned HMP Wandsworth, and asked for assistance in informing the man’s family of his death. Wandsworth agreed readily, and a governor and chaplain visited the man’s mother. This was an example of good practice, and enabled his mother to be given full details by prison staff who were able to explain the context. They also said how the Governor and staff at The Weare would make sure she could visit and have her questions answered. The Safer Custody Governor contacted his mother, offered his condolences and explained how she could visit the prison. He also gave details of how the prison would help with funeral expenses. His mother said she would ensure other members of her family were informed of the man’s death. The man’s parents both found no fault with the sensitive way they received the sad news, or the subsequent way in which the Safer Custody Governor attended to their needs. They felt, however, that an

immediate telephone call from the governing Governor would have marked the importance of the man's death, and the seriousness with which it was being taken at The Weare.

The Governor held a meeting the morning after the man's death and discussed, while the details were fresh in everybody's mind, how staff were feeling and if there were lessons to learn. Thus the Governor was able to see, and hear for herself, accounts from all staff, and she reviewed the information available at that early stage.

The Governor saw all staff personally, and talked to the Care Team Coordinator. All staff were offered counselling. Some of them took up the offer. The Governor wrote and thanked the two prisoners who had taken prompt action to try to save the man's life, and made sure they knew how to access counsellors. My investigator was present at a follow-up interview which was conducted sensitively and at length.

I commend the Governor's actions.

ISSUES

The clinical review

The clinical reviewer visited Pentonville and The Weare. He spent many hours assessing and reviewing all available information. Although he had excellent cooperation at each prison, he was hampered to a great degree by incomplete medical records at both, and inevitably he identifies that some of his comments are matters of conjecture.

We are sure, however, that the man was seen by a psychiatrist on 5 May at Pentonville and diagnosed as suffering from depression. He was prescribed daily treatment of Trazodone, an anti-depressant drug. This followed the initial diagnosis, made when the man arrived at the prison on 30 March. It is not possible to say why the man waited five weeks to see the psychiatrist. Appointments were made earlier and not kept. It is possible that the man did not know of these appointments. Pentonville medical staff said that their clinical administration arrangements were not good and there is no evidence to suggest that staff tried to identify why appointments were missed for either consultations or treatment.

The man took his medicine intermittently between 6 and 22 May. Again, the reasons for his non-attendance for treatment are not known. Prisoners do not have freedom of movement, and it is simply not possible to say why he did not go for his medicine.

The man transferred on 24 May to The Weare. No medical information accompanied him from Pentonville. To all intents and purposes, staff at The Weare started with a blank page.

On the day of his arrival, the man was identified as needing to see a doctor. He did not see one. The Weare's record keeping was poor. Only one of nine prisoners received there the same day as the man had a reception questionnaire completed by staff. An appointment may or may not have been made for the man to see a doctor. It is possible that he did not know whether or not an appointment was made. It is possible also that when his appointment did not materialise, he later exercised his own free will in not seeking out a doctor. Relationships were relaxed at The Weare, and the man could have completed a simple application form or made a verbal request. The absence of an audit trail does not help. In the clinical reviewer's own words, '... the lack of records does not inspire confidence.' The man died on 3 June without having seen a doctor.

My report into the death by natural causes of another prisoner at The Weare, in July 2004, also noted the poor record keeping at the prison health care centre. The report said it was impossible to say whether or not a prisoner who died had been prescribed antibiotics the month before he died. The report also noted poor communication between medical staff at The Weare and another prison. I recommended that staff be reminded of the importance of keeping comprehensive medical records.

The clinical reviewer makes other points which in summary are;

- Prisons should be free to reject prisoners if medical staff think their provision is not adequate. The Weare did not have Pentonville's sophisticated 'in reach' psychiatric facilities.
- The Primary Care Trust should investigate how eight from nine medical records were not completed on the day the man arrived there, and should establish whether or not the other prisoners listed to see a doctor on that day were in fact seen.
- The Primary Care Trust should make greater efforts routinely to establish reasons for prisoners missing appointments.
- Prisons should ensure details of ongoing medical treatment are available immediately to other prisons when a prisoner is transferred.

FINDINGS

The man gave no indication to anybody that he was contemplating taking his own life. Indeed, he may not have made plans to hurt himself and his death might have been the result of a spontaneous act.

He could also have asked to see a doctor at The Weare, and he could have been more insistent in respect of the shortcomings of both Pentonville and The Weare. Certainly at The Weare, which my investigator found to be the most relaxed prison he had ever visited, it should have been a simple matter for the man to ask what had happened to his doctor's appointment. This would have been possible without the necessity of formal applications to governors or the Independent Monitoring Board. We can never know why he chose not to pursue medical matters on his own behalf.

Nevertheless, having made both these points, a pattern of poor attention to detail in the medical care of the man emerges in respect of both Pentonville and The Weare.

A commendably an early diagnosis at Pentonville was not matched by an early psychiatric appointment, although two were apparently made and not kept. Neither was a follow-up appointment made in the terms directed by the psychiatrist. Nobody seems to have asked why he did not attend his psychiatrist's appointments and similarly, when treatment was prescribed, the man took it only intermittently and again nobody seems to have asked why he did not attend regularly for his treatment. The answers to the questions posed by the clinical reviewer do not inspire confidence in Pentonville's medical administrative arrangements.

There is no evidence that Pentonville took into consideration the man's medical condition when allocating him for transfer to The Weare. Pentonville provided no medical details to The Weare. It could be that his condition was capable of being managed at The Weare, but running through this investigation is paucity of information which would identify whether or not consideration was given to The Weare's ability to take on the man's medical management. All this may be symptomatic of a wider malaise at Pentonville, extending beyond the circumstances of the man's care.

At The Weare, the man saw a member of the health care staff who identified that he should see a doctor. Medical record keeping was poor at the prison, and it is not possible to say whether or not an appointment was made. If it was, it is unlikely the man knew of it, and The Weare's answer to the clinical reviewer's question about what would have been done to ensure The man kept his appointment is disappointing. Prisoners often miss appointments because they do not know about them or they simply cannot get to the place they are required. After all, prisoners do not have keys and must rely on staff to unlock and often escort them to appointments. I appreciate that it is not practical to follow up every missed appointment, but if there is an identified physical or mental health risk then the reason for the failure to attend should be followed up and documented accordingly. The Weare, as a training prison, was not particularly busy, and I think the medical staff could have done more to ensure the man had better care. Other prisoners who should

have seen a doctor following their reception at The Weare may not have seen a doctor, and many medical reception records were not completed. Given also the criticism made in my earlier report in respect of The Weare's medical record keeping, I think that, had the prison remained open, a review of medical practice should have been instituted.

Overcrowding drafts are a feature of life at almost all local prisons. While I understand the reasons for them, I understand also the man's parents view that to send the man, who was in prison a few miles from his home and was part of his very close family, to one that was 140 miles away, cannot make sense. Nevertheless, I know that the Prison Service has to make these difficult decisions daily. Large city prisons are full and overflowing. The prison population is at an all time high, and space must be found for new prisoners. Yet, prisoners are not always easily accommodated across the estate. Some have security considerations, some need to stay in cities for further court appearances and some have behaviour problems. In the man's case, he was a reasonable man who could be relied on to behave well in community life at The Weare, he was not of a high security category and his release date was within the projected life span of the ship. I question, however, whether or not the man's medical condition was considered when he was identified as suitable for The Weare.

My overriding regret is that the Prison Service was unable to communicate, either within its own establishments or across them, the man's medical needs. Good communication might not have changed the course of events, but it could have ensured prompt and systematic treatment and the passing on of important information when the man transferred from Pentonville to The Weare.

CONCLUSIONS

The man was not a sophisticated prisoner. He had served part of this sentence in an open prison, and he had given himself up having cut off his monitoring device when he had taken early release. In Pentonville and The Weare he behaved well, and, if not sitting patiently awaiting the end of his sentence, he would have been a reasonable man living a life as near to normal within the confines of prison.

The man had a complicated personal life, and this drove his thinking and his behaviour in prison. He spent hours on the telephone to the woman who had ended their relationship, and he spent long hours either accessing funds for the telephone, or in talking to his cellmate about his troubles. A member of staff at Pentonville had also tried to help by telephoning on his behalf. At the same time, the mother of his baby daughter hoped that they could all begin a new life together. The man's mother also saw this as an opportunity for him to settle down to a happy life.

At Pentonville, the man had an opportunity to cope with his depression through psychiatric treatment, and he made a start. The treatment did not continue. We do not know in what circumstances he took his medication only intermittently. Record keeping at the prison was not good. It may be that he decided not to take his treatment. It may be that he was unable to access it.

Transfer to The Weare may well have been appropriate. Although the prison did not have Pentonville's psychiatric in reach facilities, it could arrange for a mental health assessment if there was an identified urgent need. It is also possible that, had staff at The Weare known of the man's prescription, or if they had arranged for him to see a doctor, the treatment could have continued.

At The Weare, he should have seen a doctor. He was identified, albeit in an unusual shorthand '4MO', as needing to see one. The Weare should have made a more detailed assessment than simply '4MO'. In any event, the man did not see a doctor, and the reason is unclear. He may have chosen not to attend an appointment, or he may not have known of one, if in fact one was made. Again records are poor, and I cannot say what happened.

The man became increasingly agitated in prison. Although The Weare's mandatory drug test results show low illegal drug usage, we know that drugs are available in prison other than through proper prescription, and the man may have accessed amitriptyline to help him sleep.

The man was single minded. His failed relationship appears to have occupied every waking thought. On the morning of his death, he made two impassioned phone calls to try to renew his broken relationship. The transcripts show that both failed, and that the man was in poor emotional state at the end of them.

The man gave no indication to prison staff, to his family, or to his cellmate with whom he had formed a close friendship, that he was considering taking his own life, and it is impossible to say what was in his mind when he tied a bed sheet around his neck. It may be that the all-consuming regret at the loss of his relationship led him to feel that he had no life to which he could look forward.

Recommendations

Pentonville should establish arrangements to ensure, when arranging transfers of prisoners, that receiving prisons have medical facilities appropriate to meet the need of the individual.

The Prison Service responded by accepting this recommendation. They said, "Pentonville are setting up formal discharge clinics on each of the wings to be run by appropriate nurses. In the interim, a doctor has been screening the transfers and building up a comprehensive file of the acceptance criteria for each prison healthcare."

Pentonville should establish arrangements to ensure that medical records accompany all prisoners on transfer and that information of special importance is highlighted.

The Prison Service responded by accepting this recommendation. They said, "At Pentonville, all IMR's (inmate medical records) are now sent to reception the night before a prisoner transfers out, ready for transfer with the prisoner."

The following recommendations are reproduced from the clinical review.

Receiving prisons need to be able to refuse to accept prisoners if they are constrained by the facilities from offering them proper care, especially if that care was being provided at the original prison. The principle that a doctor is not obliged to accept a patient into their care, if they do not feel it is appropriate, is enshrined in medical lore and The NHS Act 1946. It should apply to HM Prisons as elsewhere.

The Prison Service did not accept this recommendation. They said, "We would say that this is an advocacy issue and that health providers should ensure that prisoners are not transferred when it is detrimental to their current treatment. Decisions to transfer patients under current treatment should be identified if is easily transferable and an attempt to ensure continuity of care made. The NHS Act 1946 does not apply to prisons. There are methods of preventing the transfer of prisoners even when there are overcrowding pressures. This report indicates that the transfer of the man from Pentonville was neither communicated not challenged. If staff at Pentonville felt this was an unsuitable transfer they could have indicated that his treatment was not transferable and placed him on medical hold on discussion with the governor and a suitable replacement found. It is not clear if The Weare attempted to return the man or if a local psychiatric service was contacted? Potentially neither prison may have felt that they had concerns as he appeared both stable and manageable. However, as indicated in the report the lack of records does not inspire confidence in effective processes."

As a matter of great urgency the PCT needs to establish whether it was human or computer error, or both which led to the lack of reception records on at least eight of its patients at HMP The Weare.

The Prison Service responded by accepting this recommendation. They said, "This is a reasonable request and should be taken up locally with the PCT."

If it is policy that Reception Medical Questionnaire answers given by prisoners arriving late in the evening are not recorded on the System1 at the time then either

- **A proper paper record needs to be kept or**
- **Foolproof ways for the information to be transferred into System1 and acted upon the following day need to be devised at once.**

The Prison Service responded by partially accepting this recommendation. They said, "This is a reasonable request but perhaps difficult to proceed as The Weare is now closed. The local PCT should perhaps ensure that this is not happening in other prisons in the trust."

The PCT needs to set in motion an investigation as to how many of its patients in The Weare have not had their Reception Medical Questionnaire answers recorded in their record and ensure that no matters of significance have been overlooked.

The Prison Service responded by partially accepting this recommendation. They said, "This is a reasonable request but perhaps difficult to proceed as The Weare is now closed. The local PCT should perhaps ensure that this is not happening in other prisons in the trust."

A brief look at the records of the nine prisoners who arrived on 24 May showed that only one record was complete. How many others, who arrived on other days, have similarly inadequate records I do not know?

The PCT needs to ensure that the remaining four prisoners who were listed as "4MO" have in fact seen the GP.

The Prison Service responded by partially accepting this recommendation. They said, "This is reasonable and possible if these individuals can be identified and remain within prison custody."

There is a major problem within the prison estate of appointments with health professionals being missed. It feels sometimes that there is not the will within the custodial staff to see that changing this is a priority.

A thorough audit within each of the Cluster's prisons as to why prisoners miss appointments with Health Care staff ought to lead to improvements.

The Prison Service responded by partially accepting this recommendation. They said, "This is reasonable but should be resolved by local clinical audits expected by the PCT. The Department of Health will note this as a potential trend in deaths in custody."

As the PCT is responsible for the efficient running of the Health Centre it should employ, train and be responsible for all medical centre staff, excluding discipline officers.

The Prison Service responded by partially accepting this recommendation. They said, "The PCT are commissioners of services. The providers are responsible for this core task. It is expected that the PCT should ensure that the services they commission are of a high quality and that deficits in care created by poor skill mixes and staffing in post by people with unsuitable core competencies is addressed through their providers."

Good practice

The man was confirmed to be dead at 12.50pm. By 2.00pm, The Weare had received confirmation from colleagues at HMP Wandsworth that his mother had been told. This represents excellent cooperation between prisons, and all concerned should be congratulated on the swift completion of this unenviable task.

The then Governor of The Weare is to be commended for her actions in the aftermath of the man's death.