

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Patrick Clayton, a prisoner at HMP Garth, on 4 September 2024

A report by the Prisons and Probation Ombudsman

Third Floor, 10 South Colonnade
Canary Wharf, London E14 4PU

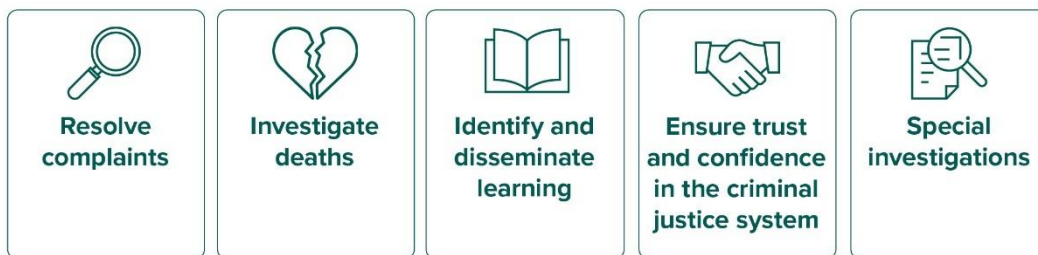
Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk

T | 020 7633 4100

OUR VISION

To deliver high quality and timely independent investigations and work closely with partners to achieve tangible benefits for the safety and confidence of those in custody and under community supervision.

WHAT WE DO



WHAT WE VALUE



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The Prisons and Probation Ombudsman aims to make a significant contribution to safer, fairer custody and community supervision. One of the most important ways in which we work towards that aim is by carrying out independent investigations into deaths, due to any cause, of prisoners, young people in detention, residents of approved premises and detainees in immigration centres.

If my office is to best assist His Majesty's Prison and Probation Service (HMPPS) in ensuring the standard of care received by those within service remit is appropriate, our recommendations should be focused, evidenced and viable. This is especially the case if there is evidence of systemic failure.

Mr Patrick Clayton died in hospital on 4 September 2024, after being found hanging in his cell at HMP Garth on 3 September. He was 29 years old. I offer my condolences to Mr Clayton's family and friends.

Mr Clayton was the fifth prisoner to take his own life at Garth since September 2021. Up to the end of December 2024, there has been one further self-inflicted death at Garth.

Mr Clayton was held under segregation conditions (separated from other prisoners and the normal regime) for three and a half months before he died. We consider that staff took positive actions to try and reintegrate him, which Mr Clayton refused. His death is a reminder of the impact that long-term segregation can have on prisoners and their increased risk of suicide and self-harm.

On the day he was found hanging, two significant events took place. For the second time in under two weeks, Mr Clayton was unable to complete a planned video call with his children, and on his return to the segregation unit force was used to return him to his cell. Unlike the first occasion, Mr Clayton did not have credit to call his family from his in-cell phone and staff did not make provision for him to use an office phone as they had the time before.

Mr Clayton's death highlights the inequalities in access to phone calls for prisoners and the consequences for prisoners in crisis. Maintaining family ties is essential for prisoners and the disappointment of not being able to speak to his family appears to have been a trigger for Mr Clayton's actions. The importance of a reliable means of contacting family is particularly the case for prisoners serving long sentences and the Governor will want to consider what provision there is to help prisoners when planned contact does not proceed.

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

Adrian Usher
Prisons and Probation Ombudsman

November 2024

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Summary

Events

1. On 21 December 2021, Mr Patrick Clayton was sentenced to 23 years in prison for murder.
2. Mr Clayton had a history of anxiety and depression and had taken antidepressant medication in the past. He also had a history of self-harm and attempted suicide. During this period in prison, staff monitored Mr Clayton under suicide and self-harm prevention procedures (known as ACCT) several times.
3. On 14 July 2023, Mr Clayton transferred to HMP Garth. He spent time on the Building Hope Unit (a psychologically informed therapeutic environment) before moving onto a drug recovery wing.
4. On 16 May 2024, Mr Clayton assaulted another prisoner. He then barricaded his cell, set a fire and damaged his emergency cell bell. Prison staff moved Mr Clayton to the segregation unit and started ACCT procedures, which were closed in the middle of June. Mr Clayton stayed under segregation conditions until he died.
5. On 24 August, Mr Clayton had a scheduled video call which did not go ahead.
6. On 27 August, staff moved Mr Clayton to the Residential Support Unit (RSU) where he remained under segregation conditions pending the approval of his application to the unit.
7. On 31 August, Mr Clayton climbed onto the pool table and would not get down until he returned to the segregation unit. Staff decided to send him back to the segregation unit.
8. At around 2.30pm on 3 September, officers took Mr Clayton for a video call with his children which did not go ahead. Mr Clayton was angry that his call had not taken place, threatened to smash up his cell and prevented officers closing his cell door. Officers used force to move Mr Clayton away from and close his door.
9. At 2.48pm, Mr Clayton pressed his emergency cell bell. A prisoner attended his cell, spoke to Mr Clayton, and turned off the cell bell.
10. At 3.24pm, two officers found Mr Clayton hanging in his cell. An officer immediately radioed a medical emergency 'code blue', indicating a life-threatening situation.
11. Prison and healthcare staff began CPR. Paramedics arrived at around 3.39pm and took over Mr Clayton's care. They took him to Royal Preston hospital, where he died at 5.41pm on 4 September.

Findings

12. Mr Clayton was held under segregation conditions for around three and a half months before he died. We found that the original decision to segregate Mr Clayton was reasonable and that staff continued to review options for pathways out of

segregation. However, we found that when staff moved Mr Clayton to the RSU, they should have properly communicated this to him, so he fully understood the next steps and what to expect when he was there.

13. Mr Clayton had a number of risk factors for suicide and self-harm but there were no particular indications that his risk of suicide had increased in the days before he died. On the day he was found hanging there were two potential triggers: not being able to speak to his children through a video call, and a use of force incident. While it was reasonable that officers gave Mr Clayton a 'cooling' period after this incident before returning to speak to him, there was a missed opportunity to identify increased risk when a prisoner, rather than an officer, answered his emergency cell bell.
14. Segregation procedures in general were not always well managed. Mr Clayton was not seen every day by a member of healthcare staff. There is little evidence that staff had quality conversations with Mr Clayton during his time in the unit, and there is no evidence of interaction with a designated officer. Some staff did demonstrate that they knew Mr Clayton and were able to communicate well with him, particularly an officer who was able to partially de-escalate the incident shortly before Mr Clayton's death.
15. Mr Clayton had two failed video calls with his children leading up to his death. We found that there was limited information recorded about the reasons for failed video calls and a lack of consistency of what happened when a call did not go ahead. Mr Clayton had no phone credit when he died and so was unable to speak to his family at a moment of crisis.

Recommendations

- The Governor should ensure that plans to re-integrate prisoners from the segregation unit are properly recorded and discussed at multi-disciplinary meetings and communicated appropriately to the prisoner.
- The Governor should review the quality of and compliance with policy of segregation procedures, identify any improvements required, and devise a plan to deliver those improvements.
- The Governor should investigate the frequency of video calls which are not completed and the reasons for these and ensure that appropriate mitigating action is taken when a call does not go ahead for reasons outside of a prisoner's control.

The Investigation Process

16. HMPPS notified the PPO of Mr Clayton's death on 4 September 2024.
17. The investigator issued notices to staff and prisoners at HMP Garth informing them of the investigation and asking anyone with relevant information to contact her. One prisoner contacted the investigator as a result. She interviewed him as part of this investigation.
18. The investigator visited Garth on 12 September 2024. She obtained copies of relevant extracts from Mr Clayton's prison and medical records. She also obtained CCTV, body worn video camera footage of the emergency response, the HMPPS Early Learning Review and Ambulance Service records.
19. NHS England commissioned a clinical reviewer to review Mr Clayton's clinical care at the prison. She and the investigator jointly interviewed 15 members of prison and healthcare staff in October and November 2024.
20. The investigator interviewed two additional members of prison staff and two prisoners between September and November 2024.
21. We informed HM Coroner for Lancashire and Blackburn with Darwen of the investigation. The Coroner gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.
22. The Ombudsman's office contacted Mr Clayton's ex-partner to explain the investigation and to ask if she had any matters she wanted us to consider.
23. Mr Clayton's ex-partner asked if Mr Clayton was getting the right medication for bi-polar disorder and the reason why ACCT procedures were ended before he died. She said it was very obvious when Mr Clayton was struggling with his bi-polar disorder, as his mood swings would be extreme, and asked why prison staff did not notice.
24. Mr Clayton's ex-partner said that on the day he died, Mr Clayton was due to have a video call to see his children. She told us that the technology did not work, and the call did not take place. She noted that in the past when this happened, prison staff would allow Mr Clayton to phone her from an office. Mr Clayton's ex-partner explained that she believes that the disappointment of the failed video call, followed by not being able to speak to her on the phone, was why Mr Clayton took his life.
25. We shared the initial report with HM Prison and Probation Service (HMPPS). HMPPS pointed out some factual inaccuracies, and we have amended this report accordingly.
26. We also shared the initial report with Mr Clayton's ex-partner and Mr Clayton's mother. Mr Clayton's mother made a number of comments that do not impact on the factual accuracy of this report and which we have addressed through separate correspondence. Mr Clayton's ex-partner did not make any comments.

Background Information

HMP Garth

27. HMP Garth is a category B training prison and holds long-term and life-sentenced prisoners. It is part of the Long-Term High Security Estate (LTHSE). At the time of Mr Clayton's death, Greater Manchester Mental Health NHS Foundation Trust provided physical health, mental health, social care and clinical substance misuse treatment. (From April 2025, Practice Plus Group will provide healthcare services.) Delphi Medical is subcontracted to provide psychosocial substance misuse services.

HM Inspectorate of Prisons

28. The most recent inspection of HMP Garth was in July and August 2024. Inspectors reported that the prison had become noticeably less safe than their last visit and some of the wings felt chaotic. They found that without better support from the regional team and the prison service, Garth would continue to be a jail of real concern.
29. Inspectors commented that the very high levels of sickness among officers were affecting the prison's ability to operate effectively in many areas. Inspectors found that morale among staff was poor, and the many inexperienced officers had not had sufficient training or support in their roles.
30. Inspectors found that there was no up-to-date safety strategy or action plan, and records of meetings were poor, indicating limited oversight. They found that the safer custody team was small and vacancies and cross-deployment led to limited oversight, support and guidance. They found that ACCT assessments were not thorough and care plans were very limited and not regularly updated with no quality assurance in place.
31. Inspectors also found that use of force had doubled since the last inspection and that while force was justified and mostly proportionate in the incidents reviewed, they did see examples of excessive force. They found that debriefs of prisoners after a use of force incident did not take place. Inspectors also found that there was poor attendance at medical appointments.
32. Inspectors found that the number of prisoners segregated had decreased but the average duration had increased by 14 weeks, that the unit was often full and many prisoners were segregated on residential units. They found that most prisoners had a detailed one page plan which looked at behaviour, risks and routes out of segregation. They found in the segregation unit that staff knew their prisoners well and prisoners spoken to were largely positive about their treatment.

Independent Monitoring Board

33. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report, for the year to November 2023, the IMB

reported that constant changes to the regime had caused unrest amongst prisoners. They also found that the keyworker scheme was disrupted by staff shortages.

34. The IMB found that the segregation unit was frequently full to capacity but from observations it offered a safe environment for prisoners. They found that it was not unusual for prisoners to be segregated on residential wings. The Board had concerns that prisoners were frequently kept in the segregation unit for excessively long periods, the reason for this being the unavailability of suitable placements in other prisons and secure mental hospitals.
35. The Board found that incidents requiring the use of force are managed competently by well-trained officers.

Previous deaths at HMP Garth

36. Mr Clayton was the thirteenth prisoner to die at Garth since September 2021. Four of these deaths were self-inflicted. There were no significant similarities between our findings in the previous self-inflicted deaths and those in this investigation. To the end of January 2025, there has been one further self-inflicted death and four deaths due to natural causes at Garth.

Assessment, Care in Custody and Teamwork

37. ACCT is the Prison Service care-planning system used to support prisoners at risk of suicide or self-harm. The purpose of ACCT is to try to determine the level of risk, how to reduce the risk and how best to monitor and supervise the prisoner. After an initial assessment of the prisoner's main concerns, levels of supervision and interactions are set according to the perceived risk of harm. Checks should be irregular to prevent the prisoner anticipating when they will occur. There should be regular multidisciplinary review meetings involving the prisoner.
38. As part of the process, support actions are put in place. The ACCT plan should not be closed until all the support actions have been completed. All decisions made as part of the ACCT process and any relevant observations about the prisoner should be written in the ACCT booklet, which accompanies the prisoner as they move around the prison. When Mr Clayton was at Garth, guidance on ACCT procedures was set out in the Prison Service Instruction (PSI) 64/2011, Management of prisoners at risk of harm to self, to others and from others (Safer Custody). From January 2025, this was superseded by the Prison Safety Policy Framework, in which the principles of how an ACCT is managed remain largely unchanged.

Segregation units

39. Segregation units are used to keep prisoners apart from other prisoners. This can be because they feel vulnerable or under threat from other prisoners or if they behave in a way that prison staff think would put people in danger or cause problems for the rest of the prison. They also hold prisoners serving punishments of cellular confinement after disciplinary hearings.

40. Prison Service Order 1700 sets out the purpose and reasons for segregation, together with the process that should be followed when a prisoner is segregated. The PSO specifies that an initial segregation health screen must be completed within the first two hours of a prisoner being placed in segregation. This is in the form of an algorithm and is a snapshot assessment of a prisoner's mental well-being to decide whether it is safe to segregate them, although physical health concerns should also be considered.
41. Segregation unit regimes are usually restricted, and prisoners are permitted to leave their cells only to collect meals, wash and have a daily period in the open air. The segregation unit at Garth is known as the Care and Separation Unit (CSU).

Key Events

42. On 12 March 2021, Mr Patrick Clayton was remanded to HMP Lincoln for murder. On 21 December 2021, he was sentenced to 23 years in prison.
43. Mr Clayton had a history of anxiety and depression. He was previously prescribed antidepressant medication but stopped taking this in February 2022. He also had a history of self-harm and attempted suicide via cutting, overdose and hanging, both inside and outside prison. Before moving to HMP Garth, staff had monitored Mr Clayton under ACCT procedures on four occasions.
44. Mr Clayton had an extensive history of substance misuse in the community and in prison. During his time in prison, he engaged with substance misuse teams and had an allocated drug recovery worker.
45. Before transferring to Garth, Mr Clayton spent around nine months in the segregation unit at HMP Full Sutton. While he was originally sent to the segregation unit for disciplinary reasons, Mr Clayton subsequently refused to move to a standard residential wing.

HMP Garth

46. On 14 July 2023, Mr Clayton transferred to Garth. During his reception health screen, Mr Clayton explained that he used "Spice" (a psychoactive substance) but did not want input from the drug and alcohol recovery service. During his health screening, a nurse noted Mr Clayton's history of anxiety and depression but that he did not have any thoughts of suicide or self-harm. Mr Clayton was not prescribed any medication at the time.
47. Mr Clayton initially lived on the Building Hope Unit (BHU - a psychologically informed therapeutic environment). Staff removed Mr Clayton from this unit in November when they found him under the influence of illicit substances and in possession of an improvised weapon.
48. During his time at Garth, Mr Clayton isolated on several occasions, saying that he felt paranoid and had issues with the Muslim population which had followed him from previous establishments. Staff did not refer him for a Challenge, Support & Intervention Plan (CSIP, a tool used at Garth to manage those who present a risk of violence to others as well as to offer support to vulnerable individuals) on any of these occasions.
49. In November, Mr Clayton moved to the drug recovery unit where he engaged well with the drug recovery groups and worked on the servery.
50. On 30 April 2024, Mr Clayton began to isolate. On 14 May, staff submitted an intelligence report recording that Mr Clayton was isolating due to threats and issues which had followed him from previous establishments. There is no evidence that any investigation was done into these issues or that staff referred him for CSIP.
51. On 15 May, Mr Clayton requested to stop isolating. He explained to an officer that he was being paranoid and had resolved his issues.

Segregation

52. On 16 May, Mr Clayton went into another prisoner's cell with a kettle and assaulted him. Later that morning, staff told Mr Clayton that they would move him from the drug recovery unit. Following this, Mr Clayton barricaded his cell, set a fire and damaged his emergency cell bell.
53. Staff charged Mr Clayton with a prison disciplinary offence and segregated him under Prison Rule 45, which allows prisoners to be segregated for the good order of the establishment.
54. The mental health team leader completed Mr Clayton's segregation safety algorithm (a snapshot assessment of a prisoner's physical, emotional and mental well-being to decide whether it is safe to segregate them). She assessed that there were no clinical reasons or concerns to advise against segregation at that time. At interview, she recalled that Mr Clayton was in distress and that he told her about the troubles that he experienced on the wing and said that he felt safe in the segregation unit.
55. Around an hour after completing the initial segregation health screen, the mental health team leader started ACCT procedures. On the ACCT concern form she recorded that Mr Clayton had said he would end his own life as he had just been told he would have to be relocated to a different wing. Mr Clayton told her that he had 20 years to serve and had no protective factors. She explained at interview that she started ACCT procedures as a precaution so that staff could keep an eye on Mr Clayton. She booked Mr Clayton for a mental health assessment. (On 20 May, a mental health nurse carried out a mental health review with Mr Clayton. She noted in Mr Clayton's medical records that she was unable to complete the notes due to workload and her notes would follow. There is no subsequent entry in Mr Clayton's records.)
56. At 2.45pm, an operational manager authorised Mr Clayton's segregation. A Supervising Officer (SO) completed a segregation unit initial risk assessment, which noted that Mr Clayton was subject to ACCT procedures and that agreed levels of observations would be five times per hour. (There is no evidence that an operational manager authorised this document, with the field for their signature left blank.)
57. On 17 May, the previous Head of Segregation chaired Mr Clayton's disciplinary hearing. Mr Clayton pleaded guilty to the charge. He explained during his hearing that he had assaulted the other prisoner as this prisoner was "out to get him". He explained to staff that he could not isolate as he had 20 years left to serve. The Head of Segregation gave Mr Clayton a reduction of privileges (such as use of a TV and access to the prison shop).
58. During Mr Clayton's ACCT assessment, he shared that he felt better and explained that he had set fire to his cell as he would rather "not be there" than be moved back to A Wing or C Wing. Staff discussed future pathways and Mr Clayton explained that he hoped to be able to move back to the BHU.
59. On 19 May, a SO chaired Mr Clayton's first ACCT case review. Attendees included a mental health nurse and a segregation unit officer. The officer who had completed the ACCT assessment, was not present at this review.

60. Mr Clayton said that he had spent time in the segregation unit before and liked being segregated. He shared that he was not currently experiencing depression but had in the past. Mr Clayton explained that he had set the fire to his cell as he was told he would be moving to another wing, where he had issues. Mr Clayton said his main source of support was his sister. Attendees decided to lower Mr Clayton's observations to one per hour. Staff did not complete a support plan at this review.
61. That day, an operational manager chaired a segregation review board (these boards are to be held within 72 hours of first segregation under Prison Rule 45 and then at least at 14-day intervals afterwards). Attendees included a SO and a nurse. During this review, Mr Clayton said that he would only live on the BHU. A few days later, Mr Clayton changed his mind and said he no longer wanted to be at Garth as he felt he was under threat from the Muslim population.
62. Mr Clayton continued to have fortnightly segregation review boards (there are two reviews which are missing paperwork). Within these reviews, Mr Clayton continued to refuse to move to any residential unit at Garth. Staff continued to discuss different options for Mr Clayton including referring him to the Bridge unit (a reintegration wing at HMP Whitemoor for prisoners leaving segregation units). However, Mr Clayton decided that he did not want to do this due to the location of the unit. There is little evidence from the segregation review boards that staff sought to address the reasons why Mr Clayton felt that he could not live on a standard residential unit at Garth.
63. On 28 May, staff increased Mr Clayton's unlock level as he threatened to throw excrement at staff. (This meant that three officers were required to unlock Mr Clayton each time he came out of his cell.)
64. On 31 May, a SO chaired an ACCT review. Another SO also attended. Mr Clayton said that he was now settled on the segregation unit and felt better. Those present decided to close the ACCT procedures. A care plan was put together at this review with actions which had already been completed. The care plan included actions to (i) settle in the segregation unit and (ii) to get his contact book in order to phone family and friends. (Mr Clayton frequently made phone calls, mainly to his ex-partner. He also kept in touch with family via email. He did not apparently receive face to face visits.)
65. Senior prison managers and chaplaincy staff saw Mr Clayton every day in the segregation unit. The GP visited Mr Clayton three times a week and healthcare staff saw him on regularly, but not every day.

June – August

66. On 5 June, Mr Clayton told a member of PROSPECT (a trial run by University of Manchester looking into the prevention of suicide in prisons, which Mr Clayton had volunteered to participate in) that he had recently felt upset and depressed. She therefore recommended for Mr Clayton's ACCT procedures to be reopened. An SO noted that a full ACCT review was to be held on 5 June. There is no evidence that a multi-disciplinary review took place until 10 June and there were no updates to Mr Clayton's care plan.

67. On 10 June, the previous Head of Segregation chaired an ACCT case review. Attendees included the psychology lead, a mental health nurse, an officer and an SO. Mr Clayton explained that after speaking to his sister he felt okay. Staff decided to continue the ACCT procedures with two meaningful conversations per day.
68. On 18 June, an SO chaired an ACCT review. An officer attended. Mr Clayton explained that he had been told that staff were looking into a transfer to a different prison and that he was happy about this. The SO noted that there were no outstanding actions on the care plan and closed the ACCT procedures.
69. On the same day, Mr Clayton started therapy sessions with a member of PROSPECT as part of the PROSPECT programme. (Over the next few months, Mr Clayton had six sessions with her.)
70. On 21 June, the previous Head of Segregation completed a review form and sent this to a senior manager in the long term high secure estate directorate. (When a prisoner is to be segregated for longer than 42 days, a senior manager in the Prison Group Director's (PGD) office is required to review and authorise the continuing segregation.) He recorded that the multi-disciplinary team were exploring a referral to the Bridge Unit. On 27 June, the senior manager concluded that Mr Clayton should stay in the segregation unit and staff should continue to explore a referral to the Bridge Unit and other alternatives.
71. On 24 June, an operational manager chaired a segregation review board meeting. The segregation review paperwork notes that the attendees included the segregation clinical lead and a mental health nurse. (No one made an entry in Mr Clayton's medical record.)
72. In the segregation database document (a file used by the psychology team to monitor prisoner's progress in segregation), staff recorded that Mr Clayton explained that he wished to take antipsychotic medication as he was having "mad thoughts". He explained that he was having thoughts about harming himself and others. The mental health nurse advised that he would make an appointment for him to see the mental health team. No reference to this was made in Mr Clayton's medical records, his ACCT post closure monitoring document, or his segregation review document. (Healthcare staff subsequently made an appointment for Mr Clayton to have a mental health assessment.)
73. On 25 June, Mr Clayton refused to exit the exercise yard. He removed all of his clothes and defecated into his sock, threatening to throw this at staff. Staff charged Mr Clayton with a prison disciplinary offence. (This disciplinary hearing did not take place before Mr Clayton's death.) Staff moved Mr Clayton to the annex cell in segregation, used for prisoners who choose to live in dirty conditions. (Mr Clayton did not repeat this behaviour and continued to live in clean conditions.)
74. That day, an SO conducted an ACCT post-closure review. He noted that Mr Clayton felt better being in the segregation unit and was focusing on his potential transfer to another prison. He recorded that Mr Clayton did not raise any other issues. He decided to keep the ACCT closed.
75. Over the next few days, Mr Clayton told healthcare staff on the segregation unit that he needed to have antipsychotics as he was "going insane". He submitted an

application explaining that he needed help, and that he was struggling with his mental health. Healthcare staff responded the same day and explained that they had transferred the application to the mental health team.

76. On 29 June, Mr Clayton moved out of the annex cell and into a standard segregation cell.
77. On 3 July, Mr Clayton covered his observation panel, threw liquid through the door and threatened to throw a bowl of excrement.
78. On 9 July, a mental health nurse saw Mr Clayton for a mental health assessment. Mr Clayton explained that he had struggled with anxiety and depression throughout his life. Mr Clayton told the nurse that he was not on any medication but would like to explore medication options. Mr Clayton told the nurse that he had no history of self-harm but also that he had tried to end his life in the past, by cutting, and that he had previously set a fire in his cell. The nurse concluded that therapy was not required and referred him to the GP for a review of anxiety and depression. The nurse booked a GP appointment for 31 July.
79. On 19 July, the Head of Segregation sent another review form to the PGD's office for authorisation to continue segregation. She set out that Mr Clayton no longer wanted to pursue a referral to the Bridge unit. She also noted that staff had discussed moving Mr Clayton to the Residential Support Unit (RSU - a unit for vulnerable prisoners who have not been convicted of sexual offences). She recorded that while Mr Clayton initially considered this option he had since discussed it with his ex-partner and said that she had advised against locating there as there might be sex offenders on the unit. (Staff explained to Mr Clayton that this was not the case and that sex offenders lived on other units at Garth.)
80. On 23 July, the segregation clinical lead and a member of PROSPECT discussed the mental impact of Mr Clayton's long term stay in the segregation unit. They explored options for moving out of the segregation unit and the impact that transferring establishment would have on his ability to continue with the PROSPECT programme. They asked Mr Clayton to consider moving onto the RSU. Mr Clayton explained that going onto a VP unit would have an impact on his reputation and his ex-partner had told him not to move. He also raised concerns that he could be under threat if he were to go to the RSU.
81. Following this meeting, the segregation clinical lead wrote to the Head of Segregation. She explained that if Mr Clayton did choose to go to the RSU, it would be key to have an agreement in place that he could return to the segregation unit if he did not feel safe. She explained that this should be communicated to staff more widely so that this happened. (We do not know if such an agreement was made with Mr Clayton or if this was communicated to staff.)
82. On 31 July, Mr Clayton declined to attend his GP appointment.

August

83. On 5 August, the previous Head of Segregation chaired a segregation review. Attendees included the mental health team lead, an SO and a member of the IMB. (The prison has not been able to locate the paperwork for this review, but we have

based the following on an entry in Mr Clayton's medical records.) During the review, Mr Clayton agreed to put in an application to the RSU. He explained that he would go to the RSU if another prisoner he was friends with was accepted.

84. On 7 August, staff discussed Mr Clayton as part of the Safety Intervention Meeting (SIM, a multidisciplinary safety risk management meeting - at Garth all prisoners in the segregation are discussed as part of the SIM). The minutes record that Mr Clayton had submitted an application to the RSU. In his part of the RSU application Mr Clayton recorded that he needed to start progressing and stay out of conflict. Mr Clayton recorded that he needed to start thinking about himself and on trying to work towards getting out and changing his ways. (We do not know exactly when Mr Clayton submitted this application.)
85. On 12 August, Mr Clayton spoke to the GP completing the routine segregation rounds. Mr Clayton explained that he was concerned about his mood and would like antidepressants and the GP recorded that he had "non-specific" suicidal ideation. The GP told Mr Clayton that he had an appointment scheduled for 30 August. The GP did not record having considered ACCT procedures.
86. On 13 August, Mr Clayton met his drug recovery worker. He discussed feeling depressed and reported that he had spoken to the GP about this and asked for antidepressant medication. They discussed his next move and options of progression from the segregation unit. Mr Clayton said that he had been in contact with his ex-partner and children via a video call, which he was happy about. (Video calls are a secure video-calling system used in prisons to maintain family contact in addition to physical visits.)
87. On 19 August, the Head of Segregation chaired Mr Clayton's segregation review board. Attendees included a mental health nurse, an SO and a member of the IMB. They discussed that Mr Clayton was settled on the second landing and compliant with the regime. During this review, Mr Clayton asked to speak to a mental health nurse. The nurse saw him on 25 August and recorded that there were no identified mental health issues and no concerns of suicide and self-harm.
88. On 21 August, staff discussed Mr Clayton at the SIM and noted that they were considering a transfer of establishment for him.
89. On the same day, an SO filled in his part of the referral form for the RSU. (The RSU application requires contributions from an SO or keyworker, security department, safer custody and the RSU SO before it can be approved.)
90. On 24 August, Mr Clayton had a scheduled video call with his ex-partner and children, but this did not take place. (We do not know the reason for it not going ahead. A visits officer told us that calls often do not go ahead due to staffing issues.) An SO explained that Mr Clayton was very angry that the call had not gone ahead and threatened not to return to his cell when his door was unlocked.
91. Mr Clayton told an SO that he did not have any credit on his in-cell phone. (Mr Clayton made some calls shortly afterwards on his in-cell phone, so this does not appear to be true.) The SO decided to let Mr Clayton call his ex-partner from the office phone so he was able to speak to his children for a few minutes. The SO said

that Mr Clayton calmed down after the call. Staff did not record anywhere that they had given Mr Clayton this phone call.

92. That afternoon, Mr Clayton submitted an application to rebook his video call, saying that it was cancelled due to there not being enough staff. (We do not know who told Mr Clayton this.) Prison staff re-booked the video call for 2.30pm on 3 September.
93. Following this, Mr Clayton made several calls to his ex-partner and another friend. (Prisoners' calls are recorded and staff listen to a random sample for security purposes. No one listened to Mr Clayton's calls until after he had died.) He explained during a call that he had walked to the video call room and staff then told him his call was cancelled. Mr Clayton asked for them to send in money so that he could buy more phone credit.
94. Mr Clayton did not make any more phone calls after this day. Mr Clayton checked his balance on an almost daily basis, including the morning of 3 September. He did not have any phone credit left and had £2 in his general account at the time of his death.
95. On 27 August, an operational manager authorised Mr Clayton to move to the RSU. An SO told the investigator that he spoke to Mr Clayton before he moved, explained that his application to the RSU was in its final stages and asked whether he would be happy to move. The SO explained to Mr Clayton that he would continue to live in segregation conditions on the RSU until the application had been approved. (We have not seen evidence of any segregation paperwork from Mr Clayton's time on the RSU.)
96. That day, psychology staff shared an updated one-page plan for Mr Clayton with segregation staff. (A one-page plan is developed by the psychology team to support staff in understanding and better managing prisoners in segregation.) Mr Clayton's plan included details of his risks and problem behaviours, what made things worse and better and warning signs for increased risk. (The warning signs for Mr Clayton's increased risk included the following: (i) an inability to manage his emotions effectively i.e. being argumentative or damaging property (ii) refusing direct orders (iii) making verbal threats to assault others.)
97. During the next few days, Mr Clayton was held under segregation conditions on the RSU. During this time, Mr Clayton wrote a number of applications on his prison laptop. In one of these, written on 30 August, he asked if anyone could tell him whether his application for the RSU had been approved and questioned why he had been put on the wing if that was not the case. He wrote that if he was not let out of his cell that day he would go back to segregation "one way or another". Mr Clayton rejected this application himself before it was answered.
98. On 29 August, a SO on the RSU noted that Mr Clayton did not suit the criteria for the RSU. He noted that Mr Clayton's behaviour was problematic. He recorded on the RSU application that Mr Clayton had been demanding to staff over the two days he had been on the RSU and had threatened to set the cell on fire until he got back to the segregation unit. (This behaviour was not recorded in Mr Clayton's prison records or in the wing observation book.)

99. The same day, a staff member from Safer Custody recorded that, due to Mr Clayton's recent behaviour, he did not appear suitable for the RSU. They also recorded that his ACCT document was in post-closure, that 100 per cent of his self-harm incidents were of low physical harm and that his most used method was cutting, shown in 50 per cent of these incidents.
100. On 30 August, Mr Clayton did not attend a GP appointment to review anxiety and depression. A prison GP recorded that he called Mr Clayton in his cell, but that the line was busy. He re-booked the appointment for 4 September.
101. Mr Clayton told a member of the chaplaincy team that he was frustrated as he expected to be out of his cell by now.
102. On 31 August, when he was let out of his cell, Mr Clayton climbed onto the snooker table and said he would not get down until he was back in the segregation unit. After 45 minutes, staff decided to relocate him to the segregation unit.

September

103. On 2 September, Mr Clayton moved to a cell on the second landing in the segregation unit.
104. That day, the Head of Segregation conducted a segregation review. Attendees included the segregation clinical lead and a mental health nurse. The nurse told the investigator that Mr Clayton was angry as he said that he had been told that if he did not settle on the RSU he could move back to the segregation unit. Mr Clayton said that he felt like he had lost trust in all the prison staff and had been "set up to fail".
105. The nurse asked Mr Clayton if he had any mental health concerns. He responded that he was fine now that he was back in segregation and denied having any thoughts of self-harm or suicide. The Head of Segregation told the investigator that Mr Clayton explained that he wanted to transfer out of Garth and that the custodial manager of the segregation unit had contacted a couple of establishments about a potential transfer.

Events of 3 September

106. The following account has been drawn from staff statements, interviews, body worn video camera (BWVC) footage, CCTV footage and ambulance service records.
107. At around 8.43am on 3 September, officers went to Mr Clayton's cell as part of the daily segregation rounds. At 9.45am, a chaplain went to Mr Clayton's cell and left around a minute later.
108. At 9.50am, officers took Mr Clayton out of his cell for exercise. He returned to his cell at around 10.20am.
109. A member of PROSPECT told the investigator that she had a brief conversation with Mr Clayton during the morning. He told her that he felt angry as he had moved to the RSU, but they did not want him there and had kept him locked behind his

door. He explained he felt that he had been “stitched up”. She reminded Mr Clayton that they had a session the next day and they could explore this further then.

110. At around 2.25pm, Mr Clayton pressed his cell bell. Officers attended, switched off the cell bell and left a few seconds later. At 2.28pm, Mr Clayton pressed his cell bell again. At around 2.30pm, two officers unlocked Mr Clayton to take him to his scheduled video call (the call was scheduled for 2.30pm). One of them told us that Mr Clayton was angry and said that they had unlocked him late.
111. The officers walked Mr Clayton down the landing towards his video call. Due to an issue elsewhere in the prison they needed to wait for a few minutes by the staff office before they were able to continue.
112. An operational manager told the investigator that he was in the staff office at this time and spoke to Mr Clayton as part of his governor rounds. He said that Mr Clayton was frustrated because he was waiting to move, and he was going to be late for his call.
113. When he arrived at the video call room, Mr Clayton tried to call his ex-partner and children, but was unable to speak with them. Several staff told us that Mr Clayton said that his ex-partner did not pick up the call, whereas she told us that the technology did not work. (Mr Clayton’s video call history sheet recorded that the call was “missed”. A visits officer told us this was either a connection issue or the call recipient did not log on to the meeting.)
114. Both officers then collected Mr Clayton from the video call room.
115. At 2.41pm, following his return to the segregation unit, staff escorted Mr Clayton back to his cell. As they did so, Mr Clayton shouted that he would “smash his cell to bits”. On the body worn camera footage, a voice is heard telling Mr Clayton to “grow up”.
116. As Mr Clayton reached his door, he picked up something from outside the door. (It is not possible to see from the CCTV footage what he picks up, but officers have told the investigator that it was a flask.) As they entered the cell, Officer A asked Mr Clayton what he was doing with the flask, and he said that he was taking it inside.
117. Mr Clayton continued to shout and said that he wanted to speak to an SO. He held onto the door and would not let the officers shut it. Officer A told Mr Clayton that he could speak to someone if he moved away from the door. Mr Clayton then asked him why he had grabbed hold of him. Officer A replied that he had done this as he did not know what Mr Clayton was doing with the flask. (The angle of the body worn camera footage does not show him taking hold of Mr Clayton at this point.)
118. Another officer joined a around a minute later. At 2.43pm, Officer A used force to move Mr Clayton away from the door and took control of his head while Officer B took control of his arm, pinning him briefly against the wall and then over the bed.
119. A prison manager joined around 30 seconds later. He told us that he pressed the general alarm (to notify all staff of any emergency), and additional officers came to the door. Officer A told the investigator that he feared for his safety because Mr Clayton was very irate, and he was becoming aggressive. He and Officer B bent Mr

Clayton over the end of the bed frame while he continued to shout. The manager instructed the officers to “take him to the floor”.

120. At this point, Officer C arrived at the cell, asked the other officers to let go of Mr Clayton, and attempted to de-escalate the situation. Mr Clayton continued to shout, saying to Officer A that he would “smash him up”. He shouted to an SO that he was “fucking with [his] calls” and shouted that he “wanted [his] call”.
121. Officer C continued to speak to Mr Clayton as they shut his cell door. He told Mr Clayton to sit down and that they would speak to him in a minute. (The officer told us that he knew Mr Clayton well from his time on the segregation unit and that he had been able to calm him down on other occasions.)
122. As the door was shut, a nurse arrived in the corridor. She did not approach the cell door and walked back down the corridor with the officers. She told the investigator that Officer C assured her that they had not placed Mr Clayton in “full restraint”. She explained that as he was aggressively pounding on his cell door, she did not want to antagonise him and did not go to the door. She explained at interview that she had spoken with the nurses due to do the medication rounds that afternoon and asked them to go back and check on Mr Clayton.
123. The prison manager explained that there was not an official debrief afterwards, but that the staff spoke about what had happened. He told us that staff said they would check on Mr Clayton in 15-20 minutes to see if he had calmed down. He could not remember who had said this but thought this was Officer C. Officer C told us that he remembered saying that he would check on Mr Clayton later.
124. At 2.48pm, Mr Clayton pressed his cell bell. At 2.51pm, Prisoner A, who works in the segregation unit, went to Mr Clayton’s cell door. He told us that Mr Clayton was angry and said that he had not got his call. Prisoner A told him he would get him a phone call.
125. Prisoner A said that Mr Clayton then calmed down and asked him to turn off his cell bell, which the prisoner did at around 2.54pm. (The prisoner told the investigator at interview that he went back to Mr Clayton’s cell and said to him that he had managed to get him a phone call and this would be done later in the afternoon. There is no evidence of him returning to the cell on the CCTV footage.) An SO told the investigator that he recalled the prisoner telling him that Mr Clayton had asked for a phone call. He said that he told the prisoner to let Mr Clayton know that he was busy, but he would make sure he got his phone call.
126. At 3.24pm, Officer C went to Mr Clayton’s cell to check on him and told us that he also intended to help to arrange a phone call for Mr Clayton. He found Mr Clayton hanging and went into the cell straight away. Another officer radioed a medical emergency code blue, indicating a life-threatening situation. Both officers cut the ligature and started CPR. An SO joined around a minute later.
127. At 3.25pm, a member of healthcare arrived, and officers continued CPR. At 3.39pm, paramedics arrived and took over Mr Clayton’s care. At 3.44pm, Mr Clayton’s heart started beating but he remained unconscious.

128. At around 4.08pm, paramedics took Mr Clayton to Royal Preston Hospital. Mr Clayton died at 5.41pm on 4 September.

Contact with Mr Clayton's next of kin

129. At 4.15pm on 3 September, the prison appointed a family liaison officer (FLO). At 4.20pm, he attempted to phone Mr Clayton's ex-partner, his nominated next-of kin, on a number of occasions, to tell her that he had been admitted to hospital but was unable to get through.
130. At 4.35pm, Garth contacted HMP Hull to ask if they could send a FLO to Mr Clayton's ex-partner's address (as Hull was geographically nearer). At 8.30pm, a FLO from Hull replied that they had gone to the address, but Mr Clayton's ex-partner had not lived there for several years. At 8.10am on 4 September, the Garth FLO managed to get in touch with her. Mr Clayton's ex-partner was with him in the hospital when he died.
131. The prison contributed toward the cost of Mr Clayton's funeral in line with national policy.

Support for prisoners and staff

132. Postvention is a joint HMPPS and Samaritans initiative that aims to ensure a consistent approach to providing staff and prisoners support following all deaths in custody. Postvention procedures should be initiated immediately after every self-inflicted death. Key elements of postvention care include a hot debrief for staff involved in the emergency response and engaging Listeners (prisoners trained by the Samaritans to provide confidential peer-support) to identify prisoners most affected by the death.
133. After Mr Clayton was taken to hospital, an operational manager debriefed the prison and healthcare staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.
134. The prison posted notices informing other prisoners of Mr Clayton's death and offering support. Two Listeners (prisoners trained by the Samaritans to provide support to their peers) were sent to the segregation unit and other Listeners were made available across the establishment.

Post-mortem report

135. A post-mortem examination found that Mr Clayton died of hanging.

Findings

Identifying the risk of suicide and self-harm

136. Prison Service Instruction (PSI) 64/2011, on safer custody, which was in place at the time of Mr Clayton's death, required staff who had contact with prisoners to be aware of the risk factors and triggers that might increase the risk of suicide and self-harm and take appropriate action. Any prisoner identified as at risk of suicide or self-harm must be managed under ACCT procedures. From January 2025, PSI 64/2011 was superseded by the Prison Safety Policy Framework, in which the principles of how an ACCT is managed remain largely unchanged.
137. Mr Clayton had several risk factors for suicide and self-harm during his time at Garth. He had a history of anxiety and depression as well as a history of self-harm and attempted suicide. Mr Clayton had a history of substance misuse and had been in the segregation unit for an extended period of time. During his current sentence, Mr Clayton had been monitored under ACCT procedures, with the most recent ACCT being closed on 18 June 2024.
138. On 24 June, Mr Clayton said to staff during a segregation review board that he was having "mad thoughts" and wanted antipsychotic medication. He said that he was having thoughts about harming others and himself. There is no evidence that anyone considered reopening the ACCT procedures, although Mr Clayton was booked in for a mental health assessment which took place a few weeks later.
139. These comments were not recorded in Mr Clayton's segregation review board document, medical records or on his ACCT document. (They were recorded separately on the segregation database.) A segregation SO completed Mr Clayton's post closure review the next day. There is no evidence that he was aware of the comments from the previous day and therefore it was difficult for him to make an informed decision as to whether to close or re-start the ACCT procedures.
140. Following the closure of Mr Clayton's ACCT procedures, while his risk factors remained, there were no particular events that might have indicated that Mr Clayton was at increased risk of suicide or self-harm.

Events of 3 September

141. There were two potential triggers on the day Mr Clayton hanged himself: not being able to speak to his children in the video call, which was followed by a use of force to put him into his cell. It is apparent that Mr Clayton's emotions were heightened both during and after these events.
142. Mr Clayton's one-page plan set out warning signs for increased risk. Some of these warning signs – difficulty managing his emotions, refusing direct orders, and making threats of violence – were present shortly before Mr Clayton was found hanging.
143. The one-page plan is shared between segregation staff and kept in the prisoner's folder. It is important that all staff – including those working temporarily in the segregation unit – are familiar with the risks and triggers highlighted in the one-page plan or know where to look for them following an incident.

144. The events of 3 September might have been enough to signify an increase in risk for any prisoner. Given Mr Clayton's one-page plan, these events should have indicated that he was potentially at increased risk. Staff discussed giving Mr Clayton a period to calm before returning to check on him and Officer C returned to speak to Mr Clayton around 40 minutes later with the intention of helping him to arrange a phone call. While staff could have more readily acknowledged that, given the information in Mr Clayton's one-page plan, he might have been at increased risk, it was not unreasonable that staff chose to give Mr Clayton a 'cooling' period before returning to check his welfare and discuss more practical support.
145. However, there was an earlier missed opportunity for staff to check on Mr Clayton's wellbeing. A few minutes after the use of force incident, Mr Clayton pressed his emergency cell bell. Prisoner A (who works on the segregation unit) answered this and turned off the cell bell. He explained in interview that sometimes staff asked him to answer cell bells and that when he answered them he would ask the prisoner if they wanted him to switch the cell bell off. He said that staff have now told him that he should not turn cell bells off.
146. HM Chief Inspector of Prisons' expectation is that staff answer cell bells within five minutes. Prisoners should never be asked to answer emergency cell bells. Both SOs working on the segregation unit said that they understand the expectation and always aim to answer cell bells within five minutes. Staff told us that the segregation unit is frequently understaffed, and one officer said that this means that sometimes there are not enough staff to monitor cell bells. However, at the time that Mr Clayton's cell bell went off, there were several staff in the segregation office. (There was also an officer undertaking constant supervision near to Mr Clayton's cell who would have seen the prisoner answering the cell bell.) We would have expected one of those staff to answer the cell bell, particularly had they identified that it was Mr Clayton's cell and that he had pressed it shortly after a use of force.
147. The Head of Safety told us that the Governor will issue a notice to staff highlighting the importance of answering cell bells within five minutes. We do not make a recommendation pending that action but note the general lack of efficacy of notices to staff. The Governor will want to ensure that he continues to monitor the answering of cell bells to ensure that these are answered in line with HMIP expectations.

Use of force

148. The Prison Service Use of Force Policy Framework states that force should only be used:
- If it is reasonable in the circumstances;
 - If it is necessary;
 - If no more force than is necessary is used; and
 - If it is proportionate to the seriousness of the circumstances.
149. The policy sets out that the application of physical techniques is only to be used when other methods not involving the use of force have been repeatedly tried and failed.

150. When Mr Clayton returned to his cell he was shouting and threatened to smash up the cell. It is clear from the body worn footage that he was angry and distressed and continually asked to speak to someone. He picked up a flask and ignored repeated orders to move away from the door.
151. Officer A, who initiated the use of force, explained that he feared for his safety as Mr Clayton had become very aggressive. Officer B said that she was not sure if he could have used the flask he was holding as a weapon against her or other staff. (Neither officers were normally based on the segregation unit and had had limited or no interaction with Mr Clayton before this incident.) An operational manager explained that he did not consider speaking to Mr Clayton when he arrived at the cell as he was “too far gone” to have a conversation.
152. Officer C, who entered the cell shortly after the use of force had started, managed to partially de-escalate the situation, telling the staff to let go and prevented them from taking Mr Clayton to the floor.
153. We consider that it was not unreasonable that the officers used force in this incident, given Mr Clayton’s aggressive behaviour and the flask that he was holding, which they might reasonably have thought he could use as a weapon. However, the fact that Officer C was able to partially de-escalate the situation shows both the value of having staff permanently on the segregation unit who know the prisoners well and understand how to interact with them, and staff willing to attempt de-escalation even when a prisoner is in a heightened state.
154. The Use of Force Policy Framework sets out that when a registered healthcare professional is on site then they must attend whenever there is a use of force incident as a priority. It goes on to say that the incident manager must ensure that a registered healthcare professional is present and briefed on what force has been used and that they understand they are expected to take an active role in ensuring the medical wellbeing and safety of prisoners whilst they are under restraint.
155. When a nurse reached the segregation unit, officers had already shut Mr Clayton’s door. She did not approach the door as she said she did not want to antagonise him further. She told the investigator that officers told her that Mr Clayton had not been placed in “full restraint” and that he had been guided back to his cell, which was not accurate.
156. Prison staff were unable to tell us whether healthcare staff had been present in the debrief held after the use of force and there is no evidence that healthcare staff were fully briefed on what had happened in the incident. The Governor will want to ensure that prison staff are aware of the importance of adequately briefing healthcare staff following a use of force incident, to ensure that proper aftercare can be provided.

Mr Clayton’s segregation

157. Mr Clayton was segregated on 16 May 2024, after he assaulted another prisoner and set fire to his cell. We consider that the original decision to segregate Mr Clayton was reasonable and appropriate.

158. By the time that Mr Clayton was taken to hospital, he had been in segregation conditions for 110 days. We found that staff continuously reviewed whether it was appropriate to keep Mr Clayton segregated, actively explored other options and persisted in encouraging him to consider pathways out of segregation. Mr Clayton wanted to stay in the segregation unit and generally did not want to pursue other options.
159. Towards the end of August, Mr Clayton was moved to the Residential Support Unit (RSU), despite his application for the unit still pending. An RSU manager told the investigator that prisoners are sometimes kept in segregation conditions on the unit until their applications are processed. While an SO told the investigator that he had explained to Mr Clayton that he would be kept under segregation conditions until the application was approved, it is clear through applications Mr Clayton wrote and comments on his return to the segregation unit that he either did not understand this or was not aware of the potential timeframe.
160. While it was positive to see staff exploring how to move Mr Clayton out of the segregation unit, there was little evidence of this move being properly discussed through segregation review meetings or safety intervention meetings as to how the move would be managed. Evidence suggests that Mr Clayton had not been fully briefed on what would happen on the Residential Support Unit, or at least did not properly understand what he might have been told.
161. We make the following recommendation:
- The Governor should ensure that plans to re-integrate prisoners from the segregation unit are properly recorded and discussed at multi-disciplinary meetings, with evidence that they have been communicated appropriately to the prisoner.**
162. Prison Service Order 1700 sets out guidance and mandatory requirements for managing segregation units. It notes that establishments should have a published policy for the selection of staff who work in the segregation unit, that staff are selected on the basis of their competence to deal with difficult situations and their ability to form constructive, positive relationships with prisoners. It notes that the Governor should personally endorse the selection of each staff member. It goes on to state that staffing levels in segregation units must be adequate to ensure prisoners located within the unit remain supervised during adjudications.
163. We found that staff members are sometimes cross deployed to the segregation unit from other units. Staff also told us that the segregation unit is frequently understaffed, with officers often being cross deployed to other parts of the prison. We were told that on occasions, staffing can drop to only one officer and one SO during the afternoon. While we acknowledge the current staffing challenges across the prison, given the risks associated with prisoners on the segregation unit, it is essential that the segregation unit is well staffed with officers who are adequately trained.
164. PSO 1700 sets out that a designated officer should be allocated to each prisoner in the segregation unit. It goes on to say that the designated officer should engage in purposeful dialogue and record this on the segregation history sheet and there should be at least three quality entries daily.

165. Garth's Segregation Strategy sets out that each segregated prisoner must have a P16 entry made daily (we understand this to be referring to the segregation history sheet) and an entry should be made on a prisoner's record by unit staff to reflect any notable behaviour and engagement in the regime. It sets out that the segregation SO should check 10 per cent of P16 entries every week and the segregation CM should check 10 per cent of entries on a fortnightly basis.
166. We found little evidence of individual and quality one to one contact with Mr Clayton in the segregation unit, in line with national and local expectations. Although an officer was noted to be Mr Clayton's keyworker, they did not record having ever had a quality conversation with him. On most days there was no evidence that anyone had anything other than a basic conversation with Mr Clayton, although officers told us about some conversations they had with Mr Clayton that do not appear to have been recorded. The Head of Segregation, who has been in post since July 2024, told us that, to her knowledge, prisoners on the segregation did not have designated officers. While more meaningful contact would not necessarily have identified Mr Clayton's risk, this was a missed opportunity to identify any underlying issues he might have had and support him with the move to the RSU.
167. There is no evidence of management checks and a segregation SO explained to the investigator that he had not been informed that there should be a 10 per cent check of the P16 entries. The Head of Segregation told us that she was not aware of any quality assurance process for ensuring that segregated prisoners' paperwork was completed properly. She explained that the CM did monthly management checks of the wing diary (which covers the unit as a whole rather than individual prisoners).
168. We make the following recommendation:

The Governor should review the quality of and compliance with policy of segregation procedures, identify any improvements required, and devise a plan to deliver those improvements.

Video calls

169. Mr Clayton had a video call scheduled on 24 August with his ex-partner and his children. This was recorded as "no monitor" which means that the visit did not go ahead. We do not know for certain the reason why but understand that this is sometimes due to staffing issues. Mr Clayton noted that he was escorted to the call room and was then told it was cancelled.
170. After this failed video call, an SO decided, acknowledging that Mr Clayton said that he did not have phone credit, to give him a phone call shortly after he came back to the segregation unit. This was a positive decision that helped Mr Clayton to maintain family ties.
171. On 3 September, Mr Clayton's video call did not go ahead again. We understand that this was either a connection issue or the visitor did not attend. (The system does not record which side connection issues are. Mr Clayton's ex-partner told us that she was available to take the call, but the technology did not work.) On this occasion, staff did not give Mr Clayton a phone call (although Officer C said that he

intended to help Mr Clayton with this shortly before his death) and he did not have any credit to make a call himself from his in-cell phone.

172. There was no reason recorded for either of these calls not going ahead, other than that there was “no monitor” (on 24 August) and it was “missed” (on 3 September).
173. A prisoner we spoke to as part of this investigation told us that there were often issues with video calls at Garth, including frequent connection problems and prisoners being given notice about a video call after it should have taken place.
174. An SO told us that shortly before Mr Clayton’s death, he was supervising the video calls and there were technology issues. The operational manager with responsibility for video calls, told us that since they got a new system in July, there have not been issues with connection. He said that at the monthly prisoner council meeting, prisoners bring issues. He explained that a while ago prisoners had reported technology issues with the video calls but for the last three months they had not reported further issues. He also said that prisoners would send applications or complaints to say when the video calls were not working.
175. We found that there was a lack of evidence of any monitoring of how many video calls are not completed and the reasons for this. Prisons should not solely rely on prisoners to raise these issues and should have their own systems for monitoring and identifying any technology issues and escalating them to the service provider as necessary. We also found that there was a lack of consistency about how to assist the prisoner when a call does not go ahead.
176. We make the following recommendation:

The Governor should investigate the frequency of video calls which are not completed and the reasons for these and ensure that appropriate mitigating action is taken when a call does not go ahead for reasons outside of a prisoner’s control.

Mental health provision

177. The clinical reviewer concluded that the mental health care Mr Clayton received at Garth was partially equivalent to that which he could have expected to receive in the community.
178. Mr Clayton had mental health assessments (both at HMP Full Sutton and Garth) and staff assessed that he did not meet the threshold to be under the care of the mental health team. In line with the stepped care model (a system of delivering and monitoring treatments for common mental health problems), healthcare staff put plans in place for the GP to review his anxiety and depression and rebooked appointments when Mr Clayton did not attend.
179. PSO 1700 sets out that a daily healthcare visit must take place for each prisoner held in segregation to assess the physical, emotional and mental wellbeing of the prisoner and whether there are any clinical reasons to advise against the continuation of segregation. It sets out that a doctor must visit at least every three days and that a registered nurse must make the assessment on all other days.

180. In Mr Clayton's case, there was no evidence of daily healthcare visits. While the GP visits occurred every three days, Mr Clayton was not seen every day by other healthcare staff.
181. As a result of this investigation, the mental health team manager has confirmed that there has been clear management instruction that the segregation rounds are the responsibility of the mental health team and that they are now allocated to do this four days a week (with GP rounds taking place on the other three days). We therefore do not make a recommendation, but the Head of Healthcare will want to ensure that healthcare rounds are being conducted as expected and that that they are properly recorded.

Governor to Note

Informing next of kin

182. On 3 September, the FLO recorded on the FLO log that he attempted to phone Mr Clayton's ex-partner on several occasions and was unable to get through. He also attempted to contact Mr Clayton's mother, father and sister.
183. It was positive that the FLO then contacted HMP Hull and asked them to attend the next of kin's address. However, given Mr Clayton's critical condition, we found that further attempts should have been made to call the next of kin throughout the afternoon and evening to ensure that they could get to the hospital as soon as possible. Instead, Mr Clayton's next of kin were not told that he was critically ill until the next morning.
184. The Governor will want to ensure that in such situations, staff make continued attempts to contact the next of kin and difficulties doing so are escalated to an appropriately senior manager for advice or action.

CCTV

185. There were significant delays in sharing some of the CCTV footage from the 3 September with the investigator. Sharing CCTV footage with the PPO has been an issue in another recent death at Garth. The Governor will want to ensure that there is a clear process in place for retaining and sharing footage with the PPO to assist with investigations.

Inquest

186. The inquest into Mr Calyton's death concluded on 4 August 2026 and recorded a verdict of suicide by hanging, with anxiety and depression as a contributing factor.



Third Floor, 10 South Colonnade
Canary Wharf, London E14 4PU

Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk

T | 020 7633 4100