

# Learning lessons bulletin

## Fatal incident investigations | Issue 21

### Segregation

#### Foreword

This learning lessons bulletin shares learning from Prisons and Probation (PPO) investigations where prisoners have died while segregated. We hope that this bulletin emphasises the importance of following policy when segregating prisoners and the potential risks associated with placing prisoners in segregation.

In 2015, we published a learning lessons bulletin on self-inflicted deaths of prisoners being held in segregation units. In 2026, we continue to see several of the same issues. We still investigate the deaths of prisoners who were placed in segregation despite being managed under suicide and self-harm procedures (ACCT). As the Prison Safety Policy Framework makes clear, this should only be done in exceptional circumstances.

This bulletin also summarises the investigations of some deaths where prisoners have died from natural causes while being segregated, highlighting the importance of checking a prisoner's physical health before deeming them fit for segregation. We continue to investigate cases where policy requirements to segregate a prisoner are not followed. We urge Governors to assure themselves that there are effective quality assurance arrangements in place within their establishment to ensure that the requirements on segregation are being followed correctly.



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# Introduction

Segregation is an isolating form of custody for a prisoner. In segregation units, prisoners will generally spend most of their time alone in a cell, leaving only to shower, make telephone calls and exercise for a short period. Prisoners can be segregated under different prison rules. The authorised reasons for segregating a prisoner are: (1) for reasons of good order or discipline, (2) where it is in their own interest, (3) where a prisoner is awaiting a disciplinary hearing, (4) following a finding of guilt at a disciplinary hearing. Segregation: PSO 1700 (the Segregation Policy) makes clear that “segregation should only be used as a last resort whilst maintaining a balance to ensure it remains an option for disruptive prisoners”. The Segregation Policy requires that an initial segregation health screen is completed by a doctor or nurse within two hours of a decision to segregate, and that regular Segregation Review Boards are held to authorise the continuation of segregation. The Segregation Policy is currently in the process of being updated. There is no published data from HMPPS on the number of prisoners segregated, so it is uncertain how often it is used and whether its use is increasing. However, using PPO data, we found that out of 602 deaths investigated by the PPO between 1 April 2024 and 31 December 2025, 14 individuals were located in the segregation unit, 8 of whom were on an open ACCT at the time. It is concerning how many prisoners were on an open ACCT and were segregated.

## Segregation and mental health

Assessment, Care in Custody and Teamwork (ACCT) is the care planning system used by HMPPS to support prisoners at risk of suicide and self-harm. Being placed in segregation reduces protective factors against suicide and self-harm, such as activity and interaction with others, and is likely to heighten the vulnerability of a prisoner on ACCT.

The Segregation Policy states that: “Segregation should be used only as a last resort ... this does include prisoners on an open ACCT plan, but only when they are such a risk to others that no other suitable location is appropriate and where all other options have been tried or are considered inappropriate”.

The Prison Safety Policy Framework (Safety Framework) makes clear the use of segregation conditions for prisoners receiving support through ACCT is only defensible in “exceptional circumstances” and that the reasons for segregation must be clearly documented. When a prisoner on an ACCT is placed in segregation, the duty governor should complete and sign a defensible decision log. This should reflect the consideration given to a prisoner’s risks, triggers and protective factors.

We continue to investigate the deaths of prisoners on ACCT who were placed in segregation units without exceptional circumstances or detailed consideration of alternative options.

### Case study 1

Ms A was remanded into custody; it was her first time in prison. Ms A had an extensive mental health history, had attempted suicide two days before she entered prison and frequently tied ligatures around her neck. Ms A was sent to the segregation unit after climbing onto the landing railings on her residential unit. Over the next few weeks, staff held regular ACCT and segregation reviews. After 27 days, staff removed her from segregation. Staff noted that Ms A was coping well on the wing and interacting well with staff and prisoners.

The following month, Ms A was involved in an altercation with another prisoner and ran off. When staff found her hiding, they immediately restrained her and moved her to the segregation unit. While walking to the segregation unit, Ms A said, “I hate it in here, please help me”. She was distressed about how long she would have to stay there and whether she would be there over Christmas. Shortly after being segregated, Ms A tied a ligature around her neck on two separate occasions. Staff removed the ligatures but did not hold an ACCT review and Ms A remained on five checks an hour. During an ACCT check, an officer found that Ms A had tied a ligature around her neck and was unconscious. Paramedics arrived and pronounced life extinct. Ms A was 25 years old. At the time of her death, she was awaiting a decision on her suitability for transfer to a secure mental health unit.

We found issues with Ms A’s first period in segregation. When prisoners on an ACCT are held in segregation, a prison manager must complete a daily review summary that includes justification for why a prisoner should remain in segregation. The review summary was only completed on 18 of the 27 days that Ms A was segregated. The summaries that were completed lacked detail and did not clearly set out the exceptional circumstances justifying segregation.

Prison managers did not demonstrate that they had considered the impact that continued segregation may have had on Ms A’s mental health. Indeed, we found that Ms A had been settled and engaged when living in standard residential units, and her mental health and behaviour sharply and clearly declined after she was segregated. Instead of managers considering the impact continued segregation was having on her, they considered her deteriorating behaviour as justification for prolonged segregation.

At the beginning of Ms A’s second period of segregation, the defensible decision log should have shown a clear rationale for the decision to segregate Ms A. The Duty Governor completed the defensible decision log, but it lacked detail and did not record if alternative options and locations had been considered, and if they had, why they had been discounted. We considered that there was insufficient evidence that Ms A needed to be held in a segregation unit and found that Ms A’s behaviour that morning did not meet the threshold for either “last resort” or “exceptional circumstances”. On that basis, we found the decision to segregate her was contrary to national policy.

Ms A’s risk of suicide and self-harm was not reassessed after she tied two ligatures around her neck. The Safety Framework makes clear that if a prisoner self-harms, an immediate case review should be held. We considered that given Ms A’s level of self-harm and distress, and the increased risk of being segregated, staff should have held an immediate case review and considered whether constant supervision was appropriate.

## Case study 2

Mr B was recalled to custody for breaching his licence conditions. He had no contact with family or friends after his recall to prison. Mr B had diagnoses of ADHD, autism and anxiety, as well as a history of suicide attempts and self-harm in prison. Mr B was transferred from the segregation unit to another prison and located on a standard wing. After transferring, Mr B received several negative behaviour entries. He was placed on basic regime (incurring a loss of certain privileges) and on report pending a disciplinary hearing. Within a few days, Mr B was taken to the segregation unit pending his disciplinary hearing. An assistant director authorised his detention. A mental health nurse completed the segregation healthcare assessment and concluded he was fit to be segregated. The nurse did not think Mr B’s mental health would significantly deteriorate in segregation conditions.

The following day, officers went into Mr B's cell and found him suspended from a ligature made of bedding. Body-worn video camera footage showed Mr B crying and in distress stating that he could no longer cope. At Mr B's 72-hour Segregation Review Board, he said he could no longer cope with segregation and felt it was negatively affecting his mental health. The review lasted only three minutes. Five days later, prison staff found Mr B hanging from the end of his bed frame. Nurses, prison staff and paramedics tried to resuscitate him, but he was pronounced dead. Mr B was 30 years old.

Mr B tied ligatures frequently in the days before his death. He told staff consistently that he was struggling to cope in the segregation unit. There were clear indicators that his risk of suicide was high. We considered staff underestimated his risk and focused instead on his challenging and non-complaint behaviour.

An assistant director completed a defensible decision log for Mr B, recording that he had a documented history of aggressive, non-compliant behaviour. She noted that all other options had been considered but concluded the segregation unit was the only appropriate location for Mr B due to his volatile, aggressive and refractory behaviour. The defensible decision log lacked detail, and it was unclear which alternative options and locations had been considered and why they had been discounted. A prison intelligence report suggested Mr B did not feel safe on a standard residential wing and wanted to move to the vulnerable prisoners' unit. There is no evidence this was explored further as, when the intelligence report was analysed, Mr B was already in the segregation unit. The log did not specifically consider the impact of segregation on Mr B's risk of suicide and self-harm.

All prisoners subject to ACCT monitoring while segregated must be referred to the Safety Intervention Meeting (SIM) – a multidisciplinary safety risk management meeting which aims to manage and support prisoners at significant risk of harming themselves or others. Mr B should have been referred to the SIM but was not. This was a missed opportunity to provide multidisciplinary management and support to Mr B.

In another self-inflicted death we investigated in a different prison, the prisoner was segregated while on ACCT and was referred to the SIM. However, we found little evidence that those present had specifically considered the increased risk of being segregated while on an ACCT. There were no recorded action points on what might be done to support him. Following our investigation, the prison ensured that SIMs now have a full discussion on the prisoners referred and support plans are put in place.

We also found there to be lack of individual and quality one-to-one contact with Mr B in the segregation unit. Staff were not fully informed about his needs as someone who was neurodivergent and dismissed his explanations about these. Mr B also had no recorded key worker at the prison. Regular sessions with a consistent key worker may have offered him the support he needed. There was also no evidence that the transferring prison completed a pre-transfer form as required by the Segregation Policy (as Mr B was a prisoner who had spent more than 14 days in segregation).

Segregating prisoners who are being managed under ACCT should only be done in truly exceptional circumstances, as required by HMPPS policy. It is important that all potential alternative options are considered and that this information is recorded. It is also crucial that ACCT procedures are properly followed where a prisoner on ACCT is segregated as they will likely be at higher risk of suicide and self-harm.

## Lessons to be learned

- Prisoners on ACCT must only be segregated in exceptional circumstances, and only after all alternative options have been fully explored. Clear reasoning for the decision should be recorded in the defensible decision log.
- Prisoners on ACCT who are segregated must be referred to the Safety Intervention Meeting and discussed properly, with clear support actions recorded.

## Continued segregation

The reasons for initial and continuing segregation decisions should be regularly monitored so that prisoners do not spend longer in segregation than is necessary or justified. The Segregation Policy highlights that research indicates a person's mental health is very likely to decline when they are kept in segregation.

Given these risks, the Segregation Policy sets out the importance of regular Segregation Review Boards to consider whether to authorise the continuation of segregation. The boards should consider any concerns about how the prisoner is coping with segregation. As the Segregation Policy makes clear: "If the mental health of the prisoner is so at risk as to suggest that they will be totally unable to cope with segregation then they should not be kept in the segregation unit".

## Case study 3

Mr C was sentenced to 23 years in prison for murder. He had a history of anxiety and depression, as well as self-harm and attempted suicide. Following an incident where he assaulted another prisoner, he was charged with a prison disciplinary offence and segregated. A nurse completed an initial segregation health screen. Segregation Review Boards were completed for Mr C in line with the Segregation Policy. During the reviews, Mr C continued to refuse to move to any standard residential wing. Staff discussed different options including referring him to a reintegration wing at another prison. Mr C was moved to the Residential Support Unit (RSU) – a unit for vulnerable prisoners who had not been convicted of sexual offences – where he remained under segregation conditions pending the approval of his application to the unit.

During this time, Mr C wrote asking if anyone could tell him whether his application for the RSU had been approved. When he was let out of his cell, he climbed onto the snooker table and said he would not get down until he was back in the segregation unit. Staff decided to relocate him to the segregation unit. Mr C was taken for a video call with his children which did not go ahead. Mr C was shouting and visibly annoyed by this. An officer who knew Mr C was able to de-escalate the situation. When another officer went to Mr C's cell to check on him, he found Mr C hanging. He died one day later in hospital. Mr C was 29 years old.

By the time Mr C 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 C segregated, actively explored other options and persisted in encouraging him to consider pathways out of segregation. Unfortunately, we continue to investigate other cases where it is not clear from the Segregation Review Board paperwork that the prison has considered all potential pathways out of the segregation unit for the prisoner.

It is clear through the applications Mr C wrote and comments on his return to the segregation unit that he did not understand that he had been moved to the RSU in segregation conditions until his application had been processed. This was explained by a manager of the unit when we investigated the prisoner's death. There was little evidence of Mr C's move being discussed in segregation review meetings. Evidence suggests that Mr C had not been fully briefed on what would happen on the RSU or at least did not properly understand what he might have been told.

Whilst investigating, staff told us the segregation unit was frequently understaffed, and staff were sometimes cross deployed to the unit from elsewhere. Given the risks associated with prisoners on the segregation unit, it is essential that units are well staffed with officers who are properly trained. The Segregation Policy notes the importance of selecting staff who are able to help prisoners in segregation, who are often those that require the most support.

Two scheduled video calls between Mr C and his family did not take place in the two weeks before his death, including one on the day he was found hanging in his cell. On both occasions, Mr C had no phone credit. When the first scheduled call did not take place, staff decided to give him a phone call. This did not happen on the day Mr C took his life.

This meant he was unable to speak to his family at a moment of crisis. It is disappointing that we continue to investigate the deaths of prisoners who, due to having no phone credit, are unable to contact their family in moments of distress. Staff should support prisoners in segregation to maintain family contact and seek out alternative means of communication if visits or video calls are not possible.

### Lessons to be learned

- Staff should consider and record details of all potential pathways out of segregation during Segregation Review Boards. Plans to re-integrate prisoners from the segregation unit should be recorded and discussed at multi-disciplinary meetings and communicated appropriately to the prisoner.

## Segregation procedures

In many of the cases we investigate, there are failures to follow the procedures in the Segregation Policy. Concerningly, in some cases, staff are unaware of the requirements. In Ms A's case the daily summaries were only completed on 18 of the 27 days that she was held in segregation. The summaries that were completed lacked detail. We also found that the form OT026 (reason for initial segregation), which should have been shared with Ms A, was not completed. This meant she did not know the reasons why or for how long she would be segregated. In Mr B's case, he was not referred to the SIM in line with procedure. When we investigated Mr D's case below, we once again found failures to meet the requirements of the Segregation Policy.

## Case study 4

Mr D was remanded in custody for a range of offences. He had complex needs and behaviours, a range of mental health issues and a long history of suicide attempts and self-harm. As he approached his 21st birthday, he was referred to the Close Supervision Centre (CSC) at an adult prison. He transferred prisons and was accommodated in the segregation unit while awaiting the outcome of his CSC application. A nurse completed the initial segregation health screen. Mr D's first segregation review was chaired by the segregation unit manager who gave authority for his continued segregation. During a subsequent segregation review, the board shared concerns about Mr D returning to a standard residential wing. They noted his vulnerability due to his age and the risks associated with him mixing with other older prisoners. A trainee forensic psychologist recorded that she felt Mr D displayed some traits of autism. She completed a referral for Mr D to be accommodated on a smaller unit for those who have autism. This unit was full. However, another referral was made for a specialist unit at another prison for men who had spent 30 days or more in segregated conditions. Seven days later, during a routine check an officer found Mr D hanging from his cell window. Paramedics pronounced life extinct. Mr D was 21 years old.

Our investigation found issues with the mental health care Mr D received when he transferred prisons. Despite receiving a handover of Mr D's medical information, the mental health team at the receiving prison did not undertake an assessment to identify his individual needs and how they could be met. This should have been a priority for a young person who was transitioning into segregation in a Category A adult prison and who presented significant and documented needs and risks.

A nurse completed the initial segregation health screen when Mr D first arrived at the prison. She did not access his medical records and did not review available and relevant risk information. She incorrectly noted that he had no current self-harm or ACCT history. His most recent ACCT was only closed eight days before this, and Mr D was in ACCT post-closure. The daily segregation healthcare review meetings were held at the cell door, with prison staff in attendance, rather than in a confidential setting. When we reviewed the daily segregation history sheets, there were numerous blank entries by healthcare staff. Overall, they attended fewer than 50% of the daily segregation reviews for Mr D.

The Segregation Policy states that a GP must visit each prisoner in segregation as often as their individual health needs dictate and at least every three days. A registered nurse or healthcare officer must make the assessment on all other days, so that a member of healthcare staff visits the prisoner on a daily basis. Healthcare staff must assess the physical, emotional and mental wellbeing of the prisoner and whether there are any clinical reasons to advise against the continuation of segregation. There was no evidence that healthcare staff saw Mr D in the days leading up to his death. We also found that segregation visits by the GP were not undertaken in accordance with the policy. We did find the decision to keep Mr D segregated, given the information that was known at the time of the review boards and their concerns about his potential exploitation by other prisoners, reasonable.

## Lessons to be learned

- Governors and healthcare providers should ensure that there are effective quality assurance arrangements in place, so they are satisfied that the requirements under the Segregation Policy are being met.

## Segregation and physical health

Many of our investigations consider the negative impact segregation had on a prisoner's mental health but we also investigate deaths which highlight the importance of properly considering a prisoner's physical health when deciding whether to segregate them.

### Case study 5

Mr E was 79. He had spinal damage which reduced his mobility and affected other aspects of his life. Mr E's wing buddy (a prisoner who helped him with daily living tasks) tested positive for COVID-19 and Mr E was placed in isolation. Mr E also later tested positive for COVID-19. An officer raised concerns about Mr E's wellbeing, and a nurse assessed Mr E. The nurse recorded that Mr E was struggling to breathe and had a headache. He could not take Mr E's temperature as there was no thermometer available. The nurse booked a follow-up appointment, but this was not actioned. Two days later, an officer noticed faeces smeared around Mr E's cell. Staff treated this as a "dirty protest" and the next morning, they moved Mr E to the segregation unit. A nurse assessed that Mr E would be able to cope with a period of segregation.

A nursing associate was surprised to learn that Mr E had been taken to the segregation unit and went to see him later that afternoon. She found him cold, dehydrated, confused, unable to communicate and wearing only a t-shirt covered in faeces. After further clinical assessments, Mr E was moved to another unit for observation. That evening, Mr E was short of breath, shaking and confused. His clinical observations showed that he was very unwell, and the nurse called an ambulance. Mr E died in hospital from COVID-19 pneumonia six days later.

Our investigation found multiple concerning failings, including the fact that all of Mr E's regular personal care from healthcare staff stopped when Mr E was placed in precautionary isolation. Concerningly, staff failed to make efforts to ascertain the reasons for the alleged dirty protest and consider whether there may have instead been health reasons which caused it.

A nurse refused to complete the initial segregation health screen because she had not yet been trained to do so. A different nurse completed the form, without seeing Mr E. The nurse who completed the initial segregation health screen was an experienced mental health nurse. We found it difficult to understand how Mr E was assessed as fit to cope with segregation. The failure to conduct the health screen in person was a missed opportunity to identify physical health risks and to distinguish between incontinence and a dirty protest. We have investigated a case more recently where a nurse failed to assess the prisoner in person to complete the initial segregation health screen. This is not in line with the Segregation Policy. It is crucial to see the prisoner in person to assess whether it is clinically appropriate for them to be segregated.

### Case study 6

Mr F had epilepsy, sickle cell anaemia, and a diagnosed delusional disorder for which he was prescribed antipsychotic medication. After an incident where Mr F resisted officers who were guiding him to his cell, three officers used force to restrain him and began escorting him to the segregation unit. On the way, Mr F collapsed to his knees and refused to stand. Staff lifted him using an incorrect carry technique. He complained that he could not breathe, so they placed him in a seated position before continuing the escort using the correct method. The accompanying nurse did not witness his collapse.

On arrival to segregation, Mr F was deemed noncompliant with the regulation full body search and was carried naked, covered only by a blanket, into a cell. The nurse did not complete the initial segregation health assessment, but segregation staff believed she intended to return later to do it. The supervising officer later observed faeces in the cell and noted that Mr F, still naked, was unresponsive. The nurse confirmed she would not be completing the initial segregation health screen. A mental health nurse assessed him, found him mentally unwell and unfit for segregation, and arranged for a transfer to the inpatient unit. He was moved there later that evening. He appeared frail, unable to support his own weight, and told staff he could not breathe, requesting a doctor. Shortly after, staff believed he was asleep, but night staff became concerned he was not breathing. He died later that night. Mr F was 40 years old.

We found multiple issues during our investigation, including that the initial use of force was not justified, the nurse who attended the incident failed to monitor and assess Mr F during his removal to the segregation unit and that Mr F's request to see a doctor in the inpatient unit was not properly explored or followed up.

The nurse's failure to complete the initial segregation health screen and to make it clear she did not intend to return and the supervising officer's failure to escalate the situation when the two hour window elapsed, meant that it was some three and a half hours before the duty mental health nurse advised that Mr F was unfit for a period of segregation. After our investigation, the prison introduced a reception checklist and a supervising officer checklist which ensures the completion of the initial segregation health screen within the two-hour limit.

We also found that the initial segregation health screen predominantly relates to a prisoner's mental health. We find this omission illogical given that prisoners subject to use of restraint techniques (which are likely to cause physical injury) are more likely than others to be taken to the segregation unit (as happened in this case). The screen does not require staff to review the clinical record, record physical observations, or use recognised physical health assessment tools such as NEWS2 (which helps detect deterioration in a patient). We recommended to HMPPS that the guidance on completing the initial segregation health screen is amended to address this. HMPPS have accepted this recommendation and will be amending the initial segregation health screen to address this when the revised Segregation Policy is published.

These cases illustrate the importance of considering a prisoner's physical health conditions as well as their mental health when deciding whether they are safe to be segregated. Staff should ensure that the initial segregation health screens are completed within two hours to avoid prisoners being inappropriately segregated.

### **Lessons to be learned**

- The Initial Segregation Health Screen should be completed within two hours.
- A prisoner's physical health is also important when considering whether it is safe to segregate a prisoner.

## Summary of lessons to be learned

- Prisoners on ACCT must only be segregated in exceptional circumstances, and only after all alternative options have been fully explored. Clear reasoning for the decision should be recorded in the defensible decision log.
- Prisoners on ACCT who are segregated must be referred to the Safety Intervention Meeting and discussed properly, with clear support actions recorded.
- Staff should consider and record details of all potential pathways out of segregation during Segregation Review Boards. Plans to re-integrate prisoners from the segregation unit should be recorded and discussed at multi-disciplinary meetings and communicated appropriately to the prisoner.
- Governors and healthcare providers should ensure that there are effective quality assurance arrangements in place, so they are satisfied that the requirements under the Segregation Policy are being met.
- The Initial Segregation Health Screen should be completed within two hours.
- A prisoner's physical health is also important when considering whether it is safe to segregate a prisoner.



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