The death of a man at Wakefield prison on 13 January 2004

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

March 2004

Preface to the published version

Although this case has been well publicised, and to most people in Britain the identity of the man who died will be obvious, I have judged it right to publish this report in an anonymised version. This is in line with the practice I am required to follow in respect of all deaths in custody that have occurred since April 2004 (when responsibility for the investigation of all such deaths passed to my office). It is also consistent with the approach I have taken to the other deaths I investigated before that date when – as in this case – I was acting on behalf of a commissioning authority (the Minister or Director General).

With that exception and some very minor amendments, the text of the report is as I submitted it in March 2004.

Stephen Shaw
Prisons and Probation Ombudsman for England and Wales
May 2005

Preface to the originally submitted version

I was invited by the Director General of the Prison Service to investigate the death of a man on 13 January 2004 at Wakefield prison. This reports sets out my findings.

It is hard to imagine just how difficult the weeks following the man's death must have been for his family. Losing someone while they are in custody is traumatic in any circumstances. In the man's case, the family has also had to cope with intrusive and prurient media interest. I offer them my sincere condolences.

I also offer my sympathies to management and staff at the prison. This was the second death within a week at Wakefield, and will have had a profound effect on everybody, especially those most closely involved with the man and with trying to resuscitate him. Two such members of staff have themselves suffered close family bereavements during recent weeks. They, in particular, will need the continued support of their colleagues in the weeks and months ahead.

I am grateful to the Governor for the help and hospitality we have received during the investigation. Every assistance has been made available and all staff have co-operated fully and readily with the inquiry.

I am grateful too to Dame Janet Smith, who chaired the independent public inquiry into the issues arising from the case of the man, for offering to share with me records in the inquiry's possession.

I should also thank the Director General of the Prison Service and the Governor at Whitemoor prison for seconding to me three members of Prison Service staff to assist with the inquiry. Their knowledge, commitment and hard work have been of immense value in expediting the investigation.

Finally, I should record my thanks to the typing pool at Whitemoor for their excellent work typing up the interview transcripts.

Stephen Shaw
Prisons and Probation Ombudsman for England and Wales
March 2004

Contents **Page No.**

Glossary of terms

Category A	Prisoner for whom the highest level of security is required
CPR	Pertaining to Chest (Heart and Lung) resuscitation
DST	Dedicated Search Team
ECR	Emergency Control Room
ETS	Enhanced Thinking Skills
F2050	Prisoner's Main Core Record
F2052SH	At Risk of Self Harm Record
FOCUS	Drugs treatment course
Fish knife	Knife which cannot be used as a weapon but is designed specifically to cut through ligatures
Food boat	Informal arrangement whereby a number of prisoners each contributes an item towards a meal
Governor	Senior Manager Graded A – F
HCC	Healthcare centre
Hotel 5	Healthcare radio contact in an emergency
IEPS	Incentives and Earned Privileges Scheme
IMB	Independent Monitoring Board
IMR	Inmate Medical Record
Lifer	Prisoner serving a life sentence
LIDS	Local Inmate Database System (computerised)
Listener	Prisoner trained by Samaritans to support prisoners at risk of self harm or suicide
NOU	National Operations Unit
Oscar 1	Night Orderly Officer
Oscar 2	Assistant Night Orderly Officer

PDPR	Personal development course
Peg	Electronic keying in system for demonstrating that staff have completed the requisite patrols
POA	Prison Officers' Association
Remand	Prisoner held in custody before conviction
Safe Cell	A cell from which ligature points have been designed out or removed. The term 'safer cell' is the more common usage. There are very few 'safer cells' in the older prisons like Wakefield.
SIR	Security Information Report
SO	Senior Officer
SO and three unlock	A senior officer and three officers must be present when the cell is unlocked
SOTP	Sex Offender Treatment Programme
SPAB	Suicide Prevention and Anti Bullying
Standard Audit	Prison Service Internal Audit System
Visiting Order	Form that enables someone to visit a prisoner

Executive summary

1. This is the report of an investigation commissioned by the Director General of the Prison Service into the death of a man on 13 January 2004 at Wakefield prison.

2. The investigation team reviewed the man's prison records and spoke to a number of staff and prisoners. It also received correspondence from a number of parties.

3. The man had been in prison custody since September 1998 and at Wakefield since June 2003. Although considered a long-term suicide risk at previous prisons, he was not considered to be at specific risk during his time at Wakefield and was not subject to any special measures. He was found hanging from the window of his cell at 6:10am during the morning roll count. Extensive efforts to revive him proved fruitless and he was pronounced dead at 8:10am.

4. The report reviews the man's suicide ideation and care before his move to Wakefield. It then explores in some detail events over the Christmas period just before his death. This included him being downgraded to basic on the Incentives and Earned Privileges Scheme (IEPS) and subsequently restored to standard. I make criticisms of the operation of the IEPS and of the specific decisions made relating to the man.

5. I also refer to a review of the man's medical care whilst in prison custody conducted on my behalf by the Northumberland Care Trust. This concludes that his care was appropriate at all times and that staff do not appear to have missed any warning signs. It also reports that the man was not on any medication at the time of his death that would have caused him to suffer depression. Having said that, I am critical of the fact that staff at Wakefield do not appear to have been alerted to the man's long-term risk of suicide or what might finally trigger it.

6. I detail allegations by other prisoners that the man was pressurised by staff generally and by a specific prison officer in particular. Prisoners alleged that the prison officer told the man he should do them all a favour and that he sang to taunt him. They also alleged that another prison officer told the man he should kill himself. Both officers flatly denied the allegations and I found no evidence to substantiate them.

7. The report describes in detail the actions taken by staff following discovery of the death. The investigation was unable to establish exact timings for the sequence of events. I am critical of Wakefield's record keeping in this respect and also suggest that local instructions on entering a category A cell at night are not clearly understood by staff. Contrary to local guidance, staff laid the man on a bed in order to carry out resuscitation. I have not criticised them for this. Resuscitation was continued for approximately half an hour, despite clear indications that the man was dead. I query the

appropriateness of local guidance on when resuscitation should not be started or should be discontinued. No ambulance was called and the doctor did not arrive until almost two hours after the death was discovered. I am critical of both the failure to call paramedics and the delay in contacting the doctor. I have no reason to believe the doctor could have got to the prison any faster, however, given that he lived on the far side of Leeds.

8. Both the National Operations Unit (NOU) and the police were put on stand-by before the man was formally pronounced dead. I see nothing wrong in this. Unfortunately, the address held on the prison's computerised prisoner records for the man's next of kin was incorrect. This, together with a decision by Home Office Press Office to issue an early press release and a possible leak from the prison itself, resulted in the man's wife learning of her husband's death from a family member who had heard about it on the radio before the police were able to speak to her. This is extremely regrettable, but I can find no fault by managers at Wakefield or staff in Press Office. I do, however, query Wakefield's policy which relies routinely upon the police to inform the next of kin.

9. The report explores the source of the material used for the ligature but draws no conclusions. It also describes the situation pertaining to the man's forfeited pension, as the man had said he would not kill himself until his pension had been resolved. I could find nothing in relation to the man's pension which explained why he killed himself when he did.

10. The report also sets out some statistics relating to suicides by life sentence prisoners. The man did not fit any profile. It also contains some analysis by Safer Custody Group which suggests there may be a slightly heightened risk of self inflicted death on or just before a birthday. The man died the day before his birthday.

11. I conclude that, while there are procedural issues relating to the management of the incident which should be addressed both locally and nationally, from the evidence we have, the man's death could not have been predicted or prevented.

12. The report makes 17 recommendations.

Background

The man was remanded to Manchester prison on 8 September 1998, charged with murder and forgery. He was transferred to Preston prison the next day and to Liverpool prison on 14 October. He was returned to Manchester on 13 November, where he spent the rest of his time on remand.

The man was convicted on 31 January 2000 at Preston Crown Court of the murder of 15 patients. He was sentenced to life imprisonment. The judge recommended that he serve a minimum of 40 years for the purposes of punishment and retribution. He was convicted simultaneously of the forgery of the will of one of his victims and sentenced to four years imprisonment, to be served concurrently. Further investigations have suggested he might have been responsible for at least 215 murders.

Following conviction, the man moved to Frankland prison on 7 February 2000, where he was accommodated in the healthcare centre. He remained there until being transferred on 18 June 2003 to Wakefield. He had not undertaken any offending behaviour work at Frankland and staff considered that a fresh start might encourage him to do so.

The man was housed on normal location for the duration of his stay at Wakefield, occupying, at different times, two cells on D wing. At 6:10am on 13 January 2004, he was found hanging in his cell. He had trapped a length of material in his window and secured the other end round his neck. The source of the material is not known. Staff tried for some considerable time to resuscitate him, but were unsuccessful. A doctor pronounced him dead at 8:10am. He had not left a suicide note in his cell.

During the mid 1970s, the man had suffered a period of depression. He apparently abused Pethidine, a controlled drug, and was convicted in 1976 of possessing and misusing drugs, forgery and deception. He was fined a total of £600. He was subsequently treated at The Retreat in York.

Wakefield prison

Wakefield started life as a House of Correction in the late 16th century. It became a prison when it was taken over by the Prison Commission in 1887. In 1966, it became a dispersal prison, and it remains within the high security estate.

The establishment is a lifer main centre, focussing on sex offenders, who comprise the majority of its population. Wakefield's population profile is as follows:

70% - lifers
34% - murderers
28% - over 50 years of age
86% - white

As far as convicted prisoners are concerned, Wakefield takes only those serving sentences of four years or more. Last year, however, it also took on a remand function for potential category As. Despite additional funding being made available as a result, the change of role has had a significant impact on staffing. This has led to difficulties in escorting prisoners to work, resulting frequently in prisoners being unable to work.

The prison has five or six workshops and an Education Department which provides both full and part time education. Offending behaviour courses include FOCUS, SOTP and ETS.

The population on 12 January 2004 was 563, five of whom were considered to be at active risk of self-harm or suicide and subject to F2052SH (suicide and self-harm prevention) procedures. Just over 100 were category A prisoners, including around 20 remands. D wing, which housed the man, held 179 prisoners.

The last full inspection of the prison was in 1997, but an unannounced inspection was conducted in October last year.

The last Security and Standards Audit was in May 2002. The prison achieved a 'Good' rating for both.

Investigation

I formed a team comprising myself, the Deputy Governor of HMP Whitemoor, one of my Assistant Ombudsmen, and a Manager and Principal Officer from HMP Whitemoor.

I received a very helpful brief from the Governor before visiting the wing and cell where the man died.

I agreed a protocol with the police and subsequently visited the local police station to view some of the items that had been removed from the cell, including the ligature. The police subsequently provided me with a summary of everything they had removed, including some entries from the man's diary and other papers. I also listened to recordings of the man's last seven telephone conversations with his wife. The final one was on the evening before he died.

I contacted the Coroner. I also spoke with the chair of the Independent Monitoring Board (IMB) and the branch secretary of the Prison Officers' Association (POA).

At the outset, we issued a notice to prisoners and staff inviting anyone with information relating to the man's death to make themselves known to the inquiry. This resulted in a number of messages from prisoners asking to speak to us. In the event, we spoke to about 20. We also received two notes (one anonymous) apparently from members of staff.

Following the original submission of this report, I received an e-mail from Home Office Press Office explaining the circumstances relating to the early release of information about the man's death to the media. I also received a letter from a firm of solicitors asking me to speak to a number of prisoners who apparently had information about staff entering the man's cell during the night of his death. In the event, only two would speak to my Assistant Ombudsman. Neither suggested the man's cell had been entered during the night, but one, the man's neighbour, said he heard a bang in the man's cell between 1 and 2am.

I read the, at the time unpublished, report on Wakefield by HM Chief Inspector of Prisons and the most recent IMB annual report. I also received correspondence from Dame Janet Smith, the chair of the independent public enquiry, drawing my attention to the concerns of psychiatrists to the inquiry that the man might become a suicide risk when the inquiry's first report was published on 19 July 2002, and from prisoners in other jails, ex-prisoners and other members of the public.

We interviewed a number of staff who had been involved in the attempt to revive the man and in the immediate period thereafter, and spoke to others likely to be able to provide background information.

We reviewed the whole of the man's prison file covering the duration of his time in custody from his first remand on 8 September 1998. In addition, I commissioned the Northumberland Care Trust to conduct a clinical audit of the man's care whilst in prison custody.

I have been in touch on several occasions with the man's family, and arrangements were made for us to meet. In the event, the family decided not to go ahead at this time. Should they wish to meet, then I shall of course make myself available to them. If matters emerge that are significant, I will submit a further amended report.

The man's pre-Wakefield prison history

Prior to his move to Wakefield, the man had been subject to F2052SH procedures on four occasions. In each case, the procedures were instigated as a result of external factors considered likely to place him at risk. These were:

- his first remand to prison on a serious charge;
- his trial;
- bad news relating to his pension; and
- notification that he was to be stripped of his pension.

The most recent F2052SH was opened on 17 July 2002 and closed on 30 August 2002.

There are numerous references to suicide in the man's files. In his first few years in custody, he spoke apparently unemotionally about suicide as

something which he might consider in the future, should his appeal against conviction fail and once he had ensured his wife was financially secure. A Support and Supervision Record dated 23 September 1999 says:

> "Although remains tearful says he will not commit suicide until after his trial. Says he had discussed with his wife and he will take his own life if faced with a life sentence."

A case conference on 12 October 1999 noted:

> "He is denying suicidal thoughts at the moment, but is giving the impression that if he was found guilty, and after all appeals had been heard, then he would consider suicide as a last resort, as he could not bear to spend the rest of his life in prison. He is very close to his wife and he could not see himself being without her for the rest of his life."

On 23 January 2000, a summary of a review noted that the man was still depressed, but "will not kill himself as will affect wife's pension – if appeals exhausted does want to die."

On 1 February 2000, a case conference noted:

> "[The man] had said that he would not take his life within the next five years as his wife [ ] would then not get a pension."

The report of the case conference added (probably quite presciently):

> "It was generally felt by all at the case conference that if [the man] had decided to take his life it would be 'calculated', he would 'lull staff into a false sense of security,' showing no signs of depression or self harm ideation, in fact, he would probably give the impression of being quite settled, jovial in mood and planning activities for the future."

On 7 February 2000:

> "[The man] told [the SMO at Frankland] that his main concern was for his family. He was especially concerned that his pension should not be endangered. Apparently his family would forfeit the pension if he committed suicide prior to its award or up to one year from the first payment. The actuarial details are entirely based on [the man's] account and need to be confirmed. [The man] added that if the state withdrew the pension, he would be taking legal action to recover his contributions.
>
> "[The SMO at Frankland] felt that his very plausible testament about his will to live could easily be constructed specifically for the authorities."

An extract from his Inmate Medical Record (IMR) in February 2000 reads: "Feels long term prisoners should be offered option of suicide every 5 years."

An F2052SH was opened on 9 May 2000. The initiating member of staff commented:

> "As a result of a taped telephone call, ECR informed us that he was very upset over pension – states only two ways he can now collect his pension – either he reaches 60 or he's dead."

A case review on the same date noted, "Adamant that he would not attempt suicide until every last avenue had been exhausted."

On 17 July 2002, a letter advising that the man was to forfeit his pension was received, by prior arrangement, by the Governor and passed on to the man. An F2052SH was opened immediately. On 15 August 2002, however, a note of a case conference recorded that, "He has refused to take part in any F2052SH reviews stating that staff are behaving in a ridiculous manner and that he has no intention of committing suicide." Nevertheless, the F2052SH remained live for a further two weeks. During that time, healthcare staff advised the correspondence office that:

> "Following a recent case conference, it was agreed that it was <u>imperative</u> [their emphasis] that all mail either incoming or outgoing relating to the above inmate and his appeal against his pension being withheld be monitored. Could you please advise us <u>immediately</u> [their emphasis] if any mail indicates that the appeal has been unsuccessful."

A Sentence Planning Review Board report dated 30 September 2002 commented that, "It is still a concern ref. [the man's] threats of suicide/self harm relating to his wife's personal and financial well-being."

Each F2052SH indicates a high level of care for the man during times at which he was considered to be at risk of self-harm. Multi-disciplinary case conferences were held on a regular basis. The records of meetings show that considerable thought and insight was applied to his management.

The man's diary also records his ideation at times during this period:

- 13/01/2001 - "So depressed. If ?[illegible] says no then that is it. There is no possible way I can carry on, it would be a kindness to [ ]."

- 14/01/2001 - "[My wife] and the kids have to go on without me when it is the right time. Got to keep the façade intact for the time being."

- 27/03/2001 - " … I'm looking at dying, the only question is when and can I hide it from everyone?"

- 13/04/2001 (Good Friday) - "If I was dead they'd stop being in limbo and get on with their life perhaps. I'll think a bit more about it. I'm desperate, no one to talk about it to who I can trust. Everyone will talk to the PO's then I'll be watched 24hrs a day and I don't want that."

- 26/06/2001 (Wednesday) - " … As near suicide as can be, know how and when just not yet."

- 14/01/2002 (Monday) - "56 today, cards from everyone – very very sad day, not what life is about at all. [ ] not very good, it must be dreadful for her."

I note that two of these entries were on the man's 55th and 56th birthdays in 2001 and 2002 respectively. I discuss below the possible connection between the timing of his death and his 58th birthday in 2004.

History at Wakefield

The man arrived at Wakefield on 18 June 2003. Records show that he was not happy at the move and suggest that this might be because he had missed a visit as a result. He was apparently aggressive and dismissive on reception, refusing to engage in any of the procedures. There is no record in his IMR of his being seen by a doctor at the time of his transfer. However, the Suicide Prevention and Anti Bullying (SPAB) Officer completed a reception pro forma, apparently after having spoken to the man. He noted that there was no live F2052SH, no history of self-harm and no serious attempt on his own life. Although the form refers to the likelihood of his being bullied because of his high profile and records his "confrontational nature towards staff and inmates", there was no reference to previous F2052SHs, the possibility of suicide in the future or what might trigger it.

There are just thirteen entries in the wing observation book relating to the man. None of these suggests he gave staff any reason to believe he might kill himself. The main issue was with his giving medical advice to other prisoners.

During autumn 2003, reports were prepared for the man's sentence planning review. A psychology report noted that, "Following sentence it is reported that [the man] again voiced suicidal intentions stating that after he secured his pension for his wife he would end his life and it is indicated that his wife was in agreement that it was preferable to spending the rest of his life in prison." (This information was drawn from a post sentence report by a Probation Officer, who had noted, "There is further concern with regard to [the man's] stated intentions to commit suicide in the future, therefore his mental health and emotional well-being need to be assessed and monitored on a regular basis.")

The officer who completed the personal officer report, however, said simply in relation to vulnerability, "There are no recorded events to date, he was originally placed on a 2052SH after initial conviction but there have been no further concerns at this establishment."

On 11 December 2003, the man's Incentives and Earned Privileges Scheme (IEPS) level was reviewed as part of his annual sentence planning review. He was reduced to basic. The principal consequences of this were that:

- his in-cell TV was removed;
- he was not allowed to wear his own clothes;
- his visits were reduced to two ½ hour visits per 28 days;
- his access to cash was reduced (which impacted on his ability to make phone calls); and
- he had to lock up 1½ hours before other prisoners.

He appealed, but was turned down on 17 December.

The man's wife visited on 24 December and again on 28 December. Two prisoners told us that a senior officer (SO) on one of the man's last visits had told him loudly beforehand that, because he was on basic, his visit would be curtailed. One wrote to me:

> "The effect of the basic regime created only one problem for [the man ....] which was driven home in a cruel fashion a day or two before Christmas … Whilst they counted in, the visits SO seemed to take great pleasure in announcing that [the man's] visiting time was reduced."

This had apparently upset him deeply. (I note that in her report of the unannounced inspection in October 2003, HM Chief Inspector of Prisons recorded that prisoners on basic were restricted to half hour visits rather than their statutory entitlement of one hour.) He sent out his last visiting order on 2 January 2004 – no date had been fixed for the visit at the time of his death.

The man had noted on a calendar in his cell that no work had been available since 31 December. He also mentioned the non-availability of work in several phone conversations with his wife.

On 8 January 2004, the man's IEPS level was reviewed in line with standard procedure. His interaction with officers was considered to have improved and he had indicated his willingness to undertake non-offence related work. He was awarded sufficient marks to enable him to return to standard.

At unlock on the morning of 9 January, another category A lifer was found dead in his cell. He was 67 years old and had been suffering from major heart problems.

Later that day, the man applied to be allowed to hand out on a visit from his wife arranged for 14 January (his birthday) two calendars, one greetings card "plus enclosed 'confetti'" and magazines "sent in before being told that Wakefield HMP has its policy of nothing being sent in." The application was referred (undated) to reception and again (undated) to visits. The man also applied on 9 January for the return of his trainers (confiscated as a result of his downgrade to basic – he always wore prison issue clothing but not trainers). This was authorised on 12 January (presumably because the weekend intervened). He does not seem to have asked for the return of his television. Also on 9 January, the man ordered his canteen for the following week – some phone credits, some small envelopes, a pepper and a potato (he was apparently a member of the wing food boat).

On 12 January, the man sent out five letters. These were to his wife, his sister, his daughter, some friends and (so far as I can ascertain) his solicitors. As a category A prisoner, all his mail was read before being sent out, but I have not been able to establish who read it on this occasion. He also requested a visiting order. In the evening, he phoned his wife as usual. There did not appear to be anything out of the ordinary in their conversation. He ended, as usual, by saying he would call her tomorrow.

No staff or prisoners had perceived anything different about the man on the evening before his death (or the period leading up to it). One prisoner suggested he might have been a little quieter than usual, but others said he seemed quite cheerful and had played cards the evening before he died. One prisoner commented that, unusually, the man had not returned to his cell until the very last moment at lock up, returning instead for a further chat after he had collected his water.

At the time of his death, the man was still appealing against the decision to withdraw his pension and was pursuing an appeal against his conviction. The man spoke to one prisoner for about 20 minutes on the evening before his death. He referred to his pension. He was still waiting for information from the British Medical Association, but he was apparently hopeful he would win the appeal. Another prisoner confirmed that the man was still pursuing the matter of his pension, although he said he did not go about it as vigorously as he would have expected. He suggested the man might have been depressed. I note that his last letter to the General Medical Council was on 19 November 2003. Another prisoner told us that a toxicologist was due to come over from the USA within the next month. He was to provide advice in support of the man's appeal.

Discovery of the death

The prison officer who found the man apparently dead believes he last checked the man at just a few minutes past five on the morning of 13 January. Certainly, it would have been before 5:40am, since he told us that he carried out his last peg at 5:40 or 5:45am and then immediately started his roll count. It was during the roll check that he discovered the man's apparent death. He reached the man's cell at approximately 6:10am. He looked in and saw the man apparently looking out of the window. He was partially obscured by the curtain, but the prison officer could see a shoulder and two legs. He attempted to get a response from the man, by calling out his name half a dozen times and kicking violently on the cell door. There was no response. He therefore went for help.

The prison officer ran down to the next landing and summoned assistance from the Assistant Night Orderly Officer on the Centre. He told us that he did not use his radio as it would have been noisy and he did not want to alert the whole wing to what was going on. The Assistant Night Orderly Officer telephoned the Control Room and asked that the Night Orderly Officer be informed, and that a nurse and dog handler also attend the scene. The

Control Room asked the Night Orderly Officer to return to the Centre immediately. The Night Orderly Officer was in healthcare at this point. He rang the Centre and was informed by the Assistant Night Orderly Officer that the man had been found hanging in his cell. The Night Orderly Officer asked who was present at the Centre, and the Assistant Night Orderly Officer said that the dog handler was present with him. (The dog handler had heard the radio transmission to the Night Orderly Officer and had immediately gone to the Centre.) The Night Orderly Officer instructed the Assistant Night Orderly Officer to tell the night patrol officer on B wing and the prison officer who had raised the alarm to enter the cell.

The Night Orderly Officer then set off for the Centre with a nurse, who collected the resuscitation bag on the way. The healthcare centre is situated some way from D wing and it therefore took a few minutes for the Night Orderly Officer and the nurse to reach the incident scene.

The prison officer who raised the alarm collected the fish knife from the self-harm box in the night office on D2 landing and went back to the cell with B wing's night patrol officer. They entered the cell, while the Assistant Night Orderly Officer and the dog handler waited outside. They saw the man hanging from the window area. The ligature was apparently made from bedding sheets. The man's legs were resting on the heating pipes, which were situated below the window. A knot at one end of the ligature was trapped between the window and the frame. (This was an obvious ligature point – but there were many others in the cell. The man was not in a 'safe cell'.)

The man was not breathing and no pulse could be found. His legs were purple while his upper body was white. He also had an injury just above his left eyebrow where he had apparently hit his head against the window, and a large blister or burn mark on one of his knees, apparently from the heating pipes.

B wing's night patrol officer lifted the man to ease the pressure from the ligature while the officer who had raised the alarm cut through the ligature above the man's head using the fish knife. They then placed the man on the bed. The officer who had raised the alarm cut the noose again to remove any pressure from the neck and checked for a pulse but found none. He commenced resuscitation while B wing's night patrol officer performed chest compressions.

The nurse and the Night Orderly Officer arrived shortly after (B wing's night patrol officer thought inside five or ten minutes later). The Night Orderly Officer told the officer who had raised the alarm to leave the cell as he seemed to be very shaken. The nurse saw that the man was not breathing and found, on checking, no pulse. He was cold but his legs were slightly warm. She placed an airway in his mouth. This was difficult as his teeth were clenched very tight. She then placed a bag over the airway through which air was pushed into the man's lungs. B wing's night patrol officer continued chest

compressions. The nurse asked whether paramedics were on the way, but no-one knew.

Once he was satisfied everything possible was being done, the Night Orderly Officer temporarily left the scene to check that adequate staffing arrangements were in place elsewhere in the prison.

Resuscitation continued for approximately half an hour. The officer who had raised the alarm went back in at one point to relieve B wing's night patrol officer. On a number of occasions during this period the nurse asked staff outside the cell when the paramedics would be arriving, but no-one was sure. At about 7:00am she left the cell to find out what was going on. The Night Orderly Officer told her that no ambulance had been requested but that the Control Room had contacted the Duty Doctor. She recommenced resuscitation. About five minutes later she again went to the cell door. At this point an officer told her she needed to write a statement. She became unsure of what she should do – whether she should continue with resuscitation, write a statement or contact healthcare. After thinking for a while, she telephoned healthcare at approximately 7:15am. Five minutes later she was told she would be relieved, and a second nurse duly arrived. The first nurse was then directed to wait on her own in one of the Governor's offices nearby for a debrief.

The second nurse had been informed before she arrived at the scene that the man had been found dead. When she arrived, she saw that resuscitation had not been continuous as the first nurse was standing some way from the cell. The first nurse had not told her at what point she had stopped administering resuscitation, but had told her that the man had been found at about 6:20am. With all this in mind, and seeing the man's condition when she entered the cell, she did not re-commence resuscitation.

The Duty Governor arrived on the scene a few minutes before 7:30am. He was briefed by the Night Orderly Officer and entered the cell to assess the situation. Resuscitation had stopped at this point and the doctor was awaited. The Duty Governor then arranged for reliefs for those staff who had been involved and posted an officer outside the cell to guard the integrity of the scene. The governing Governor visited the site at approximately 7:50am.

The doctor arrived at about 8:00am – that is, some 77 minutes after he was contacted. He examined the man and pronounced him dead at 8:10am.

After the doctor pronounced the man dead, the cell was sealed by the establishment's Dedicated Search Team.

The prison's Head of Operations arrived in the establishment at approximately 7:15am. Shortly afterwards, he telephoned the Duty Governor to receive a briefing. The Head of Operations then took over co-ordination of the incident, principally in relation to dealing with outside parties.

The Head of Operations explained that staff were leaving the establishment at the end of their shift. He said he knew from experience that some (and one in particular) would give out information about the death straightaway. He therefore decided to inform Headquarters immediately to put them on standby, given the likely interest in the death. This was at approximately 7:45am. He phoned the police soon after to put them on stand-by also. Once the doctor had pronounced death, he phoned both parties again to confirm and to ask the police to arrange for the man's wife to be told. NOU in turn contacted Press Office and the Deputy Director General.

The Head of Operations took the man's wife's address from LIDS. This turned out to be wrong. The police did not inform the prison of the wrong address until some time after 8:30am. By this time, the man's wife had heard the news from her family. The Head of Operations said that, had the police got back to them earlier to say the man's wife was not at the address given, they would have phoned her. However, due to a bad experience several months earlier, they did not routinely phone next-of-kin direct. The Head of Operations explained that the difficulty with LIDS was that the prison could only put on the system the information provided by records or by the prisoner or his family.

The Head of News in the Home Office Communication Directorate understood the message that the police were informing the man's wife of the death to mean that they were doing so at that moment. He therefore took the decision to release information to the Press Association. He said he felt it was important for the Home Office to take control of the flow of information, not least to ensure that the public had an accurate picture of what had happened. By the time he was informed that the police had gone to the wrong house, the information about the death was in the public domain.

The Head of News at the Home Office has pointed out that news of this magnitude can be difficult to contain and that he feared a 'leak' from elsewhere. There was to be a shift change of prison officers within a few minutes; prisoners were due to be released from their cells; the police and Coroner's office knew. Any of these might make a call to the media. The Head of News said that all in all it seemed the correct thing to do at the time.

In the event, managers at the prison believe that there was a leak. Some of the detailed information relayed by the media had not been made available to the Home Office Press Office.

The Head of Operations also dealt with family liaison issues, asking the man's wife whether the prison could do anything to assist and whether she wanted to visit the scene of her husband's death. The Head of Operations kept the man's wife updated on arrangements the police were making in respect of her husband's body. The Governor sent a letter of condolence to the man's wife.

The following were all contacted according to the establishment's contingency plans:

- The Chaplain
- The Police/Prison Liaison Officer
- The Care Team Leader
- The Suicide Prevention Team Leader (who arranged for a review of all prisoners on an open F2052SH)
- The Independent Monitoring Board
- The Samaritans
- National Identification Bureau
- The man's Supervising Probation Officer

The police (Coroner's Officers) attended the establishment at 9:10am. At 10:43am, the man's body was taken from the establishment by the undertakers to Sheffield Mortuary to await a post mortem.

A debrief of staff was conducted following the incident and a notice to staff and prisoners issued.

Examination of the issues

Medical care

A doctor from the Northumberland Care Trust reviewed the man's IMR on my behalf to determine whether his medical care whilst in custody was appropriate. He noted without comment the man's various ailments and the treatments he had been given for them. He also commented that the man was seen repeatedly by mental health professionals including several Consultant Forensic Psychiatrists and was frequently reviewed by Prison Medical Officers. All agreed that the man was not suffering from a delusional state, nor was he clinically depressed. The man repeatedly denied feeling suicidal or having any immediate suicidal intent, but equally made it clear that he did not intend to serve a life sentence. Expert medical opinion indicated that the man was, and would remain, a long-term suicide risk.

The doctor from the Northumberland Care Trust noted that procedures for observation of potentially suicidal patients were implemented and carefully reviewed at all times when the man's clinical state appeared to merit it.

The doctor found nothing in the man's IMR which indicated any significant change in the man's mental state, nor were there any changes in medication which might have affected his state of mind. He could detect nothing which might have alerted a member of the healthcare team to the man's intention to harm himself when he did. He concluded that the man was recognised as an ongoing suicide risk but had no diagnosed serious mental health problems. The medical record contained no observation that, if recognised, might have led to preventative action by the healthcare team.

IEPS

During the initial review of his IEPS level, the man was given no marks for his programmes report, as no sentence plan targets had been set. His work supervisor noted that he always attended as required, was very polite and co-operative and produced a high standard of work. She noted, however, that he had not been in the shop very long and had not yet achieved the quantity he needed to complete. She gave him three marks out of a possible four. His wing report said the man kept himself and his cell clean and tidy and was punctual at all times. He made correct use of the applications system and complied with all instructions, although he only spoke when he was spoken to. There were no concerns in relation to the keeping of inappropriate materials. Under 'Willingness to interact with all wing staff on a day to day basis and for the purposes of formulating reports', however, it was noted that, "He doesn't willingly interact with staff. He doesn't participate with the formulation of reports." He was given four marks out of a possible eight.

The IEPS Board noted that the man did not accept full responsibility for his offending behaviour and that both his wing and work reports were of average standard. With just seven marks from a possible 16, two short of the mark required for standard status, the man was reduced to basic.

Staff have reported that he did not seem unduly concerned by this development. Prisoners, on the other hand, said he was deeply upset by the ramifications for his contact with his family. One prisoner said that the full implications had not hit him immediately, but it meant, for example, that he only had 25p per day for phonecalls. Another wrote to me that, "the Wakefield regime punished him for putting him on basic at the most difficult time of the year for any inmate to cope with." A note in the man's IMR records, "It is affecting him … can't make much tel. call … Writing more letters to his wife … depressed, emotional."

The man appealed against the IEP decision on 15 December. He noted that the problem with work was one of regular attendance. He had been available for 92 sessions between September and 12 December, but had only attended 23 times. He suggested that his speed would only increase with regular attendance. He considered he should have been given four marks until he could be properly assessed. The man acknowledged that he did not attend voluntary groups but said that, since he could not be a Listener or a wing representative, he could only achieve a maximum of eight marks, rather than ten [sic] for his wing report. He noted that he was otherwise considered fully compliant in all respects, except in relation to his interaction with staff. Of this, he said:

> "It is agreed I interact with the staff. I do ask for information and that I am polite. I have NEVER discussed family, the case, religion, politics or current affairs with any staff. This is a voluntary exercise, unless HMP Wakefield have unique rules in this matter."

He therefore calculated that, “from the criteria laid down”, he should have been awarded five or six marks for his wing report. He added:

> “N.B. My personnel [sic] officer has made no contact since I sought him out to introduce myself soon after my arrival here. No wing officer has asked how I am settling in, coping or whether I have any problems (WCU excepted).
>
> “With the reduced level possible (10) it could be thought that the assessment was less than sympathetic.”

A prison officer from the Sentence Planning Unit told us that the man spoke to him about his intention to appeal against the decision. They spoke at length about non-offence related work and the benefits the man might derive from them, as well as the benefits which might accrue to other prisoners by having him on the groups. The man apparently expressed his thanks to the Sentence Planning Unit officer and said that nobody had ever explained what was on offer before.

The man actually attended the appeal hearing on 17 December (this was considered unusual in itself) and expressed a willingness to undertake non-offence related work. The Sentence Planning Unit officer told us that he and others on the board were really ‘excited’ and ‘chuffed’ at this development.

Nevertheless, the board upheld the original decision on the basis that it was appropriate in light of the information available at that time. It noted, however, his willingness to undertake some personal development work and that the Sentence Planning Unit officer would see him about this the following week.

The interview took place on 23 December. The Sentence Planning Unit officer told us that the man said he was very, very keen to do the work. He said he (the officer) and his colleague felt ‘quite giddy’ as a result. The officer thought the agreement to do personal development work was key to the man being restored to standard. He spoke about his satisfaction when he and his colleagues got prisoners off basic. He cited an example of another category A prisoner who had finally agreed, after three years, to undertake some work. The Sentence Planning Unit officer said:

> “… but I emphasise there was no forcing him, at the end of the day I have no vested interest in anybody who does or doesn’t do groups, it’s entirely up to the individual but there was no, if you don’t get this you won't get that, we never come at it from the slant that if you don’t do groups you can expect to be on basic for a long time, none of that.”

During the weeks following the man’s reduction to basic, his conduct on the wing was monitored closely, with entries being made on his history sheet at least daily. These included references to contact the man had had with staff. The Suicide Prevention strategy says, however, that the SPAB officer must make and maintain regular contact with all prisoners on basic IEP level and

endorse the prisoner's wing history sheet accordingly. This does not appear to have happened.

The man's IEPS status was reviewed on 8 January, in line with normal procedure. The Sentence Planning Unit officer told us that he expressly advised that one mark should be awarded on the programmes report in light of the man's agreement to do non-offence related work. His work report was positive once again, this time noting that his output was increasing daily and that he worked the whole time he was in the shop. He was awarded three out of four once again. His wing report recorded that the man always kept himself and his cell very clean and tidy, he was always punctual and conformed to all rules and routines, with no instances of being late for labour or lock up. He used the application system appropriately and complied with all requests made of him by staff – "has made an effort to improve his relationship with members of staff". Under 'Willingness to interact…' was written:

> "Has again made an effort to engage in conversations with staff, always being polite and well mannered. These have been on general topics and not centred around making requests. Has agreed to and been interviewed by [the Sentence Planning Unit officer and another officer] regarding sentence planning."

He was awarded five marks, giving him a total of nine, and duly restored to standard. The Board noted, "There have been improvements in your relationship/communication with staff. You have agreed to undertake non-offence focussed work, namely PDPR and stress management."

The man apparently told a prisoner subsequently that the whole episode was ridiculous and 'beggared belief'. He sounded equally nonplussed when speaking to his wife about his restoration to standard.

Views of prisoners and staff

The investigation team spoke to a number of staff and prisoners. All refuted suggestions in the press that the man was being bullied by other prisoners.

Wakefield operates a scheme whereby two officers are allocated to each prisoner as personal officers. This means that where the lead officer is not available, the prisoner will be able to speak to the second personal officer. Neither of the man's personal officers, however, was able to offer any information about him. They seem to have had little contact with him. (This reinforces the man's comments on his IEPS appeal.) One prisoner said the man had been trying to see his personal officer, but had not been able to, and no-one could tell him where he (the personal officer) was. He described the man as going round in circles trying to sort things out.

Some prisoners on the wing described the man as a kind person who did not make enemies. Others said he was a 'very nice man', who was amiable and not arrogant as staff suggested. Many spoke of his devotion to his wife and

how he valued their visits and telephone contact. He apparently phoned her every day.

One prisoner told us that the wing Principal Officer was not answering the man's applications and would not speak to him. He said the man had resorted to writing via Royal Mail. This had led to a confrontation with the Principal Officer. Other staff had also been confrontational, telling the man that it was they who ran things. A number of prisoners told us that the man was bullied by officers. They said staff were blackmailing the man via IEPS in order to persuade him to undertake courses. They would not let the man simply get on with his sentence. One prisoner wrote to me about "systematic bullying by psychologists (programmes) and throughcare. Prisoners are bullied and blackmailed into attending groups." (I note that prisoners also complained to HM Chief Inspector of Prisons during her unannounced inspection in October 2003 of disrespectful and intimidatory behaviour by staff.)

Other prisoners specifically named the Sentence Planning Unit officer as putting pressure on the man. They said the officer wanted to get inside the man's head and to make him talk about his victims. One suggested that the Sentence Planning Unit officer called the man to the office very frequently, and that he and another officer always took the opportunity to 'have a go'. He was 'on to him' all the time. One prisoner suggested that the Sentence Planning Unit officer asked the man why 'he did not do them all a favour' and subsequently sang 'Hi ho, hi ho, it's off to basic we go' to wind him up. Another reported that the two men did not see eye to eye at all. Some said it was entirely down to the Sentence Planning Unit officer that the man was downgraded.

We put these allegations to the Sentence Planning Unit officer. He was not surprised. He said a prisoner had tipped him off that a number of prisoners were going to get together to tell the investigation team that he bullied them. He suggested that a couple of prisoners who had previously been given reports by him were trying to get even. The Sentence Planning Unit officer had submitted an SIR about this at the time. (I have seen it.) He told us that, because he prepared much of the IEPS paperwork, sat with the board and relayed decisions to prisoners, he was generally perceived by prisoners to be responsible for decisions to downgrade. He emphasised (as described above) that he did not apply pressure on prisoners to engage with sentence planning, but only explained to them the benefits. With regard to the allegation about singing to wind up the man, the Sentence Planning Unit officer said, "I can't even comment on that, it's just ridiculous."

One prisoner alleged that another officer – the one who had raised the alarm when the man was found - had told the man when he came to the prison that he should kill himself and that he (the officer) would show him how to do it. The officer flatly denied this, commenting that it would be a very unprofessional thing to do.

Category A checks

National procedure is that standard risk category A prisoners need only be checked once every two hours. The practice at Wakefield, however, is for them to be checked during the course of every hour. The form recording these checks is poorly designed. It simply lists all the category A prisoners on the wing on one side and time slots of one hour on the other. The night patrol officer simply has to tick each time slot to show that all the category A prisoners have been checked within the timeframe. The form shows that category A prisoners were last checked between 5 and 6am.

The man's neighbour told us that he heard a bang in the man's cell between 1 and 2am. He subsequently woke at 5:00am and watched television until he heard the officer who raised the alarm banging on the man's door. He had heard nothing during this period.

A couple of prisoners suggested to the investigation team that category A prisoners were not in fact checked hourly. One said that he was not checked on most nights. An ex-prisoner wrote to tell me that the ex-wing tea boy used to sort out clean blankets for night staff. (He also said that, while he was a cleaner in Full Sutton prison segregation unit, he was required to ensure clean sheets and blankets were provided for the night staff.) A member of staff also wrote anonymously to me to suggest I might like to inquire how staff positioned themselves during the night. The writer suggested, that although one member of staff should be positioned in each wing, the practice was for all wing-based staff to congregate on the Centre. S/he suggests that, while this might not have had a bearing on the man's death, the practice should cease in order to ensure staff are on scene to respond to sounds or shouts.

The officer who raised the alarm confirmed that night patrol staff were not necessarily walking the wings at all times, but explained that he was required to follow a pegging rota at different points on the wing every 25 minutes. He refuted the suggestion that category A prisoners were not checked every hour, but added that staff usually wore soft soled shoes and tucked their chains in their pockets to keep the noise to a minimum. Staff also used a night-light which shone only dimly to avoid disturbing prisoners when looking through the flap on the cell doors. He told us he thought he had last looked into the man's cell just after 5am.

Entering category A cells

The 'Know Your Job Sheet' for night patrol officers advises that staff will be issued with a sealed packet containing a cell key which should be attached to them by a chain. "If it is necessary to unlock a cell door the alarm must be raised beforehand and a second Officer must be called to assist before the door is opened." The Head of Operations confirmed that the policy was that a cell door should not be opened unless two officers are present. He added that there was a prisoner in the segregation unit who was on SO and three unlock. They had had prisoners who were on SO and five. In those cases, those instructions must be followed to the letter because there was no way of

knowing, until the cell had been opened, whether the emergency was genuine. However, “With the general run of the prison we say at nights not less than two.”

The officer who raised the alarm referred during interview to the night patrol instructions. He said, “obviously being a category A prisoner, you should not enter the cell on your own anyway and there should be the Night Orderly Officer Assist, another officer and also a dog handler.”

The Night Orderly Officer told us that the Contingency Plan said staff should wait for his return before they enter the cell. He said, however, that, having ascertained that there were three officers and a dog present, he “made a judgement on that point because I thought we might have a chance, you know we could have saved him and I must admit that was paramount in my thoughts.” (Whether or not he was right about the procedure, I cannot fault the Night Orderly Officer’s judgement.)

Resuscitation

The Intervention Plan in Wakefield’s Suicide Prevention Policy and Strategy Document says that, in the case of hanging, the prisoner should be placed on his back on a flat solid surface and that resuscitation should be attempted “unless rigor mortis of the limbs has **clearly set in** [emphasis in the original]”.

The officer who raised the alarm told us that he had had no training on what to do if he found a body. He had had basic training within the training department, “but obviously that’s more to prevent suicide and things like that happening rather than actually finding it.” He said placing the man on the bed was simply the first thing that came to mind.

The B wing night patrol officer said he had not read the Safer Custody document but was aware of the first on scene instructions. He believed he had followed proper procedures. With regard to placing the body on the bed, he simply said it was “just there”.

The Deputy Governor explained “it would be very difficult to do it on the floor with its size and the state of room”.

When asked about carrying out CPR on a soft surface, the first nurse on the scene said it was probably best not to move the person because, if he was all right and survived and they had moved him, they could have damaged his neck and paralysed him. “Things happened so fast, all I was considering was getting some air into his lungs, to get his blood to circulate round his body.”

Emergency medical assistance

Wakefield’s contingency plans for the Control Room Senior Officer in the event of a death in custody are as follows:

"When informed of a suspected inmate death you will: -

"Action:- 1 . Despatch Hotel 5 and the Medical Officer to the scene
2. Contact Duty Governor (to control room)
3. Inform Security and D.S.T. to cordon off the area, and make prisoner's record available to the Governor."

It then lists the actions to be taken once death is confirmed by the doctor. The Intervention Plan in Wakefield's Suicide Prevention Policy & Strategy Document (revised July 2003) says that upon discovery of attempted or actual self-harm or suicide, the person making the discovery should:

1. Summon help and request emergency medical assistance and first aid equipment.
2. Enter the cell as soon as possible, following the local strategy for safely doing so.
3. Ensure a speedy access to the casualty by (A) the HCC staff and (B) the external paramedics.

Nowhere does it appear to be set out whose responsibility it is to call the paramedics – the officer making the discovery has only to request emergency medical assistance while the ECR is instructed only to call the Medical Officer.

The ECR Senior Officer confirmed that, although the duty Medical Officer was called, he did not make contact with paramedics - "none was requested". Subsequently, he said, "Had there been a request for any further assistance, it's a bit of a delicate line you draw between not wanting to interfere with things that are going on or any need for any further assistance." He told us that it was not part of his contingency plans to call the paramedics. He said he would, "expect to get a request by whatever means and as soon as we are asked to call in the ambulance service, then we have a method of doing that … so that's normally done through the Control Room but, of course, we don't do it as a matter of course, we do it upon request." He added that he would expect such a request to come from healthcare staff.

The first nurse on the scene told us that, when she first arrived on the Centre, there was no noise on the radio, so she thought everything was settled and that the man could not be that bad. She therefore asked 'them' to contact the doctor:

> "I thought I'll go up and assess the situation and if we need an ambulance then we can get one. When I got up there I could see he was in a right state but I assumed that whoever cut him down and when you realise someone is not breathing, or having difficulty in breathing, I would assume it was the responsibility of the people who were actually there. If you cut somebody down and you see they're not breathing, you need some sort of assistance, you need some sort of help. I mean that's my interpretation."

The Head of Operations told us that the Contingency Plans did not say that paramedics were to be called, but that they were to be called if necessary. He continued:

> "What happened is that the week before [the man's] death we had a category A prisoner died and we followed the protocol to the letter, so naturally called out the paramedics. When the paramedics arrived, we got quite a lambasting because our nurse had said that he was dead and they said, 'If you knew he was dead, why are you wasting our time? We do not need to come out if people are dead. All you need to do is, if he is dead, is to get your Doctor to come out and the Coroner.' So bearing in mind they knew early on that [the man] was dead, because they tried resuscitation, and generally speaking for want of a better word, he was actually dead. They knew at once, so I presume on that they didn't call the paramedics, particularly with the fact that we had problems the week before, having called them out and then got this lambasting because he was already dead.
>
> "But if you look at the Contingency Plans, the Contingency Plans do not say that on every incident you have to call out paramedics and we would only call out paramedics to any kind of prisoner incident if one is having breathing difficulties, blue light or if there is a bleeding difficulty, a red light."

(Wakefield has a code for identifying the type of medical emergency. There is no indication that it was used at any stage during this incident.)

The ECR contingency plans do say, however, that in the event of the discovery of an apparent death, the medical officer must be called. The first nurse on the scene said she asked for the doctor to be called when she arrived on the Centre (some time between 6:30 and 6:35am). The ECR log shows that the doctor was called at 6:43am. This suggests that the ECR waited to be specifically asked to call a doctor – that is, some 33 minutes after the body was discovered – before doing so. The doctor said he was told only that somebody had tried hanging himself. He phoned healthcare at the prison and was told it was the man, but nothing else.

The doctor told us that he was asleep when he received the call and set off immediately, without going through the normal getting up processes. However, he lived on the far side of Leeds. He added that he was not, in fact, the on-call doctor, as he did not do Mondays (which would have included Monday night, into Tuesday morning).

ECR

Exact timings have been difficult to establish. None quite marries up with another. In such cases, it would be usual to look to the ECR log for definitive information, as the ECR should be at the centre of everything that happens during an incident of any sort. There are, however, just three entries on the Control Room Log relating to the man's death. These are as follows:

"6:30 Informed by [Assistant Night Orderly Officer] (Oscar 2) [the man] hanging in cell. Oscar 1 Hotel 1 to centre – Zulu rcve.
6:35 Duty Governor informed by phone – attending.
6:43 [Doctor] contacted to attend."

We found out from the ECR Senior Officer that his involvement in the incident had been minimal. He said he did not 'particularly' have any further contact with those on the scene after the initial message from the Assistant Night Orderly Officer. When pressed on this, he said he was aware medical assistance was being given and that normal security precautions were in place.

The ligature

Four separate torn-off lengths of linen were discovered in the man's cell – one formed the ligature he used to hang himself. This was actually made of two pieces of cloth and had three knots in it – two were on either side of the man's neck while the other formed the ligature point. The other three strips were found under the man's pillow. One had knots in either end, one had one knot and one none. This suggests that he had practised with various alternatives.

Although of a sheet type material, these lengths were not torn from the man's bedding. There was a suggestion that he might have secreted lengths of material usually used for practising on from the workshop in which he worked. This would have meant that he was preparing for his death nearly two weeks before it occurred (as he last attended work on 31 December). However, having examined the 'practice' material in the workshops, it is of a slightly different shade from that used for the ligature. The ligature also seemed to be from a more worn material. In light of this, I think it unlikely that the workshop was the source for the material found in the cell.

We were advised that prisoners change their bed linen on Fridays. They strip their own beds and take the bedding down to the orderly. The linen for the whole wing is then sent off to Kirkham prison for laundering. From there, it might be sent to any prison in the country. It is possible that the man tore the strips off his own sheets before the Friday preceding his death - or even earlier. The last search of his cell took place on 18 December 2003 (although locks bars and bolt checks would have been carried out daily). In theory, therefore, he could have had the lengths of material for quite some time. The truth of the matter, however, is that we simply do not know from where he obtained the material or how long he had had it. The fact that the material did not properly belong in his cell, however, suggests that the man's death was to some extent planned rather than purely spontaneous.

Pension

We spoke to a member of staff at the Department of Health. She explained that Regulation T6 of the NHS Pension Scheme Regulations provides for forfeiture of pension benefits. The Regulation allows for forfeiture of all or part

of any benefits either payable to or in respect of the member. This includes survivor benefits payable on the member's death. The degree to which forfeiture is applied is for the Secretary of State to decide, having regard to the particular circumstances of each individual case. On 17 July 2002, the Secretary of State decided to forfeit the man's personal benefits. At the same time, he decided to leave survivor benefits payable. The letter notifying the man of the forfeiture decision clearly stated that forfeiture did not extend to the benefits payable on his death. The result of this decision was that the man's wife would not be entitled to any payment from the pension until such time as he died. In this case, 'survivor benefits' comprised a lump sum and annual payment. Once the man had turned 60, the value of the lump sum payable would have reduced year on year. Had he lived past 65, no lump sum would have been payable. There had been no change regarding the man's pension position since he was advised in July 2002 that he was to forfeit it.

Some newspaper reporting has referred to the man's wife's financial difficulties. One newspaper referred to her as living on benefits and unable to afford to modernise her cottage. It also referred to crippling legal bills. The man's diary indicated his concern on this matter:

- 31/07/2002 (Wednesday) - "[Wife] – chat, no notes sent in yet. She's getting no money off the DHSS, supported by the kids. What a terrible set up. How is she coping?"

- 17/10/2002 - "No money. [Wife] not able to get DHSS to see the poverty she is in. Only the kids who have been absolutely brilliant – the pension appeal."

- 07/01/2003 - "A new year, a visit from [wife]. Still no money off DHSS … If this year doesn't get anywhere I know it is not worth the effort. I have to lock down this overwhelming emotion or else I'd be on a suicide watch or drugs."

I do not know, and have not sought to discover, what the man's wife's financial circumstances were at the time of the man's death.

Analysis of self inflicted deaths

I understand that nine per cent of self-inflicted deaths occur in the high security estate. Relatively few involve category A prisoners. (This is to be expected given the small proportion of category A prisoners in the prison population.) Safer Custody Group advises that there is about one category A self-inflicted death per year, but that they do not routinely analyse statistics because of the difficulty interpreting rates at such low numbers. Prior to the man's death, the most recent category A self-inflicted deaths were in May 2002 and September 2003 (both at Full Sutton.) Since the man's death, a category A prisoner at Woodhill prison killed himself on 22 January 2004.

The Prison Service's Safer Custody News reported in February 2004 on a study of 20 recent lifer self-inflicted deaths and trigger points. Warning signs

immediately before the death included refusing food, work or medication. In contrast, mood and demeanour appeared to be unreliable indicators of risk. In almost 50 per cent of cases, the prisoner was described:

> "… as appearing happy, even unusually happy, just before they died, despite showing behavioural warning signs immediately before death, including:
>
> - talking to a Listener or other prisoner about suicidal intent (six cases)
> - food refusal (five cases)
> - writing (two cases)
> - refusing work or other activity (two cases)
> - refusing medication
> - agitated behaviour
> - smashing property
> - quiet and withdrawn."

The study found that the group that died more than a year after conviction:

> "… tended to have a previous history of self-harm or suicide attempts but fewer signs of immediate risk. Problems in progressing through the lifer system appeared to be a significant factor, including:
>
> - hopelessness resulting from reduced status or failed appeal
> - inability to adjust following transfer.
>
> Other triggers included disrupted relationships in and out of prison."

Safer Custody Group also provided me with some statistics related to self inflicted deaths on or near birthdays. Since January 1978, six (0.46 per cent) of 1,309 self inflicted deaths with a recorded date of birth occurred on the prisoner's birthday. This is apparently about two more (0.19 per cent) than would be expected if the deaths had been evenly distributed. During the week before a birthday, 33 (2.5 per cent) of prisoners killed themselves as against an expectation of 25 (1.9 per cent). Self-inflicted deaths in the week after a birthday are completely in line with what would be expected if there was an even spread through the year. The Safer Custody Group concludes:

> "There does appear to be a slightly raised risk of a self-inflicted death in the week before and on an actual birthday. However the overall proportion of self-inflicted deaths in which birthdays appear to be a major factor is low and may well be explained by random variation. That said, if we assume that only those deaths above the expected levels on a birthday and during the week before should be counted then we have about 0.79 per cent of all self-inflicted deaths in which birthdays appeared to be a major factor. Although this figure is low it doesn't, of course, rule out birthdays as being an important factor in any individual self-inflicted death."

I note that an entry in the man's IMR dated 12 January 1999 reads:

> "… It's his birthday tomorrow and he has received a lot of mail, feeling very low and is finding the reduction in his anti-depressants too low … states he's not suicidal and would never commit suicide unless he was sentenced to life."

Two diary entries suggesting a very low state of mind were made on the man's 55th and 56th birthdays respectively.

I understand that, during 2003, only one prisoner older than the man killed himself.

Consideration

The man was not on an open F2052SH at the time of his death and therefore F2052SH procedures are not directly relevant in this case. However, it is worth noting that the last Standards Audit conducted in May 2002 and subsequent self-audits have resulted in the achievement of 'Good' ratings in suicide prevention. In her report, HM Chief Inspector of Prisons also describes an establishment performing well in the area of suicide prevention and anti-bullying. She says that procedures are working effectively and that the establishment gives due weight to the maintenance of a safe environment.

I have not spoken to the man's wife and do not know, therefore, whether she knew that her husband was going to kill himself or why. There is evidence, however, that the man saw no point in spending the rest of his life in prison. He was anguished by being apart from his wife and at times said he felt she and the family would be better starting afresh. Financial considerations may also have entered the equation. None of this – with the possible exception of the last – explains why he chose to kill himself when he did.

I have noted the Safer Custody Group's statistics on self inflicted deaths before and on birthdays. It seems to me entirely possible that this was a factor in the timing of the man's suicide. An entry in his IMR for 12 January 1999 and two diary entries (13 January 2001 and 14 January 2002 respectively) indicate that he found it a very difficult time of year. There is no reason to suppose that 2004 was any different. This may have been exacerbated by events over the Christmas period, the fact that he had a very bad cold and the unavailability of any work for a sustained period.

(I am concerned about the low expectations and low achievements at Wakefield with regard to work for prisoners. The Governor told me that their target was 19 hours per week. They achieved, on average, just 16. This is poor and should be addressed as a matter of urgency.)

Other prisoners told us about alleged bullying by staff at the prison. I have not investigated this, other than to put the two specific allegations to the officers concerned. Nor have I investigated the allegation that the wing PO did not

deal with prisoner applications. These are, however, matters which the Governor might like to consider further.

Prisoners also told us how hard the man took his reduction to basic. More than one has made the point that the consequent reduced contact with his family came at a period which is hard to bear in prisons at the best of times. The man appears to have been mystified by the sequence of events over his IEPS level, apparently saying that it 'beggared belief'. The fact that he was restored to standard would have done little to persuade him that the process was in any way fair.

This, however, is no more than after the fact speculation. I do not consider that staff at Wakefield had any reason to suspect what the man planned or that his birthday would be any sort of trigger point. In addition, he appears mostly to fall outside the findings of the Safer Custody Group's analysis of self inflicted deaths by lifers.

I am concerned, however, that Wakefield staff were inadequately informed about the man's suicide risk. While there is a wealth of information buried in his records about the connection between his pension, his appeal against conviction and his possible suicide, none of this appears to have been flagged up for either wing staff or staff in the correspondence office at Wakefield. This means that, had there been developments on either score, nobody would have been aware of the likely implications. Frankland was well aware of the nature of the risk. They should have taken steps to alert staff at Wakefield rather than leaving them to discover it for themselves. In the event, this failure was not an issue. But it could have been.

Notwithstanding the impact or otherwise of the IEPS saga on the man's apparent decision to kill himself, I have several concerns about it. In the first place, it simply does not feel right that a prisoner universally acknowledged to present no problem to staff or other prisoners, polite, clean and tidy, should be on basic. This is not how the IEPS is supposed to work. Basic should be reserved for those whose behaviour causes real problems.

However, I have more specific concerns. The first is the lack of direct correlation between the published criteria for assessing a prisoner's level and that set out on the wing report. The IEPS document says:

> "Placement on the appropriate level of the IEP scheme depends on a number of factors and is measured against compliance and performance with the following:
>
> 1. Rules and Regimes
>
> - Following written and posted procedures
> - Acceptable level of personal hygiene, including a clean and tidy cell
> - Punctuality at lock up, labour and meals
> - Sensible use of the application system
> - Noise levels to an acceptable standard

- Wearing appropriate clothing at the appropriate time
- Compliance with mandatory drug testing provisions

2. Relationship with Staff and Other Prisoners

- Treating staff, prisoners and visitors with respect, whatever their race, religious belief or personal circumstances
- Co-operation with staff in the performance of their duties
- Absence of racist, obscene or other offensive remarks and gestures
- Appropriate attitude and behaviour to all staff and visitors
- Absence of bullying and intimidation
- Absence of bullying or threatening behaviour
- Interaction with other prisoners
- Wing representation e.g. lifestyle, Video rep, Listeners etc."

Categories on the wing report form, however, are restricted to:

- Personal and cellular hygiene
- Punctuality in relation to the wing and prison regime
- Use of the application system
- Attitude towards staff and instructions
- Willingness to interact with all wing staff on a day to day basis for the purposes of formulating reports; and
- Use or keeping of inappropriate materials, such as pornography.

This means that there is no room for following written and posted procedures, acceptable noise levels, wearing appropriate clothing, compliance with drug testing, treating others with respect, absence of racist etc remarks and gestures, absence of bullying or threatening behaviour, interaction with other prisoners and wing representation to be taken into account. The lack of correlation between published standards and those actually taken into consideration diminishes the transparency of the scheme and may well be detrimental to perceptions of its fairness. Certainly, many prisoners have spoken negatively about it. It is perhaps not without significance that, in all but the last of these omitted criteria, the man would have scored positively.

I am also concerned by an element of double counting. The inclusion of 'Willingness to interact with all wing staff on a day to day basis for the purposes of formulating reports' means that prisoners' engagement or otherwise with sentence planning can be taken into account on both the wing report and the sentence planning report. Of course, this will work in the compliant prisoner's favour. For those not engaged with sentence planning, however, there is scope to be marked down twice. It is clear that this was the case with the man.

I also consider the actual marks given to the man to have been harsh. Eight points were available for his conduct on the wing. According to the criteria on both the IEPS document and the report form, he could only have lost marks on wing representation and willingness to interact – and yet he lost half of the

marks potentially available. I have to agree with him when he suggested that, "it could be thought that the assessment was less than sympathetic".

Finally, I also agree with his comments about interaction with staff. I do not see why he should be expected to be proactive in engaging with staff. Provided he was polite and responsive and did as he was told, I believe he was doing all that should have been required of him. He should not have to engage in conversation with staff unless he chose to do so.

It is also somewhat ironic, in this respect, that the man complained of staff's unwillingness to engage with him. Interaction and communication must work both ways. I am aware that HM Chief Inspector of Prisons also has concerns about the absence of positive interaction between staff and prisoners.

I was disappointed too that neither of the man's personal officers had had much contact with him, and that they knew so little about him.

Turning to management of the incident itself, the investigation team would have found it useful to have better documentary evidence on exactly when the man was last seen by the Night Officer. The current category A check forms are lacking in necessary detail. They do not tell us any more than that all category As were last checked some time after 5:00am. Prisoners have alleged that category A checks are not carried out as they should be. A better designed form might also provide firmer evidence that they are. As to the allegation that staff cluster in the Centre, it seems to me that so long as they are doing their required patrols, this is not a heinous crime, and at least means they are not, as has also been alleged, sleeping somewhere. I take the point, though, about being readily available on the wing should anything happen. The Governor might consider this matter worthy of further review.

It was evident during the course of interviews that staff were unclear on the circumstances in which paramedics should be called, and equally unclear on who should make the decision to call them. In this respect there are discrepancies between the contingency plans for these types of incident on the wings (which are primarily contained in the Suicide Prevention Policy Document) and those in use in the Control Room. The failure to call paramedics might, in other circumstances, have proved crucial – especially given the distance the doctor had to travel. Notwithstanding the complaints from the paramedics who attended the prison the previous week, I consider it essential that a requirement immediately to call paramedics in the case of an apparent suicide should be incorporated into the ECR contingency plans. The ambulance can always be cancelled if a member of healthcare attends and finds that the situation does not warrant its attendance.

It is also a matter of some concern that there was a delay in summoning a doctor and that the doctor who was contacted was not actually on call. I do not know if the doctor who should have been called could have reached the prison any quicker. I do not believe, however, that it would have made any material difference in the circumstances.

The investigation team also found that there were many different interpretations of the circumstances in which a cell should be entered in a medical emergency, particularly in respect of how many staff should be present. This may have led to some delay, although given the imprecise timings of events, it is impossible to say with any certainty. (For what it is worth, I do not consider it likely that this had any bearing on the man's death, given the condition of his body when staff got to him.)

The first on scene staff placed the man on the bed as opposed to a flat solid surface. This is not in line with the correct procedure, but I would find it very hard to criticise them for it. Otherwise they followed correct emergency aid procedures and are to be commended for their actions. In line with establishment policy, they administered resuscitation, as they could not be sure that rigor mortis had clearly set in.

Indeed, the first nurse on the scene and the other staff present could not have tried harder to revive the man. They are all to be commended. It is hard to imagine just how distressing it must be to give resuscitation to someone who is apparently clearly dead. The suicide prevention document refers to carrying out resuscitation unless rigor mortis has clearly set in. We know that the man's jaw was tightly clenched, but it is not entirely clear whether rigor mortis had set in. It does not seem likely that a trained nurse would attempt resuscitation in a situation where it had. I wonder, though, whether the need to be certain that rigor mortis has set in is too high a test in some instances, even taking into account the need for absolute certainty of death. The first nurse on the scene, a healthcare professional, seems to have doubted the likely efficacy of continuing with resuscitation attempts but was unclear about the length of time she should be expected to carry on. In this case, it appears to me that resuscitation continued for longer than was necessary or than should have been expected from staff. Given the condition in which the man was found, and the lack of a response to emergency aid in the first few minutes, a defensible judgement could have been made by the nurse, as a healthcare professional, to discontinue resuscitation much earlier.

The establishment's management acted appropriately in alerting Headquarters as early as possible that the man was probably dead, even though a doctor had not certified death. Furthermore, while it is very regrettable that the man's wife learned of her husband's death in the way she did, I do not criticise the Press Office for releasing information before she was told. The decision to do so was clearly taken with the right intentions. That said, it is extremely disappointing that someone else apparently acted outside the proper channels.

Things might have been different had the police been given the correct address (though given the timing of the shift change, they would have had to move extremely quickly). The Head of Operations drew the address from LIDS. This was entirely reasonable. Letters sheets (from which the correct address was obtained) might have been used to corroborate the information, but the Head of Operations had no reason to suppose the information was wrong and was trying to act quickly. In any case, my limited experience of

deaths in custody shows that next of kin issues are extremely complex and sensitive. He could have gone through this process only to find that the elected next of kin had changed. As with most information systems, its accuracy is entirely dependent on what is put into it. Responsibility for ensuring information is correct and up to date must lie with the prisoner.

Prison Service Order 2710 says that next of kin should be informed before anything is reported or confirmed to the media:

> "The decision on how to inform next of kin should take into account individual circumstances, especially the distance from the establishment. Wherever possible, notification should be made by a governor grade and chaplain from the appropriate denomination … In some instances notification via the police will be preferable."

Wakefield's Suicide Prevention Strategy and Policy Document says only that, "Wherever possible, the next-of-kin should be informed in person, not by telephone." I understand, however, that Wakefield routinely relies on the police to make the first contact with the family.

I have given some thought to this issue. My preference is for contact to be made in person by staff from the prison, assuming, of course, that this is logistically possible. This means that the family gains immediate contact with someone who can talk authoritatively about what happened, what happens next, what the prison can offer the family etc. It is also important, it seems to me, that the prison is not perceived to be hiding behind the police in any way.

Nevertheless, I am aware that Prison Service staff receive no training for this type of (specialised) work and that the police do. I am also conscious of safety issues. I consider that PSO 2710 is right in its presumption that Prison Service personnel should normally inform the family, but staff undertaking this work should be adequately trained and supported. Where it is not possible (or not advisable) for staff to visit the next of kin, it might be possible to work out a partnership arrangement with the police, whereby a visit by them is timed to coincide with a call from the prison. Clearly, however, this would need very careful management.

The investigation team looked at relevant recommendations from the report of the last self-inflicted death in custody at Wakefield, in October 2002. These included one relating to the need for staff to record accurate information when dealing with incidents and another relating to the use of the establishment's Emergency Medical Response Protocol. With regard to the first of these, the team found it difficult to establish a precise chronology of events due to inconsistencies between the various accounts and the absence of clearly organised incident paperwork. The former is, of course, understandable given the pressure of the situation and that those involved do not check their watches every two minutes. However, no log of events at the scene was submitted to the investigation team and the Control Room record was extremely poor, probably in part because of the very peripheral involvement it had in the incident. We would have expected the Control Room to have a far

greater involvement in the incident, in a co-ordinating role, and therefore to be continually aware of, and recording, developments at the scene. During any incident the Control Room should be in overall charge until the arrival of the Duty Governor or other more senior manager.

As far as using the establishment's Emergency Medical Response protocol is concerned, it was clear that some of the initial briefings about the incident were sketchy. Had the specific codes referred to in the protocol been used (in this case, Code Blue for unconsciousness due to asphyxia, hanging or breathing difficulties), the picture might have been much clearer for all concerned. The investigation team found no evidence that this code system was used on this occasion.

On the whole, however, contingency plans were followed in respect of management of the incident. The Prison Service Order on follow-up to deaths in custody was implemented adequately. I particularly commend the efforts of the Head of the Care Team in the prison. There are, however, some important local and national issues requiring further consideration, notwithstanding that they do not appear to have had any direct impact on the man's death or in any way affected the outcome of the incident. These include arrangements for entering the cell of a category A prisoner during an emergency and whether rigor mortis is too high a test for determining whether resuscitation should be attempted or continued.

Conclusion

There is evidence that, during his first three or four years in custody, the man frequently indicated an intention to take his life at some stage. Due to the high profile nature of his crimes, he had been subject to close management in the early part of his sentence. This included regular management reviews of the way he was handling his situation and careful assessment of where he should be located. He had for some periods been on an F2052SH following concerns that he was intent on taking his life. I have been impressed by the standard of care and supervision afforded to him during those periods.

It is worrying that not all the relevant information on his F2052SH history had been passed to residential and correspondence staff at Wakefield. The man had not, however, given staff any recent cause for concern over his welfare and I can find nothing to suggest this failing in communication impacted on his death.

Although the investigation team has found procedural issues relating to the management of the incident which should be addressed both locally and nationally, from the evidence we have they do not appear to have affected the outcome.

Recommendations

I recommend that the Governor of Wakefield, in association – where appropriate - with the Directorate of High Security Prisons:

- reviews the IEPS in respect of its transparency and fairness both in principle and in practice;
- considers what changes are required to ensure that prisoners can attend work regularly;
- reviews the effectiveness of the personal officer scheme and arranges additional training as necessary;
- reviews the establishment's death in custody contingency plans with a view to eliminating any inconsistencies with the Suicide Prevention Policy document and instructions to staff on the residential units;
- revises the establishment's night state category A check forms to include a record of the precise time each check is carried out on each prisoner;
- ensures all staff are aware of the circumstances in which they may enter a cell in a medical emergency;
- reviews the instruction relating to when resuscitation need not be begun or may be ended in the event of any delay in the arrival of the doctor or paramedics. The onset or not of rigor mortis should not be the only test as to whether resuscitation should be commenced or continued. A judgement by a healthcare professional should be acceptable in some circumstances;
- incorporates in the revised contingency plans the code system for medical emergencies (currently published as a separate instruction);
- incorporates in the ECR contingency plan relating to death in custody a requirement to call paramedics unless explicitly advised not to do so by a member of healthcare staff;
- ensures information about the on-call doctor rota is readily available in the ECR;
- reviews the job specification of the Control Room Senior Officer to ensure it describes in full his role during any incident; and
- reviews the establishment's incident paperwork and ensure all staff are aware of it. This should include a review of incident log paperwork in the Control Room.

I recommend that the Prison Service's Safer Custody Group:

- considers what arrangement could be put in place for ensuring that long term, but dormant, suicide risk issues are communicated from one establishment to another;
- disseminates to establishments statistics on self-inflicted deaths and birthdays, perhaps via its newsletter;
- considers, together with the Department of Health, whether further guidance should be issued relating to the circumstances in which resuscitation need not be begun or may be terminated; and
- asks all establishments to remind prisoners during induction and via notices that it is their responsibility to ensure their next of kin details are up to date.

Finally, I recommend that DHSP:

- considers the appropriateness of existing guidance on entering category A cells in a medical emergency.

STEPHEN SHAW
PRISONS AND PROBATION OMBUDSMAN FOR ENGLAND AND WALES