

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Thomas Ruggiero, a prisoner at HMP Swaleside, on 16 November 2024

A report by the Prisons and Probation Ombudsman

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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 Thomas Ruggiero died on 16 November 2024, after he was found hanging in his cell at HMP Swaleside. He was 39 years old. I offer my condolences to Mr Ruggiero's family and friends.

Mr Ruggiero was a vulnerable man who struggled with mental illness and often used illicit drugs. Prison staff, substance misuse practitioners and mental health staff took action to support him. Mr Ruggiero spent several periods in the prison's inpatient wing. He struggled to maintain stability when he returned to a general wing, often self-harmed, and this led to cycles of readmission. There was not always continuity of care and there was a lack of professional curiosity about what drove his self-harm.

The clinical reviewer concluded that the care Mr Ruggiero received was not equivalent to that which he could have expected to receive in the community.

Mr Ruggiero's death was the ninth self-inflicted death in three years at Swaleside. Investigations into five of those deaths identified deficiencies in the way the prison managed suicide and self-harm prevention procedures, known as ACCT. I am disappointed that some aspects of ACCT management remain problematic. The Executive Director of the Long Term and High Security Estate and the Governor of Swaleside will want to ensure effective action is taken to reduce the likelihood of further self-inflicted deaths at Swaleside.

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

March 2026

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Summary

Events

1. On 16 July 2020, Mr Thomas Ruggiero was remanded into custody at HMP Wandsworth, charged with assault. He had been in prison before. In September, Mr Ruggiero was sentenced to an extended determinate sentence of eight years imprisonment, with an extended licence period of 18 months.
2. Mr Ruggiero had drug-induced psychosis, attention deficit hyperactivity disorder and emotionally unstable personality disorder. He had a history of chronic alcohol and drug misuse in the community and prison. He had a history of self-harm in prison. In September 2024, he said that he heard voices telling him to cut himself and that he had strangled himself to “cut off circulation around his neck and bring himself into a medicated depression” but not to end his life. Mr Ruggiero did not always comply with his medication.
3. Mr Ruggiero frequently used psychoactive substances (PS, also known as spice) in prison. This led to a deterioration in his mental health, compounded by him not taking his prescribed medications. He was admitted to the prison’s inpatient department (IPD) six times due to his deteriorating mental health. During admissions, Mr Ruggiero started taking his medication, avoided illicit drug use and stabilised. Mr Ruggiero also spent two periods in segregation after he set fire to his cell and assaulted another prisoner. He said he used periods in the IPD and segregation unit to detox from drugs.
4. On the occasions Mr Ruggiero returned to a standard wing, he said he found it hard not to use drugs. This led to a deterioration in his mental health and an increase in self-harm which inevitably resulted in him being readmitted to the IPD. Mr Ruggiero experienced this cycle many times.
5. Mr Ruggiero was monitored under suicide and self-harm prevention procedures (known as ACCT) thirteen times due to self-harm and telling staff he would kill himself. He was supported by ACCT procedures in October 2024 after he made cuts to his arms and legs. On 8 November, Mr Ruggiero was placed under constant supervision after he cut his genitals and said he was going to kill himself. He was moved to the IPD.
6. On 14 November, Mr Ruggiero was discharged and returned to B Wing. Constant supervision stopped and staff were required to check him once an hour. On his return, staff thought Mr Ruggiero looked and presented well.
7. On the morning of 16 November, Mr Ruggiero damaged items in his cell and told staff his demons had returned. He demanded to be taken back to the IPD. At 9.50am, staff found Mr Ruggiero hanging in his cell after prisoners and officers alerted them. Nurses, prison staff and paramedics resuscitated him, but Mr Ruggiero suffered a cardiac arrest as paramedics moved him to the air ambulance and paramedics pronounced life extinct at 1.43pm in the grounds of the prison.

Findings

8. Mr Ruggiero was a vulnerable man with complex needs. Prison staff took positive actions to support him during crisis periods. They supported him under suicide and self-harm prevention procedures (known as ACCT) which included periods under constant supervision. Wing staff liaised well with healthcare staff to ensure Mr Ruggiero received support through admission to the IPD.
9. ACCT measures were started promptly on 27 October and initial assessments were timely. ACCT reviews took place regularly. Records indicate these were not always multidisciplinary but healthcare staff had been consulted. Poor record keeping undermined written reviews. Mr Ruggiero's care plan was blank and did not reflect changes to his risk, protective factors and actions taken to support him. There was evidence of staff putting support in place but this was not recorded. Staff did not always see the value in completing care plans. Constant supervision was reasonably stopped on 14 November. However, the frequency of checks was reduced too quickly to one per hour which did not reflect Mr Ruggiero's risk. There was inadequate exploration about why Mr Ruggiero harmed himself.
10. The clinical reviewer found that Mr Ruggiero moved from service to service in a reactive manner and there was a lack of professional curiosity about the correlation between his trauma and mental state. Admissions to the IPD or being held in the segregation unit enabled Mr Ruggiero to stop using drugs, take his medication and stabilise his mental health. However, he quickly relapsed into illicit drug use on discharge, and this led to frequent crisis periods and repetitive cycle of readmission to the IPD.
11. Prison staff radioed an incorrect emergency code when they found Mr Ruggiero hanging in his cell. The control room log was unclear about when an ambulance was called and it is not possible to say if there was a delay.

Recommendations

The Executive Director for the Long Term and High Security Estate and the Governor should formulate a robust plan, with sufficient oversight and auditable measures to ensure that prison staff manage prisoners at risk of suicide and self-harm in line with the Prison Safety Policy Framework, and in particular, they should:

- **hold and accurately record multidisciplinary reviews, with healthcare staff and other relevant staff providing detailed input if they are unable to attend;**
- **set a frequency of observations appropriate to the level of risk; and**
- **ensure care plans are fully completed, person-centred and responsive to risk.**

The Head of Healthcare should ensure that:

- **healthcare staff are involved in all ACCT reviews while a prisoner is in the IPD; and**

- **an audit of treatment plans is undertaken to ensure that they are clearly documented in the clinical records and reviewed.**

The Investigation Process

12. HMPPS notified us of Mr Ruggiero's death on 16 November 2024.
13. The investigator issued notices to staff and prisoners at HMP Swaleside informing them of the investigation and asking anyone with relevant information to contact her. One prisoner responded and he was interviewed in January 2025.
14. The investigator visited HMP Swaleside on 20 November 2024. She obtained copies of relevant extracts from Mr Ruggiero's prison and medical records. She watched body-worn camera footage and CCTV footage from 16 November 2024 and obtained information from the South East Coast Ambulance Service.
15. The investigator interviewed four members of staff at Swaleside on 8 January 2025. She interviewed six members of staff remotely by Microsoft Teams in December 2024 and January 2025.
16. NHS England commissioned a clinical reviewer to review Mr Ruggiero's clinical care at the prison. The clinical reviewer and the investigator jointly interviewed healthcare staff.
17. We informed HM Coroner for Kent and Medway of the investigation. The Coroner gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.
18. The Ombudsman's office contacted Mr Ruggiero's mother and sister to explain the investigation and to ask if they had any matters they wanted us to consider.
19. Mr Ruggiero's mother wanted us to know that she thought her son's mental health was poor. She believed he was refused vital medication for a long time and when it was prescribed, he was unable to take it responsibly. Mr Ruggiero's mother asked some questions which we have addressed in separate correspondence. She also asked the following questions which we have addressed in this report:
 - Why did nobody intervene to help Mr Ruggiero on the morning of 16 November?
 - Where was Mr Ruggiero located? Mr Ruggiero's mother said she was concerned he was moved to a general wing from a wing for vulnerable prisoners.
20. Mr Ruggiero's sister said that she shared her mother's concerns. She had one question which we have addressed in separate correspondence and the following questions which we have addressed in this report:
 - What mental health support did Mr Ruggiero receive?
 - For how long was Mr Ruggiero left in his cell before he was found hanging?
 - Why did Mr Ruggiero kill himself?
 - Did Mr Ruggiero have access to and/or did he access illicit drugs in prison?

Mr Ruggiero did not leave a note in his cell. It is very difficult to establish with certainty a person's reasons for ending their life.

21. We shared the initial report with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies and their action plan is an additional annex to this report.
22. Mr Ruggiero's mother and sister received a copy of the draft report. The solicitor representing them wrote to us pointing out some factual inaccuracies. The report has been amended accordingly. They also raised a number of questions that do not impact on the factual accuracy of this report. We have provided clarification by way of separate correspondence to the solicitor.

Background Information

HMP Swaleside

23. HMP Swaleside, on the Isle of Sheppey, is part of the long-term high security estate, predominantly holding prisoners judged to be high risk and those serving long As. Oxleas NHS Foundation Trust provides physical and mental healthcare services, including 24-hour nursing cover. Change, Grow, Live (CGL) provides substance misuse services.

HM Inspectorate of Prisons

24. The most recent inspection of Swaleside was in September 2023. Inspectors reported that safety remained a concern. They noted that Swaleside had made real efforts to improve despite the challenges faced by the restricted regime caused by the difficulties recruiting staff.
25. An independent review of progress was carried out in August 2024. In the subsequent report, inspectors noted that the recorded rate of self-harm and the number of individuals involved had increased over the previous 11 months. There was compelling evidence that staff did not always complete the required checks on prisoners at risk of suicide and self-harm and inspectors were not confident that records they had examined were accurate. Some of the care plans in the ACCT documentation were months out of date and did not reflect the prisoners' current needs. None of the plans focused on getting prisoners into activity and sometimes the support was repeatedly stopped and restarted without addressing the underlying issues.
26. Illicit drugs were even more readily available than they had been during the previous full inspection. Inspectors also noted that there had been a substantial change in the way drugs and other illicit items were being supplied and sophisticated drones were used to deliver packages. This undermined safety and stability in the prison and the use of drugs underpinned the lack of progress in many of the concerns set out in their report.
27. Inspectors reported that they were impressed that the acute shortage of officers, which they noted in their last report, had been addressed through proactive recruitment. However, at the time of the follow-up inspection, just over half the officer group had less than a year in service. This level of inexperience inevitably led to a continuing lack of confidence and assertiveness in the management of prisoners.

Independent Monitoring Board

28. 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 30 April 2024, the IMB reported that they remained concerned about the mental health of prisoners who had suffered long-term lockdown due to the restricted regime. This was evidenced by the number of opened ACCT documents, self-harm cases and violent incidents. The IMB said that the first indications from the recent improvement in regime were

positive. However, the need for increased psychology and psychiatric services still needed to be assessed.

Previous deaths at HMP Swaleside

29. Mr Ruggiero was the twenty-second prisoner to die at Swaleside since November 2021. Of the previous deaths, eight were self-inflicted, 10 were due to natural causes, two were drug-related and one was unascertained. Our investigations into five of the previous self-inflicted deaths found deficiencies in the way the prison managed suicide and self-harm procedures (ACCT). Since Mr Ruggiero's death up until May 2025, two prisoners have died, one from natural causes and the other from an unknown cause. Both deaths remain under investigation.

Assessment, Care in Custody and Teamwork

30. Assessment, Care in Custody and Teamwork (ACCT) is the Prison Service case management approach 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. Checks should be made at irregular intervals to prevent the prisoner anticipating when they will occur. As part of the process, a support plan, also known as an action plan, should be put in place. The ACCT plan should not be closed until all the actions of the risk reduction plan 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. The Prison Safety Policy Framework sets out how staff should operate ACCT procedures.

Psychoactive substances

31. Psychoactive substances (PS) is a broad term that refers to a drug or other substance that affects mental process. Synthetic cannabinoids and synthetic opioids (including nitazenes) are substances that mimic the effects of traditional controlled drugs such as cannabis, cocaine, heroin and amphetamines. Synthetic cannabinoids and synthetic opioids can be difficult to detect as the compounds used in their manufacture can vary and use of these substances presents a serious problem across the prison estate.
32. PS can affect people in a number of ways, including increasing heart rate, raising blood pressure, reducing blood supply to the heart and vomiting. Prisoners under the influence of these substances can present with marked levels of disinhibition, heightened energy levels, a high tolerance of pain and a potential for violence. Besides emerging evidence of such dangers to physical health, the use of PS is associated with the deterioration of mental health, suicide and self-harm. Testing for PS is in place in prisons as part of existing mandatory drug testing arrangements.

Key Events

Background

33. On 16 July 2020, Mr Thomas Ruggiero was remanded into custody at HMP Wandsworth, charged with assault. He had been in prison before. On 14 September, Mr Ruggiero was sentenced to an extended determinate sentence of eight years imprisonment, with an 18-month extended licence period. In November 2020, June 2021 and February 2022, Mr Ruggiero was sentenced to further periods of imprisonment for assaulting prison officers.
34. Mr Ruggiero had drug-induced psychosis, attention deficit hyperactivity disorder and emotionally unstable personality disorder. He had a history of chronic alcohol and drug misuse and a history of self-harm.
35. Mr Ruggiero spent time at various prisons and had periods where he was monitored under suicide and self-harm prevention procedures, known as ACCT. Mr Ruggiero's mental health was unstable, and he did not always take his prescribed medications (antipsychotic and mood stabiliser). This was compounded by his use of illicit substances, typically PS. He spent two periods in the inpatient healthcare unit at HMP High Down in 2021.

HMP Swaleside

36. On 21 November 2022, Mr Ruggiero was transferred to HMP Swaleside and was referred to the mental health team when he arrived. Nurse F, a mental health nurse, noted Mr Ruggiero had a history of making but not using ligatures. Mr Ruggiero was discussed at the mental health team meeting, where they concluded he would not be taken onto their caseload because his mental health needs could be met by the primary care team. Actions were set to refer him to the substance misuse team and psychology.
37. Between January and July 2023, Mr Ruggiero spent two periods in the inpatient department (IPD) as he was not complying with his medication, his mental health was deteriorating and he was cutting his eyes and penis. Referrals were again made to the mental health team and he was kept under constant supervision on an ACCT. On discharge from the IPD, Mr Ruggiero returned to a standard wing and was soon found under the influence of PS.
38. Mr Ruggiero asked for support from the substance misuse service and was discussed at the team's complex case meeting. Ms A saw him in February 2023 and gave him harm reduction advice. Mr Ruggiero said he no longer wanted to engage with the service. Following this, Mr Ruggiero and prison staff made further substance misuse referrals for him. Ms A saw Mr Ruggiero and tried to assess him five times. Due to his mental state and not engaging, he was discharged from the service.
39. In August, Mr Ruggiero set fire to his cell and spent two weeks in the segregation unit (where prisoners are kept separate from the general population) before returning to a general wing in September. Mr A from the Swaleside Outreach Service (SOS) assessed Mr Ruggiero (SOS is a Swaleside initiative bringing together prison officers, mental health social workers and psychologists who work

with prisoners whose behaviour is challenging, violent or disruptive). Mr Ruggiero attended SOS hub and was accepted onto the psychologically-informed planned environment (known as the PIPE Unit) at Swaleside. This move did not happen due to Mr Ruggiero's deteriorating mental health and his further admission to the IPD.

40. Mr Ruggiero continued to be supported by SOS and ACCT monitoring in early 2024, including under constant supervision in the IPD in March after he cut his penis. In May, Mr Ruggiero met Mr B, a SOS worker, to complete an application to the Pre-PIPE Unit at HMP Long Lartin. Mr Ruggiero said he felt more settled.
41. Mr Ruggiero continued to be supported by ACCT due to cutting his penis which required hospital treatment. He told staff he had been using PS. He returned to B Wing on 23 March and said he was fine.
42. In June, Mr Ruggiero damaged items in his cell several times and told staff he was going to kill himself. His ACCT observations were increased to constant supervision. Following his return to B Wing, SOS continued to see Mr Ruggiero regularly.
43. In July, Ms A from the substance misuse service assessed Mr Ruggiero (the medical records do not document a new referral). He told her he did not want to engage and asked her to come back the next day. When Ms A returned, Mr Ruggiero told her he did not need or want to engage with the service but would contact them in six months' time.
44. In August, Mr Ruggiero returned to the IPD for two weeks due to a decline in his mental health and use of PS.
45. On 1 September, he cut his penis and told staff he would continue to do so unless he was moved back to a general wing. The following day, he went into another prisoner's cell and began destroying his property. He had opened cuts on his hand and penis and splashed blood around the cell. Officer A recorded that Mr Ruggiero had smashed items in his cell, destroying the cupboard, table and half his bed. He noted Mr Ruggiero was making mixed demands of wanting to return to the wing but, at other times, asking to be under constant supervision.
46. On 4 September Mr Ruggiero was discussed at the IPD ward round and his medication was reviewed. The team reflected that he continued to self-harm by cutting his penis and had destroyed two cells. Mr Ruggiero continued to be supported by ACCT procedures and SOS. After a period of settled behaviour, he was discharged from the IPD and returned to B Wing on 12 September.
47. At around 9.00pm on 15 September, Officer B asked Supervising Officer (SO) A to see Mr Ruggiero as he was hiding under his bed and was not responding during ACCT checks. When SO A unlocked Mr Ruggiero's cell, Mr Ruggiero ran towards him, threatening violence. SO A locked the door and spoke to Mr Ruggiero through it. Mr Ruggiero told him he was not in crisis and liked sleeping under the bed so they "could not use the remote control on him". SO A referred him back to the mental health team.
48. On 16 September, Mr Ruggiero attended his ACCT review with SO B and Nurse A, a mental health nurse. Mr Ruggiero told them he had been smoking PS since his

discharge from the IPD and felt “in a manic phase”. He said he had been tying ligatures to get a “drop kick”. He said they were not suicide attempts but he got a “drop” when he cut off circulation around his neck and was bringing himself down into a “medicated depression”. Nurse A spoke to him about the risks of this, including that he could kill himself without intending to. She assessed he lacked insight into the risks. The review concluded that Mr Ruggiero should return to constant supervision.

49. Nurse A and SO B spoke to Dr A, a psychiatrist, who then saw Mr Ruggiero. Mr Ruggiero told him he had smoked a mint vape and felt like he wanted to get “relief from the throat so is using the noose”. Dr A advised Mr Ruggiero needed to be moved back to the IPD under constant supervision.
50. On 20 September, Mr Ruggiero returned to B Wing. Constant supervision stopped and he was placed on hourly checks. On 27 September, SO C chaired an ACCT review with Nurse A. Mr Ruggiero said his psychotic symptoms had gone and he felt much better. He denied thoughts of suicide and self-harm. However, Nurse A noted he presented “an ongoing chronic risk” of suicide and self-harm in the context of his history and mental health symptoms. She identified PS use as a trigger for deterioration in his mental health. The review concluded the ACCT could be closed.
51. The following morning, Mr C from SOS spoke to Mr Ruggiero on B Wing. Mr Ruggiero told him he was doing well, keeping himself busy, helping on the wing and cleaning the exercise yard. Mr C noted he appeared happy and engaged. Mr Ruggiero said he did not need anything from SOS. Mr C reminded him he could send a message to SOS if he needed support and he remained on their caseload.
52. In October, SOS saw Mr Ruggiero weekly. On 2 October, Mr Ruggiero told Mr D from SOS that he was still on track and felt good. He said he did not need anything from the team but would reach out if anything changed. On 10 October, Mr Ruggiero spoke to Mr C and said he was fine and waiting for his assessment with Long Lartin for the Pre-PIPE Unit.
53. On 17 October, Mr B from SOS spoke to Mr Ruggiero through his cell door. Mr Ruggiero told him he was staying in his cell as he was fed up with other prisoners and wanted to move to another wing. He did not give any detail and said he wanted to be settled as he wanted to move to the unit at Long Lartin.
54. During the first half of October, Mr Ruggiero maintained regular telephone contact with his mother. He talked positively about a possible move to the Pre-PIPE Unit at Long Latin and that she could visit him there as it would be closer to home. He said he did not think he would be granted parole at his next review. His mother encouraged him to continue working towards it.
55. At 7.11am on 21 October, Officer C recorded that Mr Ruggiero had been wailing and shouting out of his window. Mr Ruggiero asked Officer C to contact the mental health team for him, which Officer C subsequently did by email.
56. At 10.30am, Nurse A spoke to Mr Ruggiero on B Wing. She noted he was chaotic and manic, jumping from topic to topic. She noted she was informed he had been taking PS (It is unclear whether Mr Ruggiero told her this). Mr Ruggiero asked to see Dr A as he felt manic and wanted his medication reviewed. Mr Ruggiero denied

any thoughts of suicide or self-harm. However, Nurse A assessed he posed an ongoing chronic risk of suicide and self-harm given his history and mental health. She noted a plan for a potential psychiatric review, he would remain on her caseload, he should alert staff if he was worried about his safety and staff should consider opening an ACCT (including considering constant supervision) if his risk increased.

57. At 11.14am on 25 October, Mr D from SOS spoke to Mr Ruggiero who told him he needed to move to C Wing. Mr D thought this was because other prisoners had been challenging him about his behaviour as he had kept them up over the past few nights, banging in his cell. He told Mr Ruggiero he would look into this.
58. At around 5.20am on 27 October, Officer Support Grade (OSG) A recorded in Mr Ruggiero's electronic prison record that between 4.50am and 5.25am, Mr Ruggiero pressed his emergency cell bell multiple times, asking to be moved to a "safe plastic cell". He said he was hearing voices telling him to do things he did not want to do. Officer A told him he would speak to the duty nurse and recorded he had contacted a nurse by radio.
59. At around 6.04am, staff radioed a medical emergency code red after Mr Ruggiero made cuts to his arm. He told staff demons made him do it, he would continue to do it and needed constant supervision. Nurse B attended and treated Mr Ruggiero's wounds, but Mr Ruggiero would not let him assess him. The nurse noted that Mr Ruggiero looked dishevelled, and his cell was covered in blood. Nurse B recommended that staff should open an ACCT, with a minimum of three checks an hour. He sent an urgent request for the mental health team to see Mr Ruggiero and for the doctor to review his medication.
60. Officer D began ACCT procedures and recorded that Mr Ruggiero seemed erratic and, at points, appeared to think someone else was standing next to him, talking to them.
61. Custodial Manager (CM) A completed an immediate action plan for Mr Ruggiero at around 6.30am. He recorded that Mr Ruggiero was to remain in his own cell and that staff should check him three times per hour as he was threatening to continue harming himself. He noted that Mr Ruggiero told him he had not been taking his antipsychotic medication.
62. Mr Ruggiero's medical records refer to a further emergency code blue (which indicates a prisoner is unconscious or having difficulty breathing) at 7.11am. This is not documented anywhere else and no details are known about it.
63. At around 9.35am, an officer checked on Mr Ruggiero in line with his ACCT observations. They saw he had made cuts to his arm and legs and radioed an emergency code red (indicating blood loss). Mr E, a paramedic working at Swaleside, attended. When he arrived, he noticed drying blood on the cell floor. Mr Ruggiero said his mind was telling him to do things to harm himself and he was trying to mitigate this by making small injuries to himself. He said he was being bullied on the wing and he felt the IPD would help. Mr E spoke to SO B. They agreed that as this was the third code red incident in four hours for Mr Ruggiero and he was repeatedly making statements about harming himself further, he needed to be placed under constant supervision.

64. At around 11.10am, Mr Ruggiero was moved to the IPD but he was not placed under constant supervision and the frequency of ACCT checks remained unchanged. Nurse C recorded in Mr Ruggiero's medical records that he was aggressive, restless and agitated. Mr Ruggiero told her he was going to set fire to his cell and was under attack by different people. He did not allow staff to assess him and walked away, saying he was too busy. He denied thoughts of suicide or self-harm.
65. At around 3.00pm, Ms B from the safer custody team began Mr Ruggiero's ACCT assessment and recorded information she had obtained from other departments about him. Healthcare staff advised her that Mr Ruggiero was taking his medication as prescribed, but wing staff said Mr Ruggiero had been behaving erratically.
66. At around 3.40pm, Ms B completed Mr Ruggiero's ACCT assessment. She recorded she was unable to speak to him for long as he wanted to be left alone. Mr Ruggiero told her he had a demon attached to him who told him to hurt himself and when he did so, the demon stopped talking for a bit. He said he did not want to die but it was inevitable he would one day. Ms B documented that she was unable to complete the sections in the ACCT document on sources of support because of Mr Ruggiero's mental capacity. She reflected he was to remain in the IPD. No care plan actions were identified.
67. At around 10.00am the following day, SO B, the ACCT case manager, tried to speak to Mr Ruggiero for his first review. Mr Ruggiero refused to engage. SO B spoke to healthcare staff who said that Mr Ruggiero had been up all night shouting and was clearly still unwell. The SO set a review date of 30 October to allow Mr Ruggiero a few days to settle and be more able to engage. SO B reduced Mr Ruggiero's observation levels to two per hour but did not update the care plan.
68. At 4.43pm, Mr F from SOS asked Mr Ruggiero if he wanted to attend a yoga session in the day centre. Mr Ruggiero said he did not want to as he was not in the right head space. He asked about his assessment for the Pre-PIPE Unit at Long Lartin as it was playing on his mind.
69. At 8.30am on 30 October, Mr Ruggiero made superficial cuts to his wrist. He told healthcare staff that the voices were "becoming external and more demonic".
70. At 10.44am on 2 November, Mr Ruggiero phoned his mother. He told her he was in the IPD and was looking forward to his pre-PIPE assessment. Mr Ruggiero said he was getting good support from SOS and that felt like "a light at the end of a tunnel". He told her he intended to accept his antipsychotic medication by depot injection as he was not very good at taking tablets (there is no evidence in Mr Ruggiero's medical record that staff had discussed the option of receiving his medication by injection). Mr Ruggiero told his mother he was looking forward to Christmas and was feeling quite optimistic.
71. At around 3.00am on 4 November, Nurse D observed that Mr Ruggiero had woken up and was throwing things around his cell.
72. At 1.11pm on 5 November, Mr B from SOS spoke to Mr Ruggiero in the IPD. Mr B observed Mr Ruggiero's cell was clean and tidy and his mood seemed positive. Mr Ruggiero talked about his assessment for the Pre-PIPE Unit at Long Lartin and

asked for advice about what questions he may be asked. Mr B told him he would book a session for him to attend the day centre so they could discuss it. Mr Ruggiero thanked him.

73. At 4.24pm on 6 November, Dr A recorded he had seen Mr Ruggiero during his ward round and he had seemed calm. He assessed that Mr Ruggiero could be discharged from the IPD as he was no longer acutely depressed, psychotic or suicidal. He asked the mental health team to provide follow-up support.
74. At 5.18am the following morning, Nurse E recorded that Mr Ruggiero had an unsettled night, he had been awake since 3.00am and appeared to have conversations with himself. Later that afternoon, he was placed on report pending a disciplinary hearing after he damaged his television and television cabinet.
75. At 1.10pm, Mr Ruggiero asked Ms A for support from her service. Ms A told him someone would see him in a week.
76. Mr Ruggiero was discharged from the IPD and returned to B Wing at 5.16pm that afternoon. He remained on an ACCT with observation intervals set at one per hour. Healthcare staff referred him for structured psychosocial intervention.
77. At 4.05pm on 8 November, Mr Ruggiero made cuts to his penis, testicles and arms. Nurses attended and treated his wounds. Nurse F, a mental health nurse who was the duty worker for the mental health team, also responded. Mr Ruggiero told staff he was going to kill himself. At around 5.00pm, SO B conducted an urgent ACCT review and Mr Ruggiero was placed under constant supervision.
78. Nurse F emailed the IPD's Clinical Nurse Manager, Mr G. She said she saw Mr Ruggiero in his cell screaming and shouting things that did not make sense. He told her he had tried to cut his penis and testicles off and told SO B he wanted to end his life. She thought he was in a state of psychosis or crisis.
79. Mr G told Nurse F that Dr A had seen Mr Ruggiero on his ward round on 6 November. Dr A had not assessed that he presented with acute depression, psychosis or at particular risk of suicide. Mr G said it was reported that Mr Ruggiero used spice when he returned to the wing. He felt the predominate issue was drugs and the IPD could not offer a permanent solution to his problem.
80. On 9 November, Mr Ruggiero's disciplinary hearing was adjourned as he was unfit to attend.
81. At around 11.00am on 10 November, SO D conducted an ACCT review with SO E, Ms B and Officer E from the safer custody team. Healthcare staff did not attend. Mr Ruggiero shouted that he had a heart condition and did not want to speak to staff. The team concluded that he needed to remain under constant supervision and scheduled a review for the following day. He returned to the IPD.
82. At 11.08am on 11 November, Dr B from the mental health team met Mr Ruggiero for a follow-up appointment. Mr Ruggiero told him he was offered PS almost immediately on his return to B Wing on 8 November which he accepted and took. He said he had been asked to hold "hooch" (prison slang for alcohol) for other prisoners and when he declined, he became under threat. As a result, he cut himself. Mr Ruggiero said he became stable when he was either moved to the IPD

or the segregation unit. He said he treated them as a detoxification period before using illicit substances again when he returned to general location. Mr Ruggiero denied thoughts of suicide or self-harm. He was adamant he did not want to return to B Wing as he felt under threat from other prisoners there (there is no recorded evidence that staff discussed moving him to any other wings).

83. At 8.00am on the morning of 12 November, Mr Ruggiero was unlocked and prompted to attend the medication hatch to collect his medication. He did not attend and instead mixed with other prisoners.
84. At around 10.35am, an officer saw Mr Ruggiero tying a ligature made from his blanket around the hinge of his cell door. They radioed an emergency code blue and Mr E attended. Mr Ruggiero tried to tie the blanket around his neck but officers cut and removed it. Mr Ruggiero said he was upset as he had not been taken for his medication yet that morning.
85. At 1.51pm on 13 November, Dr B recorded that Mr Ruggiero had been reviewed at the mental health team's multidisciplinary meeting. The team discussed possibly discharging Mr Ruggiero from their caseload. Dr A said he felt Mr Ruggiero needed further support before being discharged.
86. At around 10.00am the following day, SO C conducted a multidisciplinary ACCT review with Nurse A, Ms B from the safer custody team and Officer F. Mr Ruggiero attended. The team observed that Mr Ruggiero looked clean and well presented. Mr Ruggiero said he had been occupying his time by finding his spiritual/religious beliefs and working on himself as a person. He told the team he had not had any thoughts of self-harm over the past few days and knew how to reach out to staff if he needed help. The team noted that Mr Ruggiero had a positive family support network and was waiting to be assessed for the Pre-PIPE Unit at Long Lartin. Mr Ruggiero said he had planned to keep himself occupied and did not want to slip back into his old habits of using substances. He said he had re-engaged with the substance misuse team and felt it was going well. The team concluded that Mr Ruggiero no longer needed constant supervision. His ACCT remained open, with observations reduced to one per hour.
87. Nurse A recorded in Mr Ruggiero's medical records that Mr Ruggiero said he felt much better and was no longer in crisis. He acknowledged his drug use led to a deterioration in his mental health which then led to him harming himself. Mr Ruggiero said he had had time to reflect. He wanted to engage with the substance misuse team as he wanted to live a healthy life and not use illicit substances. Mr Ruggiero said he was keen to engage with the assessment for the Pre-PIPE Unit and to move to Long Lartin, if accepted. Mr Ruggiero said he had not heard voices for some time. He denied thoughts of suicide or self-harm, engaged in safety planning and agreed to tell staff if he felt distressed or had any concerns. Nurse A noted the plan was for Mr Ruggiero to remain on her caseload. She emailed the substance misuse team and asked them to check in with Mr Ruggiero.
36. At around 1.00pm, Mr C and SO A spoke to Mr Ruggiero. They noted he seemed in good spirits and did not display as someone in crisis. Mr Ruggiero told them he wanted to come off constant supervision and return to B Wing, with the intention of moving to C Wing in the future. He asked about his assessment with the Pre-PIPE Unit at HMP Long Lartin.

37. Mr Ruggiero returned to B wing that afternoon. Officer G and Officer H were working on B Wing. They told the investigator that Mr Ruggiero was smiling, and they noticed he had a new haircut. He asked them for materials to clean his cell. He told them he was fine.
38. At 4.30pm, Mr Ruggiero telephoned his mother. He told her he had returned to B Wing and was settling down for Christmas. He said he was due to have an assessment with staff from Long Lartin.
39. At 2.18pm on 15 November, Ms A completed an initial substance misuse assessment with Mr Ruggiero. She recorded that Mr Ruggiero engaged well and was interested in engaging with the service. She noted this would be raised at the referral meeting. She gave Mr Ruggiero harm reduction advice.

Events of 16 November

40. The investigator watched CCTV and body worn video camera (BWVC) footage, listened to radio traffic and obtained prison statements and South East Coast Ambulance Service records. The following account is taken from all those sources.
41. Officer B monitored Mr Ruggiero once an hour overnight in line with his ACCT observation requirements.
42. At some time between 5.00am and 5.30am, Prisoner A, a prisoner in the cell next to Mr Ruggiero's, woke up as he heard Mr Ruggiero shouting and banging his door. He told the investigator that he heard Mr Ruggiero shouting that the demons were back, and he needed his medication. Prisoner A heard Officer B tell him he could not unlock him for medication yet.
43. SO C, Officer G, Officer I, Officer H and Officer J arrived for their shifts and attended a handover and briefing in the B Wing office at around 8.30am. Officer G remembered being told Mr Ruggiero was on an ACCT. Officer I and Officer H told the investigator that they could not recall whether Mr Ruggiero was mentioned. Officer J was assigned to look after Mr Ruggiero's spur.
88. Officer G was assigned to unlocking prisoners for exercise and supervising prisoners on the exercise yard. He told the investigator that he heard Mr Ruggiero banging on his cell door and shouting that he needed his medication.
89. At around 8.45am, Officer J heard loud bangs from Mr Ruggiero's cell and noticed a prisoner standing outside. He went to Mr Ruggiero's cell and saw the observation panel was damaged and could see Mr Ruggiero inside his cell, breaking furniture. He told the investigator that Mr Ruggiero was shouting and screaming about medication, and that he wanted to go back to the IPD. Officer J said other prisoners were shouting at him through his door. He thought they were angry as Mr Ruggiero had disturbed them overnight.
90. Between 8.04am and 8.50am that morning, Mr Ruggiero pressed his emergency cell bell five times. Officers answered all the calls within three minutes. Officer J spoke to Mr Ruggiero and told him that he could not unlock him yet as prisoners who were self-isolating were unlocked but he would speak to nurses on the wing to ensure he got his medication. He told Mr Ruggiero that he would get his medication at around 9.00am when those prisoners were back in their cells.

91. At around 9.04am, Officer J, Officer I and Officer G unlocked Mr Ruggiero's cell and walked with him to the medication hatch. They all noticed that he was walking quickly which he never normally did, but he seemed calm. At 9.05am, Mr Ruggiero was locked back in his cell.
92. Officer J spoke to the nurse dispensing medication afterwards and asked why Mr Ruggiero had been discharged from the IPD as he thought he should still be there. He said the nurse told him Mr Ruggiero had been deemed fit to return to the wing. Officer I told the investigator that he heard Officer J speaking to a nurse on the wing, asking why Mr Ruggiero had been discharged from the IPD. Officer I also said that Mr Ruggiero was presenting as erratic.
93. At 9.13am, Mr Ruggiero pressed his emergency cell bell. CCTV footage shows a prisoner deactivated the cell bell by pressing the panel outside Mr Ruggiero's cell at 9.19am.
94. Mr Ruggiero pressed his cell bell a further twelve times up until 9.28am. All were deactivated by the same prisoner. Several other prisoners looked through Mr Ruggiero's cell door observation panel and alerted Officer J who went to another cell and left without checking Mr Ruggiero. CCTV footage shows ongoing activity, with several prisoners looking into Mr Ruggiero's cell and trying to talk to him.
95. At around 9.33am, Officer J went to Mr Ruggiero's cell, knocked on the door, and looked through the cell observation panel for around a minute.
96. At an unknown time afterwards, Officer J spoke to SO C and told him he was concerned about Mr Ruggiero's behaviour and asked whether he should be in the IPD. SO C told the investigator he explained to Officer J that he thought this was normal behaviour for Mr Ruggiero. He said he had known him for a long time and a doctor needed to make any decision about him returning to the IPD. He remembered advising Officer J to check on Mr Ruggiero in line with his ACCT observations and to 'keep popping down to see him'.
97. SO C thought he would have probably told Officer J that they would see how Mr Ruggiero was later that day as he would not want to lock someone in their cell all day. Officer J recalled SO C asked if Mr Ruggiero was secured in his cell and commented they were now safeguarding him from other prisoners whom they were concerned would assault him.
98. Officer I and SO C advised Officer J to document their concerns in security intelligence reports. Officer I reminded Officer J to ensure his ACCT was updated and make an entry in Mr Ruggiero's prison records to reflect his concerns.
99. At the same time, Officer G was supervising prisoners on the exercise yard. He told the investigator that he could see and hear Mr Ruggiero through his cell window which was across a pathway between the wing and exercise yard. Officer G told the investigator that Mr Ruggiero called to him and said he should be unlocked. Officer G told him he had been instructed not to unlock him. Officer G said that Mr Ruggiero then started damaging items in his cell and threatened to kill himself. He said Mr Ruggiero did not have anything around his neck at that point.

100. Officer G told the investigator that he asked Mr Ruggiero why he wanted to kill himself to which he replied he wanted to be out (of his cell). Officer G said he was unable to calm Mr Ruggiero and therefore went inside to speak to staff. He told Officer I that Mr Ruggiero was damaging his cell and said he was going to kill himself. He asked him to check on him.
101. Prisoner A was on the exercise yard and saw Mr Ruggiero across the pathway. He told the investigator that he noticed Mr Ruggiero at his cell window, with a ligature around his neck and with one hand on it.
102. Officer G said that he went back to the exercise yard and checked on Mr Ruggiero by looking through his window around five minutes later. He saw Mr Ruggiero had a ligature around his neck and had his finger underneath it. Officer G said he rushed back inside and saw Officer H and Officer I. He told the investigator that he told them it looked like Mr Ruggiero was hanging himself.
103. At around 9.50am, Officer H went to Mr Ruggiero's cell and looked through his cell observation panel. He told the investigator that he saw Mr Ruggiero hanging, with a ligature around his neck. Officer H radioed a medical emergency code red (used when a prisoner has significant blood loss).
104. Officer H struggled to open Mr Ruggiero's cell door due to debris from his damaged sink and toilet against the door. He pushed the door open and went in at 9.51am. He cut the ligature from Mr Ruggiero's neck.
105. Officer I heard an emergency code red called over his radio. At 9.51am, he ran to Mr Ruggiero's cell and saw Officer H inside. He radioed to change the emergency call to a code blue (used when a prisoner is unconscious or not breathing). They moved Mr Ruggiero onto the floor by his bed and checked if he was breathing.
106. At 9.54am, Nurse G went into Mr Ruggiero's cell with an emergency bag. Officers and Nurse G began cardiopulmonary resuscitation (CPR). Mr Ruggiero was moved onto the landing, where there was more space and other nurses assisted.
107. The ambulance service received a call from the control room at 9.54am. At 10.12am, an ambulance and paramedics arrived. They were escorted to B Wing and arrived at 10.22am. Paramedics stabilised Mr Ruggiero and moved him to close by the emergency air ambulance which landed in the grounds at 11.08am.
108. At 12.43pm, Mr Ruggiero's condition deteriorated as paramedics were preparing to move him into the air ambulance and paramedics resumed CPR. Despite their best efforts, at 1.43pm, they pronounced life extinct.

Contact with Mr Ruggiero's family

109. At 2.16pm on 16 November, the prison appointed Officer K as the family liaison officer. Officer K and CM A began travelling to visit Mr Ruggiero's uncle who was listed as his next of kin. It became apparent the address listed did not exist so they asked the duty manager at Swaleside if they could find an address for Mr Ruggiero's mother whom they knew had regular contact with him.
110. Officer K and CM A arrived at Mr Ruggiero's mother's house at around 7.30pm that evening. As there was no response, they waited at the address and contacted the

duty manager at Swaleside to ask for a telephone number for Mr Ruggiero's sister. The number recorded did not connect.

111. The following morning, security staff gave Officer K Mr Ruggiero's mother's telephone number. She telephoned her, informed her of his death and offered support. The prison contributed towards the cost of Mr Smith's funeral in line with national policy.

Support for prisoners and staff

112. 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 and on a case-by-case basis after all other types of 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.
113. After Mr Ruggiero's death, Mr H, the duty governor, debriefed the 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.
114. The prison posted notices informing other prisoners of Mr Ruggiero's death and offering support. Staff reviewed all prisoners assessed as being at risk of suicide or self-harm in case they had been adversely affected by Mr Ruggiero's death.

Post-mortem report

115. The pathologist gave Mr Ruggiero's cause of death as hanging. The pathologist found therapeutic levels of fentanyl and lamotrigine in his system. Alcohol was also identified in his system at above the legal driving level. No alcohol was found in Mr Ruggiero's cell after he died.

Inquest

116. At an inquest held between 9 and 20 March 2026, the Coroner concluded that Mr Ruggiero died by ligaturing himself in circumstances where his intention could not be ascertained.
117. The Coroner concluded that during Mr Ruggiero's time in IPD, there was a failure to complete the ACCT Care Plan and a lack of full attendance at ACCT reviews, which led to missed opportunities for all staff to understand Mr Ruggiero's triggers and other vital information in order to care for him. Subsequently, there was a missed opportunity, as not all medical professionals were aware at the time of his return to B Wing on 14 November that he had attempted to tie a ligature around his neck on 12 November.
118. Prison staff's ability to react to Mr Ruggiero's distress on the 14 November was reduced by the other prisoners resetting his cell bell. In the hour preceding Mr Ruggiero's death, the communication between prison staff was insufficient and lacked clarity. Opportunities to increase formal observations or notify health care

were missed. Staff communications failed to relay the severity of the situation and there was a further delay in emergency response.

119. The Coroner issued three Prevention of Future Deaths reports (also known as Regulation 28 reports), which can be issued following an inquest to highlight concerns and request action to prevent similar deaths in the future. The reports were directed to HMP Swaleside, Oxleas NHS Foundation Trust, and the Minister of State for Prisons, Probation and Reducing Reoffending, identifying actions required to prevent similar future deaths.

Findings

Assessment of risk

120. The Prison Safety Policy Framework requires all staff who have contact with prisoners to be aware of the risk factors and triggers that might increase a prisoner's risk of suicide and self-harm and to manage prisoners identified as at risk under ACCT procedures.
121. Mr Ruggiero had a number of evident risk factors for suicide and self-harm, including a history of self-harm including potentially lethal ligature tying, a history of substance misuse in the community and in prison and serious mental health concerns. During his two years at Swaleside, staff appropriately started ACCT procedures thirteen times and Mr Ruggiero spent five periods under constant supervision. Prison staff appropriately began ACCT procedures on 27 October after Mr Ruggiero made cuts to his arms and legs, and initial actions were timely. We have considered the management of this last period of ACCT monitoring.
122. During the initial ACCT assessment, the assessor noted that it was difficult to engage Mr Ruggiero due to his mental state. We understand exploring Mr Ruggiero's external support network could not happen due to his presentation and the assessment identified some risks, triggers and protective factors. However, key areas which directly related to his risk of suicide and self-harm were not recorded. For example, Mr Ruggiero's drug use, history of self-harm (including self-strangulation) and non-compliance with medication were not identified.
123. ACCT reviews were timely, with most chaired by the case manager and appropriate staff in his absence. Healthcare staff rarely attended in person. SO B said he had spoken to healthcare staff, and this was evidenced by information documented in reviews which he could only have known by speaking to IPD nurses. He told the investigator that he was aware his record keeping was poor, and this was something he would improve.
124. Mr Ruggiero's care plan was blank, with no actions documented. SO B said it was clear he and others had considered and taken some actions to support Mr Ruggiero and manage his risk, however, this was not recorded. SO B told the investigator that in managing ACCT generally, if a problem could be solved quickly through a simple action, this would be done and therefore there was no longer a need to record it. He suggested there were times when staff felt "held to ransom" by care plans, particularly if they thought prisoners were abusing the process to achieve goals such as a transfer. SO C told the investigator that if there was nothing on Mr Ruggiero's care plan, it meant he either did not need any support or it was already being provided through the mental health team and SOS.
125. The investigator looked at three other ACCTs on B Wing in January 2025. None had care plans. Our investigation found that staff understood care plans and expectations to complete them. However, staff did not always see the value or importance of completing care plans and sometimes felt restricted by them.
126. While we were pleased that our investigation found that all observations recorded took place and correlated with CCTV footage, observation intervals did not always reflect the risk Mr Ruggiero posed. Specifically, on 28 October, the frequency of

staff checks was reduced despite Mr Ruggiero declining to engage in the review, and staff noting he had been up all-night shouting and was clearly still unwell. Mr Ruggiero's constant supervision that commenced on 8 November ended on 14 November. Our investigation found that the decision to stop constant supervision was reasonable. However, we found that the frequency of checks was reduced too quickly to just one an hour and did not reflect the risk posed. We found this to be a systemic issue at Swaleside. Mr Ruggiero was frequently monitored under constant supervision, but when that ended, staff often reduced the frequency of checks to one an hour – the lowest frequency of checks despite evidence that his risk remained significant. The ACCT guidance allows for a range of check frequencies, which staff can adapt according to the assessed level of risk. We are concerned that staff at Swaleside essentially consider only two options: constant supervision or one check an hour which limits the support available to prisoners at risk.

127. Our investigations into five of the previous self-inflicted deaths at Swaleside identified deficiencies in the way the prison managed suicide and self-harm procedures (ACCT). We consider some of the issues identified in this investigation reflect ongoing significant systemic issues in the delivery of ACCT at the prison. We therefore escalate our concerns as follows:

The Executive Director for the Long Term and High Security Estate and the Governor should formulate a robust plan, with sufficient oversight and auditable measures to ensure that prison staff manage prisoners at risk of suicide and self-harm in line with the Prison Safety Policy Framework, and in particular, they should:

- **hold and accurately record multidisciplinary reviews, with healthcare staff and other relevant staff providing detailed input if they are unable to attend;**
- **set a frequency of observations appropriate to the level of risk; and**
- **ensure care plans are fully completed, person-centred and responsive to risk.**

Mental health care

128. The clinical reviewer concluded that the care Mr Ruggiero received at Swaleside was not equivalent to that which he could have expected to receive in the community. She found it was not clear from the clinical records or interviews that there was any professional curiosity about the correlation between Mr Ruggiero's trauma and his mental state. This led to Mr Ruggiero moving from service to service in a reactive manner rather than services being proactive in creating treatment plans.
129. Mr Ruggiero spent periods in the IPD when his mental health deteriorated as a result of PS use. Admissions to the IPD or being held in the segregation unit enabled Mr Ruggiero to stop using drugs, take his medication and stabilise his mental health. However, he quickly relapsed on discharge and struggled to maintain progress. This led to frequent crisis periods and a repetitive cycle of readmission to the IPD. He was not referred to the complex case panel (where all services attend to review the needs of a prisoner to ensure that the right treatment is being provided

by the right service). This would have allowed services to identify that there may have been too many professionals involved in his care and that this may have contributed to his lack of engagement and willingness to discuss his mental health. The clinical reviewer made recommendations related to Mr Ruggiero's death and we repeat them here:

The Head of Healthcare should ensure that:

- **healthcare staff are involved in all ACCT reviews while a prisoner is in the IPD; and**
- **an audit of treatment plans is undertaken to ensure that they are clearly documented in the clinical records and reviewed.**

Substance misuse treatment

130. Mr Ruggiero was given several opportunities to engage with the substance misuse service. Staff made efforts to assess him and provided harm reduction advice. However, his motivation to engage fluctuated. He declined to engage in three assessments offered in 2023, and in July 2024 signed a declaration form to confirm he did not want to engage with the service. Shortly before his death he referred himself to the service and engaged in an assessment the day before he died. We consider that Mr Ruggiero understood how to access substance misuse services and was offered appropriate support.

Governor to note

Cell bells

131. Cell bell records evidence that Mr Ruggiero pressed his emergency cell bell twelve times between 9.13am and 9.28am on 16 November. CCTV footage showed a prisoner quickly deactivated these by pressing the panel outside Mr Ruggiero's cell. Although these would have displayed on the cell bell panel in the staff office, staff could not reasonably have noticed or responded to Mr Ruggiero's cell bell given how quickly they were deactivated. The Governor will want to consider whether there is any learning from this to ensure that prisoners do not routinely deactivate other cell bells.

Emergency response

132. While we recognise that the officers who responded to the emergency felt scared and shaken and therefore did not activate their body-worn video cameras immediately, it is important to do so.
133. An incorrect emergency code was called when staff found Mr Ruggiero. This was rectified quickly but the Governor may wish to consider whether any further action is required.
134. Swaleside's control room log documents the emergency code red at 9.49am and the change to a code blue at 9.52am. Ambulance records show they received a telephone call from Swaleside at 9.54am. The Governor will want to assure herself

that staff in the control room call for an ambulance without delay on hearing a medical emergency code.

**Prisons &
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