.

Circumstances surrounding the death of a man at HMP Frankland on 15 April 2004

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

January 2007

This is the report of an investigation into the circumstances surrounding the death of a man in the segregation unit at HMP Frankland on 15 April 2004. He was aged 25.

I offer my sympathy and condolences to the man's family for their tragic loss. I know that those sentiments are shared by the staff and prisoners at Frankland. I very much regret that the family and the prison have had to wait so long for me to complete my inquiries.

The primary investigation was conducted under the terms of the transitional arrangements, agreed between my office and the Prison Service, when I took over investigation of deaths in custody on 1 April 2004. As such, a Senior Investigating Officer (SIO), Mr Mick Bell, assisted by Mr Mick Cooper, carried out the bulk of the investigative work on my behalf under the guidance of my colleague, Mr Ian Truffet. I am grateful to Mr Bell and Mr Cooper for their work.

I also commissioned an independent clinical review of the man's care whilst he was at Frankland. This was carried out by Mrs Lynne Preston of the Durham and Chester-le-Street Primary Care Trust. I am grateful to her.

My thanks also go to the Governor and staff at Frankland for their co-operation during the course of this investigation and subsequent review.

I issued a report of my investigation into the man's death in October 2005 having first shared a draft with both the Prison Service and the man's family. The latter did not comment, but the Prison Service commented at length, drawing to my attention both factual errors and areas where they considered my conclusions were misplaced. A psychiatrist who visited the man whilst he was at Durham and Frankland also offered some comments, addressing criticisms levelled at him. Having carefully considered all the comments received, I made substantial amendments to the draft. These were shared once again with the family and the Prison Service before I issued what I then considered to be a final report.

In February 2006, however, I received a letter from solicitors acting for the man's family. This raised a number of concerns about the changes to the report and about the investigation itself. In light of those concerns, I asked one of my Assistant Ombudsmen, Miss Ali McMurray, to review both the report and the investigation itself, taking particular account of the comments made by the solicitors. I also commissioned Ms Yvonne Frances, MSt (Cantab), BA Hons, Cert Ed, RN, RM, RHV, DN Cert, to conduct an additional clinical review of the man's care whilst in custody.

This report draws extensively on that issued in October 2005 but also reflects Miss McMurray's subsequent review. The clinical review, which is incorporated into the body of this report, is an entirely fresh examination of the

issues. The findings of both have been shared with the man's family and the Prison Service. I have altered my judgements as new information has come to light.

Sadly, the man's father died during the preparation of this revised report. I offer the family my sincere sympathies and my gratitude for their engaging nevertheless with the review.

Since I became responsible for the investigation of fatal incidents on 1 April 2004, I have become increasingly concerned at the number of deaths in Prison Service segregation units. This report and clinical review therefore offer a detailed examination of issues arising from the man's death. As well as telling the story of the man's time in custody, I believe the report has implications for the care of all prisoners held in segregation units.

Stephen Shaw CBE
Prisons and Probation Ombudsman **January 2007**

Contents

PART 1

Summary

On 13 December 2002, the subject of this report was sentenced to 8 years and 9 months imprisonment for robbery. He began this sentence at HMP Durham, where he had initially been remanded in custody. Whilst there, he assaulted another prisoner and was held in the prison's segregation unit to await the outcome of a police investigation into the matter. This was still continuing at the time of his death.

On 24 April 2003, the man was transferred to Frankland, a high security prison near Durham, and was placed in the segregation unit. A week later, he was allowed to go to G Wing - a normal residential wing. In December 2003, he assaulted his cousin who was located in the same wing. As it was felt that his safety might be in jeopardy were he to return to the main prison, the man was kept in the segregation unit after the disciplinary hearing into the assault.

On 12 March 2004, the man's father told the prison that he had received a call from his son saying that he could not cope with his sentence and was feeling suicidal. The man was therefore placed under self-harm monitoring procedures (F2052SH). On 16 March, he was admitted to the healthcare centre because of concerns about his mental health. As a result, a transfer to HMP Rye Hill that had been arranged for 17 March was cancelled. Whilst in healthcare, he assaulted another prisoner. On 26 March, the self-harm monitoring procedures were ended by a review board, and on 13 April the man was discharged from the healthcare centre. Staff were still concerned about his safety should he be located on the main wing, and the man was therefore returned to the segregation unit. Further arrangements were then made to transfer him to Dovegate prison during the week commencing 19 April, but this move was cancelled by Prison Service Headquarters because of population pressures. Arrangements were then made to transfer the man to Rye Hill, but sadly the confirmation of this move was not received until the day after his death.

At about 10:30 pm on 15 April, the man was found hanging in his cell in the segregation unit. All attempts to revive him failed. He was pronounced dead at 11:20 pm.

The investigation considered in detail:

- the decisions to keep the man segregated;
- the application of Prison Service Order (PSO) 1700, The Management of Segregated Prisoners;
- the man's clinical care;
- his discharge from healthcare on 13 April; and
- the efforts that were made to move him to another prison as an alternative to segregation in Frankland.

My consideration of each of these matters was impeded by lack of, or poor, documentation.

In the report, I question the appropriateness of keeping the man in the segregation unit so long (three months) after the assault on his cousin and of returning him there following his stay in the healthcare centre. I am also critical that in many respects the segregation unit regime did not meet the standards set out in the PSO.

Ms Frances is critical of aspects of the man's management by healthcare staff and of healthcare documentation. She finds the reception health screening at both Durham and Frankland flawed in a number of respects, and is critical of a delay in referring the man for consideration for the DSPD unit at Frankland.

Ms Frances describes as inappropriate and unacceptable the application of the segregation regime for prisoners in the healthcare centre.

She considers that standards of implementation of Prison Service Order (PSO) 2700 Suicide and Self-harm in the healthcare centre were poor in a number of worrying respects, including several clear breaches of the PSO.

However, Ms Frances concludes that the standard of the assessments and review by a visiting Consultant Forensic Psychiatrist were of a very high standard and that his contemporaneous reports directly into the continuous medical record were an example of best practice in communication and continuity of care.

Ms Frances is critical of the lack of a managed and co-ordinated approach to the man's discharge from the healthcare centre. Despite concerns raised by some of the prisoners to whom my investigators spoke, however, I am satisfied that the decision to discharge the man from the healthcare centre on 13 April was clinically justified.

On the whole, I am satisfied that delays in transferring the man largely reflected the situation in the Prison Service estate, rather than lack of effort by staff. However, with the benefit of hindsight, I might have wished the matter had been escalated through senior managers.

I make five recommendations. Ms Frances makes a further six.

Investigation

The investigation was opened on 21 April 2004. Mr Truffet and Mr Bell met the Deputy Governor of Frankland, the Chair of the Independent Monitoring Board and members of the local branch of the Prison Officers' Association. They familiarised themselves with the segregation unit so that they had an understanding of the environment in which the man had spent so much time, and talked to some of the unit staff about the regime there. They also visited other parts of the establishment, including the healthcare centre.

Notices were issued to staff and to prisoners announcing the investigation and inviting them to bring to the attention of the investigation team any concerns or any information they might have about the man's death.

Mr Truffet met the man's brother and his father. They both raised concerns about the length of time the man had been held in the segregation unit, and about the effect this might have had on his mental health. They were also concerned about aspects of his management while in the unit.

Mr Bell and Mr Cooper reviewed relevant files and documents relating to the man's time at Frankland and at Durham and interviewed a number of staff and prisoners. One of the key prisoner witnesses, the man's cousin, refused to allow the investigators to record or take a contemporaneous note of their conversation.

In reviewing the investigation, Miss McMurray examined all the evidence collated during the original inquiry. She interviewed a number of prisoners and wrote to one with whom the man was alleged particularly to have fallen out whilst on normal location. Unfortunately, he did not reply. She also obtained additional paperwork and information from the Prison Service and spoke to the then Governor at Frankland. She was unfortunately unable to meet the family or interview the man's father, due to the latter's ill health. The man's cousin declined to be re-interviewed because he remained very distressed by the man's death.

Before issuing the draft report for comment, Miss McMurray again suggested a meeting with the man's family and their solicitors to talk through the findings. Sadly, the man's father died on 15 June, so this was not possible.

The man who died

The subject of this report was born in Newcastle on 20 March 1979. He was brought up by his parents in the west end of the city. He apparently enjoyed a normal relationship with both his parents, but his adolescent years were punctuated by disruptive and violent behaviour. He attended a Special School until the age of 13 when he was expelled for violent behaviour. The man began to break the law and went on to accumulate many criminal convictions, predominantly for violence. After being given a range of non-custodial punishments, he was imprisoned at the age of 15. In 1995, he spent a period on remand in the Glenthorne Treatment Centre near Birmingham.

The man had never been employed. Although he had a partner for the last two years of his life, he remained single.

On 13 December 2002, he was sentenced to 8 years and 9 months imprisonment for robbery.

One of the prisoners to whom Miss McMurray spoke described the man as a "nice boy". He said he was polite rather than being "all shoulders and attitude" and was not "in your face" or aggressive. He was fine so long as people were fine with him. Another described him as a "nice kid" who had a very soft heart. He said the man found it difficult to say no to people.

HMP Frankland

Frankland is a high-security prison on the outskirts of Durham. It holds up to 653 prisoners in six residential units in single cell accommodation. Four of the units house vulnerable prisoners. At the time of the man's death, a unit for prisoners with dangerous severe personality disorders was about to open. The healthcare centre has in-patient facilities for up to 18 prisoners.
The most recent inspection by Her Majesty's Chief Inspector of Prisons before the man's death took place in March 2003. In the report of that inspection, the Chief Inspector commented that Frankland provided a largely safe environment based upon good relationships between staff and prisoners. Appropriate levels of interaction were in place and there was good staff understanding of individual prisoners and their needs. However, the report drew attention to 'distant contact' between prisoners and staff in the segregation unit. It added that prisoners were managed by competent staff who supervised them diligently and carefully, without being overbearing.

The last Standards and Security Audit before the man's death took place from 17 February to 7 March 2003. Frankland received a 'Good' rating in relation to suicide and self-harm, healthcare services and the segregation unit. The audit report commented that the segregation unit was run in a professional manner with all staff fully aware of their responsibilities and duties.

The Independent Monitoring Board's report on Frankland for 2002-03 recognised marked improvement in the management of the segregation unit, noting in particular that segregation unit staff worked with care and compassion.

In the context of the Prison Service's performance improvement system, Frankland was categorised as a high performing prison.

Prior to the man's death, the establishment had experienced one self-inflicted death. This occurred on 2 October 2002, also in the segregation unit.

Events at Durham

The man was received at Durham prison on 2 September 2002, after being remanded in custody from Gateshead Magistrates' Court on charges of affray and driving while disqualified. On 24 September 2002, he was remanded in custody on a separate charge of robbery, for which he was sentenced on 13 December 2002 to 8 years and 9 months imprisonment.

The man's time at Durham was punctuated by episodes of drug related activity and violence. A serious assault on another prisoner led to a police investigation. As a result, the man was located in the prison's segregation unit. (The police investigation was ongoing at the time of his death.)

On 4 April 2003, the man was seen by healthcare staff at the request of segregation unit staff who had become concerned about the level of anger he was showing. A comprehensive note of the interview was entered into his Inmate Medical Record (IMR). It seems that the man was aware of the presence in Durham of a number of prisoners whom he held responsible for his girlfriend's daughter's addiction to heroin. He also admitted that he had experienced "anger/temper problems" since the age of 15. He said that these problems had sometimes become so bad that he suffered stomach cramps. The man said that these had been treated with beta blockers and Trazodone[1], both of which had helped. He admitted that he could sometimes become angry and tense about very trivial incidents and that his tension was normally relieved by assaulting someone. He said he wanted help to overcome this problem, and welcomed the input of a psychiatrist. At the end of the interview, he told staff that he felt better having talked about his problems for the first time.

An appointment was made for the man to be seen by a visiting psychiatrist, on 7 April. As a result of that meeting, the psychiatrist advised that the man should be considered for assessment in a unit for prisoners with personality disorder, such as the Dangerous Severe Personality Disorder (DSPD) Unit at Whitemoor or the planned unit at Frankland, once the outstanding assault charge had been resolved.

On 23 April 2003, the man was considered by the doctor at Durham to be fit for transfer to Frankland. He was transferred the next day.

Events at Frankland

Upon his arrival at Frankland on 24 April 2003, the man was immediately located in the segregation unit, as he had been received from the segregation unit at Durham and staff wanted to assess his suitability for placement on a normal wing.

That day, he underwent a reception health screen. It was recorded that he had not previously committed any act of deliberate self-harm and had never been on an open F2052SH (suicide and self-harm monitoring arrangements). The following day, a Prison Service security information form was placed in

[1] Trazodone is a tricyclic antidepressant.

the man's security file, on which "No" had been entered alongside "Suicide Possibilities".

On 1 May, the man was relocated to G Wing, the induction unit. Although an induction programme was arranged for him, no sentence plan was drawn up. Consequently, no targets were set to address his offending behaviour. The man was occasionally employed as a wing painter.

On 10 May, he discovered that his cousin was also in the prison. Staff noted that the cousin appeared to offer the man protection and support as he adjusted to his long sentence in a high security prison.

During June, it was noted that the man was adhering to the wing regime and presenting no problems, although at times he manifested a "bad attitude" towards staff. On 29 June, however, he was caught attempting to swallow drugs passed to him during a visit. The drugs were retrieved and the matter was referred to the police.

In July, staff noted that, although the man often appeared to be quiet, his activities with other prisoners needed to be monitored.

In August, he was moved to the landing in G Wing where his cousin was located, so that the two could spend more time with each other.

On 14 September, staff noted that the man was spending most of his time in bed. On 26 September, he lost his temper and threw a table across the landing after being told that he could not short-circuit the visits booking system by leaving a visiting order at the gate. He was moved again to the segregation unit. The next day, he was punished with three days loss of association and returned to his wing.

There were no further events of note during October, although staff recorded that the man was a moody individual who mixed with very few people.

In November, he attended a week-long course in the gym and was reported to enjoy the experience. No other comments were recorded.

On 12 December, the man was segregated after assaulting his cousin. According to his own account at adjudication, the man and his cousin had argued, resulting in some pushing and shoving. Following unlock later on, the cousin had approached the man with his fists clenched. The man said he raised a broom to stop him hitting him, and might have hit his cousin accidentally. At a hearing before an independent adjudicator, the man said he went to hit the floor with the broom in frustration, but caught his cousin when he put his hand out. He admitted swearing at him and said he "did not deny" saying, "Come on, then". The cousin denied that he had been assaulted and corroborated the man's second account. He said he had not seen the man for some years and thought he was a child – he said he tried to be protective of him. Both dismissed the incident as a silly family argument.

A safety algorithm must be completed whenever a prisoner is to be placed in the segregation unit. The algorithm completed on 16 December suggested that the man would be able to cope with a period of segregation. The ensuing disciplinary hearing was adjourned to enable a staff witness to be present. The man was kept in the segregation unit to await the adjourned hearing.

On 15 December, the man asked to speak to a Listener (a prisoner trained by the Samaritans to provide a confidential and emotional support service to prisoners in distress). When it was explained to him that the Listener might be a vulnerable prisoner (that is, one separated from the mainstream population for his own protection), he withdrew his request. Instead, he used the Samaritans telephone during the night.

The adjudication took place on 16 December. The man was given seven added days, a punishment which would normally have enabled him to return to his wing. However, a decision was made that he should remain segregated. This was based on intelligence suggesting that the man had upset his cousin and a number of other prisoners. The man's continued segregation was therefore authorised until 17 December.

On 16 December, the man spoke to a Listener from F Wing for approximately four minutes. No entries were made in his record to show why he wanted to do this (or to speak to the Samaritans the previous day), or whether staff re-assessed the possibility of self-harm in light of the man's actions.

On 17 December, the case for continued segregation was examined by a review board. It was decided that the man's segregation should continue until 31 December. Further enquiries were to be made as to the possibility of his safe return to the wing.

On 29 December, the man repeatedly asked to be allowed a period of exercise. Staff refused, as he had not requested it on his application form that morning (segregated prisoners are asked to indicate at the start of each day whether they would like phone calls, showers etc that day). An entry was made in his record stating that he only wanted to go onto the exercise yard to receive items from other prisoners who had been relocated to the segregation unit to face disciplinary hearings.

On 31 December, the man's continued segregation until 14 January 2004 was authorised. On the expiry of this period, his segregation was again authorised for a further two weeks because it was felt that his safety would still be in jeopardy if he were to return to the wing.

On 15 January, an entry was made in his record suggesting that the man should be transferred to another establishment. The next day, staff told the man about the discussion of the previous day.

On 20 January, the man complained of chest pains. He was initially seen in the segregation unit by a Healthcare Officer who then took him to the healthcare centre for further examination. There is no corresponding entry in

his IMR. However, an entry was made in the IMR on that day about a referral by staff in the segregation unit who were concerned about the man's deteriorating mental health. They said that he seemed to be a different person. The entry does not make clear which member of the healthcare centre saw him. What is clear is that the man told this person he thought someone was controlling his life by inserting thoughts into his mind.

The next day, a further entry was made in the IMR showing that the man's situation was discussed at a mental health meeting and that his case was to be referred to the psychiatrist the next week.

The visiting Consultant Forensic Psychiatrist saw the man on 3 March. After interviewing him, the psychiatrist told the man that he had a dissocial, paranoid and obsessional personality disorder. The psychiatrist suggested to him that he might be a candidate for the Dangerous Severe Personality Disorder (DSPD) Unit in the prison, and asked him to think about it. The man agreed to do so. The psychiatrist agreed to review the man's case after a week. In the event, outside factors meant that the psychiatrist next saw the man on 24 March.

On 22 January, the following entry was made in the man's IMR:

> "seen in seg. complains of insomnia. 3 day sleepwatch ordered by GP to commence tonight. States he is anxious and has chest pain ? due to circumstances on wing."

On 28 January, a segregation review board was held. The man asked whether he was to be transferred and stated that he was willing to go anywhere. No response was recorded in his file. During the following fortnight, staff noted that he appeared very withdrawn and lethargic. On 2 February, a member of staff recorded in the man's file that he thought he might benefit from a transfer. No record was made of any follow up action. On 11 February, the man's segregation was authorised for a further 14 days.

On 13 February, the man was placed on report for damaging prison sheets. At adjudication the next day, he was given four days forfeiture of privileges - that is, loss of canteen, association, tobacco, publications, radio, occupations in cell and possessions in cell.

After his disciplinary hearing, the man asked to be allowed to take a shower. He was told that there was no time for him to have a shower that day, and that he should ask for one the following day.

On 25 February, a further segregation review board was held. The man asked to be transferred to HMP Lowdham Grange. It is recorded on his history sheet that a governor was asked to investigate the possibility of moving him there on a "sale or return basis". (Although I accept that this remark was not meant to be derogatory and that the term has often been used in prisons, I nevertheless deprecate it.)

On 28 February, the man was described as being very withdrawn. On 10 March, his segregation was authorised for a further two weeks. He asked the review board about his transfer. It was recorded in his file that he accepted that he was to be transferred to HMP Rye Hill. A list of anticipated transfers for the week commencing 15 March indicated that the man was due to be transferred there on 17 March.

On 12 March, the man's father rang the prison because he had received a call from his son saying that he was not coping with his sentence, was hearing voices and was thinking about suicide. An officer went to see the man. He admitted calling his father, but suggested that his father had over-reacted. The man did not mention to the officer self-harming or feeling suicidal. Nevertheless, after consulting a Principal Officer, the officer opened a F2052SH, offered the man access to the Samaritans phone and arranged for a Listener to be available. The Principal officer directed that the man should be observed twice per hour until seen by the Orderly Officer.

The Orderly Officer later saw the man. He wrote in the F2052SH that he repeated that he was not suicidal, that his father was over-reacting and that the call was part of an attention seeking process. The Orderly Officer decided that the man should be managed in the segregation unit and observed twice hourly at irregular intervals. The Samaritans phone was to be made available, and a review was to be carried out the following morning.

Despite the man's protestations that he was not suicidal, a review was convened at 10 am the next day to identify a support plan to carry him to the 72 hour review. The case review summary recorded the man's confirmation that he felt alright and had been trying to manipulate his father. The Senior Officer said, however, that staff were concerned because the man had been withdrawn, was not eating and said he was hearing voices. He thought the man might have been hiding his true feelings about self-harm.

The targets set at the review were for him to remain subject to the same frequency of observations, to have access to the Samaritans phone and a Listener, and for staff to monitor and support him. The view was expressed that, if appropriate, the F2052SH document could be closed on Monday 15 March. In the event, the F2052SH remained open until 26 March after three further case reviews.

Also on 13 March, the following entry was made in the man's record:

> "For the good order or discipline of the establishment following an assault on another prisoner, [the man] currently awaiting transfer to another establishment. To remain segregated until 16.04.04."

(It is assumed that the person who made that entry intended to record the date of 16.03.04, rather than 16.04.04)

A 72 hour review was carried out on 15 March and lasted for about 40 minutes. The man was present for most of the time and described feeling

depressed and paranoid and having difficulty sleeping. As a result, the Principal Officer was left thinking that the man was “really unwell”.

At 3:30 pm on 16 March, a safety algorithm was completed by a Grade E Registered Mental Nurse. He recorded that there were healthcare reasons to advise against segregation at that time. The nurse considered that the man’s mental health would deteriorate significantly if his segregation were to continue. The Duty Governor duly recommended that the man should be located in the healthcare centre. He was admitted that afternoon, but was placed on a segregation unit regime and kept separate from other prisoners in the healthcare centre. (To be subject to a Good Order or Discipline regime whilst in the healthcare centre is not consistent with either local or national policy.)

Because the F2052SH had been opened and the man had been admitted to the healthcare centre, it was decided that his transfer to Rye Hill should be cancelled.

The next day, the man was seen by a doctor who wrote that the man had reported hearing voices and was feeling depressed. The doctor decided to refer him to the mental health team and confirmed that he should stay in the healthcare centre. The Nursing Care Plan made out for the man showed that he was to be located in room H107, to be observed four times an hour and subject to a segregation regime. A further case conference was to be held in the following two days. At 7 pm that day, in spite of the fact that he was subject to a segregation regime, the man assaulted another prisoner in the healthcare centre. He was placed on a disciplinary charge for this offence. The man did not deny the charge and, as a result, no information about the circumstances of the offence are available on the record of adjudication. However, Miss McMurray learned from another prisoner in healthcare at the time that the prisoner whom the man assaulted was a “pest” who was always asking questions and seeking advice but then ignoring the answers he was given. This prisoner had apparently been bothering the man and he finally snapped. The then Mental Health Co-ordinator described the assault in an e-mail to a colleague. He said the man “was walking past [the other prisoner] the arm went out to the side, hit [name], and he didn’t even break his stride.”

On 18 March, the man told a member of the healthcare staff that he “felt better after making up with his cousin”.

A further case review was held on 19 March when it was decided that the F2052SH should remain open.

On 20 March, the man asked to be allowed to have a visit with his cousin, saying that their argument was now settled. He was advised that any visit would have to take place in the visits centre and the matter was duly referred to the security department (in light at least in part of the cousin’s category A status). Nothing appears to have come of this, although the cousin was apparently contacted and said he would like to have a visit. (At interview, a

nurse added that the cousin had sent the man a card with “quite a lot of the inmates’ names on as well wishing him all the best”.)

Also on 20 March, the man told staff that he felt well enough to leave the healthcare centre. On 21 March, staff in the segregation unit were advised of the possibility that he might soon be discharged to their care. That day, it was recorded that the man told healthcare staff that he thought that he would be stigmatised by other prisoners if they knew he had a mental illness and that he therefore preferred to be in the segregation unit rather than the healthcare centre. (The man’s family do not accept this, or that the man would have returned voluntarily to the segregation unit. They provided me with copies of letters written by the man at this time. In one letter, he refers to being back in the segregation unit “and in jail clothes so I cannot be bothered with visits. I asked to go back on the wing when I was down the hospital but they put me in the block instead.” In another, he tells his cousin that, “I tried to get back on the wing but they brought me down here instead (Block).”)

However, on 22 March, the man said that he felt “not right”. He was seen by a (different) doctor who prescribed an increased dose of Chlorpromazine.[2] He was to be moved to the segregation unit the following day if he settled overnight. On 23 March, the man complained of feeling anxious and unsettled. The Chlorpromazine prescription was continued, and he remained in the healthcare centre. A brief note of this appears in the man’s medical record.[3]

On 24 March, the man was seen again by the visiting Consultant Psychiatrist. He recorded in the medical record that the man felt calmer and that, although he occasionally felt depressed, he had no suicidal thoughts. The man told the psychiatrist that the Chlorpromazine he had been taking was having little effect. He also reported that his appetite had reduced, his sleep was erratic and his concentration was terrible. The psychiatrist concluded that the man should be referred to the DSPD Unit and wrote (on 26 March) to the Senior Medical Officer at Frankland, advising him that he would be asking DSPD staff to assess the man. He prescribed Trazodone in place of Chlorpromazine.

On 26 March, the final F2052SH case review took place in the healthcare centre. The panel comprised representatives of the healthcare centre, but none from the main prison or the segregation unit. The man was present. He told the panel that he felt fine and would not consider self-harming. He also felt that the medication he was taking was beginning to take effect. The panel therefore decided to close the F2052SH. The support plan agreed for the man included the following targets:

---

[2] Chlorpromazine is an antipsychotic medication in use for many years. It is indicated for short term use in severe anxiety and agitation.

[3] Surprisingly, entries relating to other prisoners were also contained in the same document. However, I understand that the pages on which references to other prisoners were made are copies of staff observation and handover books in healthcare at that time. They were incorporated into the man’s medical record after his death.

- he should continue to take his medication;
- he should be offered full support from Listeners, the Samaritans and staff;
- staff should continue to help him get a move;
- he should be seen by the Mental Health Team.

On the same day, he complained of a headache and low mood. He was prescribed soluble paracetamol and remained in the healthcare centre.

Frankland's suicide prevention policy document directs that the Safer Custody Officer should review, at two and eight day intervals, the cases of those prisoners for whom a F2052SH has been closed. In this man's case, this was not done as the document was not passed to him. As a consequence, the extent to which the targets set out in the man's support plan were being achieved was not reviewed.

An entry made in the man's IMR on 27 March by a Healthcare Senior Officer reads as follows:

> "Long talk with this inmate. States he does not know why he behaves as he does. He seems to operate on two levels - has good intelligence but cannot control his physical actions. No feelings of self-harm or suicidal thoughts. Realises he needs help, but remains unpredictable and will act on impulse without thought. Requires assessment from MHT [Mental Health Team] for a course of action."

On 2 April, the restriction on the man's ability to mix with other prisoners was relaxed. He was therefore allowed time out of his cell and to enjoy periods of association.

A governor told the investigation team that he saw the man in the healthcare centre on 5 April and said to him that, in the light of what he saw as an improvement in his demeanour, he would arrange for a transfer to proceed.

The next day, the man was given 14 added days for the assault he had committed on the other prisoner in the healthcare centre earlier in the month.

On 7 April, the man again complained that he had a headache. On this occasion he was prescribed Beconase.[4] On the same day, the doctor wrote, "Appears fit to be on wing". (Other records were less equivocal, stating "fitted for normal location" and "fitted for discharge".)

On 8 April, the man collected his personal belongings from reception. A letter of the same date was sent to him from HMP Lowdham Grange referring to a written request he had earlier sent to the Director (Governor) for a transfer there. The letter advised him to apply through official channels at Frankland.

[4] Beconase is a steroid spray for relief of allergic nasal congestion.

On 13 April, the man was discharged from the healthcare centre.

Healthcare staff contacted the segregation unit, as it was from there that they had received him. The Head of Residence told the investigators that the information he had been receiving "over a number of weeks from the Security department and G-wing was that the problems [the man] had with [his cousin] hadn't been resolved and that it was unsafe to send him back to normal location so the only obvious answer was to put him back to segregation." He said that he had taken into account the man's information that he had resolved his issues with his cousin, but that his experience was that prisoners commonly said this when it was not the case. He added, "on this occasion the evidence to suggest that there would be further trouble far outweighed the chance of putting him back safely."

Accordingly, he advised healthcare staff that the man could be returned to the segregation unit, but that a safety algorithm would need to be completed first. A new segregation safety algorithm was duly completed. This said that there were no healthcare reasons against segregation. The man was therefore sent back to the segregation unit. I understand that this decision was also made in the context of an understanding that he was soon to be transferred to another establishment. On his arrival in the unit, the man was allocated a Personal Officer.

The man was formally signed up for segregation by the duty governor. She said she met the segregation unit Senior Officer, who told her why the man was in the unit. She said she:

> "already had an awareness of [the man] and why he's been removed back in December from normal location. I was aware that he had assaulted his cousin and I was aware that there was fear of reprisal from other prisoners should he be returned to normal location. [A Senior Officer] in his brief that he gave me reaffirmed this and informed me that [the man] was awaiting transfer. On the basis of my knowledge and on the basis of the information that I was receiving from the Senior Officer in the segregation unit, I signed [the man] up in the unit for the Good Order or Discipline of the establishment. He'd been discharged from a healthcare centre so it clearly wasn't appropriate for him to return to normal location because if I had returned him to normal location may have presented a risk to him had I done so. So therefore I made an informed decision to actually sign him up within the segregation unit for the Good Order or Discipline of the establishment pending transfer to another establishment."

On the evening of his return to the segregation unit, the man was told that a move to Dovegate had been arranged for the following week (week commencing 19 April). However, the transfer was later cancelled by the Prison Service Population Management Unit because of population pressures throughout the estate. Rye Hill prison was then approached again and a transfer date of 21 April was agreed. The fax confirming this move was dated 16 April.

On 14 April, the man was seen by a member of the Independent Monitoring Board as part of her normal rounds of the segregation unit. She asked him how he was, and he replied that he was fine. She noted that the man had his possessions, including his radio, with him. (This conflicts with the evidence of a prisoner who said that the man was frustrated following his return to the segregation unit because his property - including his cigarettes - was not brought for him.)

That evening, the man complained of chest pains and was seen by a member of the healthcare staff. The following entry was made in his IMR by a Healthcare Officer:

> "Seen in seg unit whilst dispensing nocte meds. Complains of chest pains when wound up. States it is the same as previous spell in seg unit. Gets anxious. [The man] advised to try and settle and will be seen by someone from MHT morning 15/4/04. This accepted by [the man]."

The doctor saw the man during the routine morning round of 15 April and told him that an appointment would be made for him to see a GP at the first opportunity.

At about 8:30 pm that evening, the man asked the night patrol officer when his medication would be delivered. He also said, when asked, that he had some pains in his chest. After consulting a member of the healthcare staff by telephone, the officer confirmed to the man that his medication would be delivered at the usual time: between 10:30 pm and 11 pm. At 9 pm, the man asked the time of another officer, and again asked when he could expect to receive his medication. Once more, he was told that his medication would arrive at the usual time.

The man again asked the first officer about treatments at about 9:30 pm. The officer told him he could not give him a guaranteed time because that would not be fair. This was the last occasion that any member of staff spoke to the man.

(The man's family wanted to know if any of the visits made by staff to his cell that evening had been recorded by closed circuit television cameras. I have ascertained that, as there were no closed circuit television cameras installed in the vicinity of the man's cell at the time, any visit to his cell would not have been filmed. (CCTV has subsequently been installed.))

At about 10:25 pm, a Healthcare Officer arrived at the man's cell to administer his medication. He was accompanied by the night patrol officers, a Senior Officer Gibson and a Dog Handler.

The Healthcare Officer looked into the cell through the observation panel in the cell door while one of the patrol officers switched on the nightlight from outside the cell. The healthcare Officer immediately said, "He's hanging". He

saw that the man was suspended by a ligature made from a bedsheet. He was almost in a sitting position, facing into the cell. The Senior Officer opened the cell door and sent a message over his radio to the Emergency Communications Room to call an ambulance.

One of the patrol officers cut the ligature while the Healthcare Officer held the man's body weight. Together they then placed the man on the floor of the cell. The healthcare Officer noticed that the man was not breathing and that he had no detectable pulse. He and the Senior Officer commenced cardiopulmonary resuscitation (CPR).

The Orderly Officer was asked by the control room staff to go to the cell. As soon as he arrived, the Healthcare Officer asked him to fetch a defibrillator from the healthcare centre. He did so and arrived back about five minutes later. The defibrillator was applied to the man by the Healthcare Officer who noted that the machine advised "not to shock".

CPR was continued until an ambulance crew arrived at approximately 10:42 pm. They continued to apply CPR until 11 pm. The duty doctor arrived at the prison at 11:10 pm and went straight to the cell. He pronounced the man dead at 11:20 pm.

PART 2

Clinical review

I am indebted to Ms Yvonne Frances, MSt (Cantab), BA Hons, Cert Ed, RN, RM, RHV, DN Cert, for this part of the report.

Past medical history in custody

The period of imprisonment during which the man died commenced on 2 September 2002 at Durham prison. It was of interest, however, to see that in the medical record provided to the clinical reviewer there were documents from previous custodial episodes in 2000, 2001 and early 2002.

The man underwent a first reception health screen procedure and medical assessment on 7 April 2000, 2/3 June 2000, 23 January 2001 and 28 January 2002. Very little medical history of any significance was elicited on any of these occasions. He was assessed as having no untoward mental condition, to have normal general health, to drink alcohol occasionally, to show no evidence of heavy drinking or smoking and to have stated he used no drugs.

During those earlier periods of custody, the man attended the chiropodist regularly for a persistently in-growing toenail and other problems with his feet. Otherwise, his main contact with healthcare staff and doctors related to periods in the segregation unit following adjudications for fighting with other prisoners. Apart from a comment by the chiropodist on 27 April 2001 that he seemed “stressed out, possibly due to his trial in seven days time and anticipation of a long sentence”, there were no references to the man’s mental state.

First reception health screen

The man was remanded in custody at Durham on 2 September 2002. A Healthcare worker (HCW) completed both the first reception health screen and the secondary health assessment. It was recorded that the man was born on 20 March 1979. He was 23 years old. He gave his home address and the name and address of his general practitioner (GP). He was noted to have been in prison before but details as to where and when were not entered in the relevant parts of the form.

The man reported that he had seen his GP in the past few months for anxiety and depression. He was taking prescribed medication for his condition – Trazodone 150mg at night. He reported no recent injuries and no chronic disease. He stated that he was concerned about his anxiety. The Healthcare worker referred him to the doctor, as guided by the form, because he was on prescribed medication.

In response to a series of questions about substance use, the man said he had been “drinking a lot” in the past week and that he usually drank 12 cans of lager a day. According to the form, having given these answers, the man

should have been told by the HCW about making a self-referral to the drugs services. There was no evidence in the papers provided to the clinical reviewer that any such consultation occurred.

The Healthcare worker continued the assessment by asking the set questions about mental health. The man reported that he had received help from a psychiatrist outside prison for behavioural problems. He reported that he had (recently) been prescribed Trazodone for anxiety and depression. He said he had never tried to harm himself and did not feel suicidal.

Because he answered "yes" to the question about taking antidepressants, according to the protocol in the form the man should have been automatically referred to a community psychiatric nurse (CPN) for a psychiatric assessment. The Healthcare worker ticked the "yes" box indicating that he had asked the man whether he needed to see a doctor and recorded a positive response. This question was clearly for those prisoners for whom a medical referral had not already been made. Since he had already noted that the man must see a doctor for medication, this question need not have been asked/answered and served only to provide potential for confusion.

The Healthcare worker completed the Planned Action page by ticking a box to indicate the man was being referred to the doctor. However, he also ticked a box indicating the reason for the referral was for "DETOX" (sic). Despite the automatic requirement mentioned above, the box for referral to a CPN was not ticked. The page also included a tick box for referral to a drugs worker but that was not ticked.

On the Secondary Health Assessment, the Healthcare worker recorded that the man was 6ft 2ins tall and weighed 13 stone. His blood pressure and urinalysis was not recorded. The man was noted to be a non-smoker and not disabled. He gave no family history of illness and had no concerns about sexual health, hepatitis or HIV. The man was recorded as being aware of the importance of testicular self-examination. The healthcare worker ticked the box for referral to the doctor although none of the man's answers on the form led to that conclusion.

Medical assessment

A doctor (name illegible) assessed the man on 2 September and noted his anxiety and depression. He also noted he did not use drugs and had no history of deliberate self-harm (DSH). He described him as "stout and strong" with good general health. He found no evidence of heavy drinking. In the section on mental health the doctor wrote:

> "well, not depressed, not suicidal, no DSH ideation, good eye contact, mood … [illegible]."

He prescribed Trazodone 150mg in possession for 28 days (which was repeated on 30 September). He also found the man fit for a communal cell and in need of CPN input.

Chronology of healthcare and health-related events

The Continuous Medical Record

The first entry in the continuous medical record (CMR) was on 10 October 2002. The man complained to a HCW that he was nauseous and had been vomiting. He said he had been suffering for three weeks. The HCW noted that for those three weeks he had been in court and was still attending daily. The man's record contained a report from a Group 4 Custody Surgeon dated 10 October. He had been called to see the man at court, finding him with the same symptoms he reported later to the nurse and advising taking only weak fluids. The HCW thought the man was rather stressed and should see the doctor on Saturday 12 October. There was no entry to confirm that this happened. The next entry was on 25 October, stating the man was fit for adjudication. On 2 November, he was seen by a doctor in the segregation unit and found fit and well.

The next consecutive entry was by the chiropodist on 31 January 2003. However, this had been written out of order. On a new page there was an entry made on 15 November 2002 that the man had been moved under restraint from D wing to the segregation unit. According to the entry, there were no obvious injuries.

On 20 January 2003, a subsequent entry recorded that the man had been seen in the segregation unit after being taken there following a fracas with another prisoner on D wing. The entry stated there were no injuries apparent and the man had no complaints. Blood was seen on the front of his head, which the man said was not his own. It was not clear whether this entry was made by a doctor or nurse, but an injury to inmate form (F213) of that date and on the file had been completed by a doctor.

The next entry, dated 21 March, recorded the man receiving a Meningitis C immunisation. However, this was out of chronological order. On a new page, the first entry (dated 11 February) stated that he was fit for kitchen work. This was followed by a report from the chiropodist on 28 March. However, in the file, there was an F213 form dated 25 March. The form had been completed following an incident in the main exercise yard which resulted in the man being taken to the segregation unit under restraint. There were no injuries recorded.

On 4 April, the man was interviewed in response to a psychiatric referral. The interview was undertaken by a CPN and a doctor who wrote the report. The doctor noted that the referral had been made by discipline staff who had:

> "become increasingly concerned at his behaviour and vocalisations of anger/planning to assault somebody."

The key points that the doctor elicited and recorded were:

- The man was very disturbed by the presence in the prison of members of a gang whom he blamed for his girlfriend's 20 year old daughter being "hooked" on heroin.
- The man had experienced anger/temper problems since the age of about 15 years. His anger sometimes caused him to have physical symptoms such as stomach cramps. He had been treated with beta blockers in the past. Trazodone had also helped.
- He described himself as feeling paranoid at times, even accusing people of talking about him. He thought this was unusual.
- He denied having hallucinations.
- His anger could be triggered by trivial events, sometimes building up over weeks. The tension could be relieved by an assault which brought feelings of content until it started over again.

With regard to a recent assault he had carried out on a fellow prisoner the man said it concerned the gang members mentioned previously. He had made more than one attack, one of which was premeditated to the extent of his having made a weapon. He had been told that he had ground one man's face into the floor but he could not remember this. He feared that this assault would have carried on if it had happened outside with no-one to stop him.

The man told the doctor he wanted help and would welcome psychiatric input. He was described as much more content at the end of the interview, saying it was the first time he had really talked about the situation.

Interview by Visiting Psychiatrist

On 7 April, a visiting psychiatrist wrote a long report in the CMR after he had interviewed the man. The key points of his report were:

- The man was serving eight years for armed robbery and thought he had about five years to serve.
- He said he had a problem with his temper and was now facing an assault charge. He reported that he took out his anger on someone and then usually felt content but no longer. He was not happy about this.
- He said he had been "after" the victim of his assault for two years. He had "done a good job on him" but was not satisfied. He felt he had not inflicted enough damage and wanted to do more. He was constantly preoccupied with this man because he blamed him for getting his girlfriend's daughter hooked on drugs. He would have liked to be content with what he had done, forget the man, do his time and get out.
- The man told the psychiatrist he did not think he could help him - "I don't think it's treatable."

- The man admitted antipathy towards drug users ("smack heads") in general. He had put people in hospital before. He saw anyone connected with heroin abuse as "low life".

The psychiatrist noted that the man was on a waiting list to go to Frankland. He recorded the extent of the man's offending since the age of 15, and also noted his family background. He had been born and brought up in Newcastle and praised his parents for being "just normal people". He described his older and younger brothers and their circumstances. He blamed his problems on his temper and moving in criminal circles. The man said his childhood had been "alright" but there had been "bother" and that he had progressed from fighting in the street to armed robbery.

The man described attending school from age 5 to 11 but being expelled for being disruptive and fighting. He thought his problem was wanting everything to be perfect, which made him slow with school work and got him into trouble. He thought he might have hit a teacher. He was sent to a 'special school' but expelled for fighting. He thought the majority of places "couldn't handle" him. In 1995, he was placed in local authority secure accommodation in Birmingham for a couple of months. The man had never worked. He lived with his 38 year old girlfriend of two years who was also unemployed. He had not had many previous girlfriends. He said he had never been violent towards them but he had lost his temper and smashed things.

The psychiatrist elicited the man's psychiatric history, which began with an assessment as an adolescent and again when a young offender in Low Newton. He had been prescribed Trazodone by his GP for a short time for anxiety and depression. He also admitted dabbling with steroids, cocaine and valium. He said he drank 12 cans of lager most nights. He reported no withdrawal symptoms. The psychiatrist described the man's current state:

Mood - no get up and go
Loss of interest - in gym etc
Sleeps too much
Appetite - not very good
Concentration - problem with memory
- don't feel as though I'm switched on
Energy down
No suicidal thoughts
Thoughts of future, out of prison: - go to gym
- "only thing I'm good at is fighting".

The psychiatrist found no evidence of psychosis or mental illness. He described the man as quiet, calm, repetitive, intense, smiling occasionally and neatly turned out. He noted the man's long history of aggression and violence and wrote that he probably had severe conduct disorder from childhood. He found the man able to consider the psychological component of his behaviour and was aware of its potential consequences.

The psychiatrist advised that consideration should be given to referring the man to the Dangerous and Severe Personality Disorder (DSPD) unit at

Frankland, once the current proceedings regarding the prison assault charge were resolved (they remained unresolved at the time of his death). He recorded that the man must be considered to present a high risk of violence to other prisoners. The psychiatrist did not recommend any medication, and said he would see the man again if requested. He sent a typed copy of his report to the prison doctor on 14 April.

On 11 April, the man saw the chiropodist. On 23 April, he was assessed as fit for transfer to Frankland.

Reception at Frankland

The man arrived at Frankland on 24 April and underwent the reception screening procedure on 25 April. A healthcare officer (HCO) recorded his physical measurements. The doctor noted the man had anxiety and dizziness and required hepatitis B immunisations. A course of immunisations was prescribed but there was no evidence they were ever administered. No reference was made to the visiting Consultant Psychiatrist's recent assessment. The box entitled Psychiatric History on the form contained no information, just the word "No".

A second form listing 'Risk factors associated with suicides in dispersal prisons' was also completed. The questions about previous or current psychiatric history and current or past anti-depressant medication were both answered in the negative. The man was assessed as fit for physical education and work. He signed an in-possession medication compact.

The man's CMR at Frankland commenced on 7 June with a chiropody report. On 29 June, an unidentified person wrote in the CMR that the man had been found choking in Visits and subsequently vomited a small blue package. This resulted in an adjudication on 30 June.

The next entry was on 26 September by a nurse. She had seen the man following his removal to the segregation unit after a disturbance. She wrote that he told her he had no injuries. He was found fit for adjudication on 27 September.

According to the CMR, apart from a minor ailment on 17 October, the man was not seen again by healthcare staff until 12 December when he was back in the segregation unit following another incident on the wing. No injuries were seen or reported. Later that day, the same nurse recorded that she had completed the segregation safety algorithm. The algorithm form showed that she found no reason to advise against segregation on health grounds at that time. A second segregation safety algorithm was completed by another staff member on 14 December, who noted that the man said he was fine and had no problems.

Further entries by rubber stamp indicated that the man was found fit for adjudication on 23 and 29 December and 16 January 2004. Below an out of place entry by the chiropodist dated 30 March 2001 on the next page was an

entry made on 20 January 2004, probably by a doctor (the signature was illegible). The writer noted that segregation unit staff had asked for a review of the man because they were concerned about his behaviour and mental deterioration. They had described him as "not being the same person". The writer noted that the man thought someone was controlling his mind and it was causing him anxiety. The writer queried whether the cause might be schizophrenia or other mental illness. The man would be discussed at the next mental health team (MHT) meeting, referred to the visiting Consultant Psychiatrist and a CPN and reviewed again.

On the same day, a segregation unit officer noted in the man's history sheet that he had complained of chest pain and been taken to the healthcare centre for treatment after being seen initially by an HCO. It was evident from the history sheet that the man was not eating his meals. He told an officer that he preferred food he purchased from the canteen (prison shop).

On 21 January, it was reported in the man's segregation unit history sheet that he had complained to the doctor about chest pains. The same day the man was discussed at the MHT meeting. The minutes of that meeting confirmed the segregation unit staff's concerns as described in the CMR entry the previous day. They also noted that the reason he was in the segregation unit was that he had assaulted a prisoner in Durham. The minutes recorded that he was the only criminal in his family, whose members were all educated and working. The man had been getting chest pains and pins and needles in his hands and wanted treatment for his anxiety. He felt someone was controlling his thoughts and life, inserting thoughts into his mind telling him to do things. That is why he had assaulted the prisoners, although he had not wanted to do so. The minutes reported he said this made him anxious and apprehensive. He also hated people who dealt in heroin. The minutes confirmed that the man was to see the visiting Consultant Psychiatrist the next week.

On 22 January, the man was seen in the segregation unit complaining of insomnia. The GP noted that he stated he was anxious and had chest pains, possibly due to circumstances on the wing. The GP ordered a three day 'sleep watch' to commence that night. It was done and the record showed that the man was asleep at each time of observation on three occasions each night.

On 2 and 8 February, segregation unit staff noted that the man was very withdrawn. On 13 February, he was put on a disciplinary charge for damaging prison sheets. The next entry in the CMR on 14 February recorded that he was fit for adjudication. A rubber stamp was used to indicate the same thing on 25 February.

The next entry in the CMR was the visiting Consultant Psychiatrist's record of an assessment carried out on 3 March. He saw the man in the segregation unit. He noted that the man remembered seeing him a year before. The psychiatrist recorded a statement by the man that he had a serious problem which made him anxious. He said he had mentioned it to officers who

referred him to a nurse. He had told her how he felt. He had improved, but his problem was not fully resolved. He said he had discussed his problem with his family.

The man described his problem in terms of looking at a simple task but imagining he could not do it the simple way and so looking for an alternative. He said it felt like an obsessive compulsive thing and varied in extent. He referred to being known as a perfectionist and described his thought processes. Regarding ironing, for example, he found himself thinking, "what if there were no iron or board?" He could not then go on with the task.

The man thought there was someone else wanting him to do things differently. It seemed that someone was controlling his thoughts. He said he did not believe this now, but had done a few weeks previously. He thought now that it was obviously a part of him.

The man told the psychiatrist he was in the segregation unit because of an assault on another prisoner. The man thought there was an element of paranoia in his behaviour – "I think too much". The psychiatrist asked what he thought about. The man said it was about ill treatment he had received from others. He said he had "got back" on everyone who had harmed him, but he kept thinking about it. He reported washing his hands a lot but not to the extent of serious disruption.

The psychiatrist described the man as calm, appropriate in mood, thoughtful in manner, articulate but repetitive, giving good eye contact, having good rapport, not depressed or elated, insightful and having no delusions or hallucinations. The psychiatrist discussed his diagnosis with the man and told him he had a personality disorder. He was dissocial, paranoid and obsessional. The psychologist described him as a "good candidate" and recorded that the options were the DSPD unit or Grendon (therapeutic community prison). The man agreed to think about it. The psychiatirst noted he would review the man in a week.

In the segregation unit history sheet on 6 March, the man was described as "very withdrawn but coming out of it". The history sheet appears to have gone with the man to the healthcare centre (see below) where healthcare staff wrote in it.

The next entry in the CMR in March (day not visible on the copy) indicated that the man had been seen in the segregation unit and was asking to see the psychiatrist. The writer noted that the man now agreed to see him and asked for it to be arranged.

On 16 March, a segregation safety algorithm was completed at 3:30 pm by a psychiatric nurse. The nurse found the man unsuited for segregation. The Duty Governor acted on that advice, organising his transfer to the healthcare centre as soon as possible. No entry was made in the CMR about the man's transfer to the healthcare centre.

The man's admission to the in-patient unit as documented on his care plan

A short stay care plan was opened on 16 March. The man was on an open F2052SH (suicide and self-harm monitoring form) which had been opened on 12 March. (The healthcare input to the F2052SH is covered in a later section of this review.) He was located in a single cell and a four times per hour watch was ordered. The care plan stated that he was to continue with the segregation regime where he was held for reasons of good order or discipline (acronym: GOOD or sometimes GOAD, the A standing for 'and' instead of 'or'). A case conference was to be held in the next two days. The care plan record indicated that the man had settled in the healthcare centre and slept well.

On 18 March, the man started medication and reported feeling strange. The nurse making the entry wrote that he would be observed. On 19 March, the watch was reduced to twice an hour. On 20 March, he was reported to be feeling that he needed more medication, but felt well enough to leave the healthcare centre. He was trying to organise a visit with another prisoner (his cousin). The staff advised he would need to submit a visiting order and the visit would take place in the Visits Hall. A security information report was submitted about the visit request.

On 21 March, the man was reported to be functioning well. He was due for a review by the GP with a view to discharging him to the segregation unit. At 3:45 pm on 21 March, a long entry over an indistinguishable signature described a consultation with the man. The man had described having thoughts placed in his head, making him do things. He thought they were being placed there by someone who died when he was two years old. He said the finger of blame had been pointed at him, but would not elaborate on this. He said he was worried about the stigma of mental illness and therefore wanted to be in the segregation unit. They had discussed his medication which he was not sure was helping.

On 22 March a nurse noted that a doctor had increased the man's Chlorpromazine prescription. She also noted that if he settled overnight he would go to the segregation unit next day.

Minutes of an MHT meeting held on 23 March recorded that the man had been seen by the visiting Consultant Psychiatrist a year ago in Durham, when he suggested he might be suitable for the DSPD. The man was described as "a very intelligent co-psychopath with a capacity for serious violence" who was also quite reflective. He was noted to have "a couple of depressive symptoms" for which he was being treated with antidepressants.

It was further noted that the psychiatrist had spoken with someone who was interested in getting referrals from people serving determinate sentences. The man was serving an eight year sentence with an earliest release date in 2008. He was described as a serious career criminal who could be quite

powerful. In addition, he had a temper, brooded and took revenge. The then Mental Health Co-ordinator was to write a letter of referral.

On 24 March, the man was still in the healthcare centre and the same nurse noted he had been written up for Trazodone. No mention was made of his assessment by the visiting Consultant Psychiatrist that day (see below).

On 25 March, the then Mental Health Co-ordinator sent by e-mail a referral letter probably regarding admission to a DSPD unit. The recipient replied by e-mail the same day that she would put the referral into action straight away. In his e-mail, the then mental Health Co-ordinator mentions that the man had recently assaulted another patient in the healthcare centre.

On 26 March, a note was made in the care plan that a case review had been held which resulted in the closure of the man's F2052SH. He had been seen by a doctor and prescribed paracetamol for headaches.

On 27 March, a senior healthcare officer (SHCO) reported that he had had a long talk with the man, who could not understand his own behaviour. The SHCO felt that that the man was "functioning on two levels", having good intelligence but unable to control his physical behaviour. He noted that the man realised he needed help but remained unpredictable. He wrote that the man required an assessment by the MHT "for a course of action".

The care plan contained no entries of note from 28 March to 1 April. On 2 April an entry stated the man was "off GOAD" but under strict observation on association. The writer noted that a risk assessment had been completed but none was included in the clinical documentation and my colleague, Miss McMurray, was not able to obtain one.

The care plan contained no entries of note from 3 to 5 April. On 6 April, it was recorded that the man had had an adjudication for an assault on another prisoner for which he had been punished with 14 days added to his sentence.

On 7 April, a doctor assessed the man fit for normal location. She prescribed a beclametasone nasal spray (Beconase). Nothing else of note was recorded in the care plan before the man was moved to the segregation unit on 13 April.

The Continuous Medical Record (continued)

While the man was in the healthcare centre as an in-patient, in addition to the notes made in his care plan, entries continued to be made in the CMR. On 18 March, he was reported to be agitated and had pushed a fellow prisoner. (This was probably the assault mentioned by the mental health Co-ordinator and adjudicated upon on 6 April.) The writer, possibly a doctor, wrote that the man felt bad thoughts were taking over his mind. The writer continued, "Agrees CPZ 50mg bd." This seems to confirm that the writer was a doctor. Reference to the prescription cards indicates that CPZ was shorthand for

Chlorpromazine, which was prescribed twice daily for seven days. It was also noted on that day that the man had been assessed as fit for adjudication.

There was a third entry on 18 March by the Mental Health Co-ordinator. He had found the man concerned about his mental state but feeling better having made up with his cousin. The Mental Health Co-ordinator wrote that he would see him again the next day. He did so and wrote that he had found the man in an apparently good mood, expressing no concerns. He added that the man would be discussed at the MHT meeting.

On 22 March, a doctor wrote that staff felt the man was calmer but still agitated about bad thoughts. The doctor increased the Chlorpromazine to 100mg twice daily for 14 days and noted that, if the man settled, he could move to the segregation unit.

On 24 March, the visiting Consultant Psychiatrist reviewed the man in the healthcare centre. The man told him that he had not been well in the segregation unit and had been bothered by intrusive thoughts opposing his wishes. He said he had become increasingly distressed and was moved to the healthcare centre.

The psychiatrist noted that the man had been treated with Chlorpromazine to little effect but that he felt better being in the healthcare centre. He was now refusing the Chlorpromazine. The man said he felt restless and aggressive and said he was “not a nice person”. The psychiatrist assessed him as calmer, feeling depressed, low appetite, erratic sleep, waking early, terrible concentration, not suicidal but occasional feelings of despair. Trazodone had helped in the past. He was having obsessional thoughts. The psychiatrist diagnosed depression and increased obsessivity. He prescribed a “trial” of Trazodone 150mg twice daily for 28 days and a referral to the DSPD. The psychiatrist sent a typed report of his 3 and 24 March interviews to the prison doctor on 26 March.

On 26 March, the man was treated with soluble paracetamol for a headache which he associated with his low mood. His prescription card shows he was prescribed paracetamol 1g four times a day for seven days, not in possession. On 7 April, he was still complaining of a headache which the nurse or doctor who wrote the entry thought sounded nasal. S/he noted he had previously suffered a broken nose. He was prescribed Beconase. The writer noted that the man appeared to be fit to be on a wing.

On 13 April, an entry was made that the man had been returned to the segregation unit. On 14 April, the night time health care officer (HCO) saw him at 10:30 pm while doing the night medicines. The man was complaining of chest pains. He said it was the same as when he was in the segregation unit before. He presented as anxious. The HCO said he would arrange for the man to be seen by someone from the MHT in the morning, which the man accepted.

On 15 April, the man was seen by a doctor during the routine segregation unit round regarding his chest pain. The note, which was made by someone other than the doctor, concluded that the man would have the first available appointment with a GP.

At 8:30 pm on the same day, a HCO took a call from the segregation unit regarding the man having chest pain. The HCO explained that the man had been seen twice that day by a doctor and healthcare staff. He was on the GP's list for Monday (that is, four days later). He told the segregation unit staff he would see the man when he went to do the medicines round at 10 pm.

The next and final entry in the CMR was by a doctor who examined the man in his cell at 11:20 pm and certified his death. The North East Ambulance Trust (NEAT) form used for paramedics to diagnose adult death was also on the file. The time of death was not noted. Another Ambulance Trust document showed the ambulance was called at 10:35 pm and was on the scene at 10:42 pm. The paramedics' electrocardiograph (ECG) reading indicated the heart was in asystole (no electrical activity). The ambulance staff followed their protocol for asystole, giving adrenaline atropine and another drug, the name of which was not decipherable.

The healthcare centre log

Among the documents supplied to the reviewer was a number of pages of CMR headed paper on which events involving various patients and prisoners were recorded day by day. This collection of pages had been used as a unit diary or log would be used. There follows a summary of the references the man:

- 24 March - the man was not to be unlocked with others. Reference to a risk assessment in the history sheet. [Reviewer's note – no document found.]
- 26 March - the man's case review noted to have resulted in closure of F2052SH.
- 27 March - the man went on exercise yard for 30 minutes. Had a shower.
- 28 March - the man went on exercise yard for 30 minutes. Had a shower.
- 29 March - Refused exercise. Had a shower.
- 31 March - During the night the man had complained of sore toes. He had been given paracetamol and issued betadine paint (an iodine treatment) for his toes.
- 1 April – the man received his property from the segregation unit.
- 2 April – the man off GOAD. Risk assessment done [no document found]. No room on G wing, possibly for segregation unit. Note continued to state writer had had long chat with the man.
- 6 April – the man had been given 14 added days on adjudication. Might be transferred tomorrow.
- 7 April – the man fit for discharge, written up for nasal spray.
- 8 April - Cleaned out his cell.
- 12 April - Had a shower, swept cell. "Had a chat, asked him …" [entry ends].
- 13 April - Going back to the segregation unit.
- 15 April – A nurse wrote that the man had been seen in the segregation unit at 7 pm. He had been feeling anxious about having tachycardia (fast pulse). Pulse taken, within normal range. Has appointment with GP Monday. To be seen by doctor on segregation unit rounds. Advised to contact the healthcare centre if feeling worse. Medicines taken.
- 16 April - All the healthcare centre patients had been told of the man's death and offered support from chaplaincy and staff.

Suicide and self-harm monitoring

The F2052SH form was opened on 12 March at 7:50 pm following a call from the man's father expressing concern about his son's state of mind. The man was present at all the case reviews which took place.

The healthcare assessment section of the form was carried out by a member of healthcare staff, who gave no instructions except "twice hourly observations

in the segregation unit" and made a note that the man said he was not suicidal. A doctor completed the medical assessment on 17 March after the man had been admitted to the healthcare centre. The doctor confirmed his admission and noted he was to be seen by the MHT.

A doctor and nurse were present at the case review on 13 March. No particular action was attributed to them.

A different nurse was the healthcare representative at the review held on 16 March after the segregation safety algorithm had indicated the man should not be segregated. The decision of the review was that he should go to the healthcare centre as soon as possible and be reviewed in 72 hours or sooner if he deteriorated.

On 19 March, in the healthcare centre, the case review was attended by four nursing staff and one officer. It was not noted from which unit the officer came. The follow up action was attributed to the healthcare staff generally, not individuals. The observation watch was to be reduced to twice hourly and reviewed on 21 March. The man's mood and behaviour was to be watched, monitored and recorded, he was to have his medication as prescribed and receive psychological mental health support.

On 24 March, a member of healthcare staff made an entry in the F2052SH at 2.52pm summarising the findings of the MHT meeting. She wrote:

> "At mental health team meeting today, this inmate was identified as a cold calculating psychopath, capable of extreme and unpredictable violence. To this end and as he is fit for discharge, have requested the seg (sic) take him back, this has been declined as [a Principal Officer] has stated he is not to return to seg. Duty Governor informed, will attend in due course. Risk assessment completed, not to be unlocked."

The man is not described in such terms in either the CMR or the care plan and the entry was not an accurate reflection of the MHT minutes of the 23 March meeting. Nothing in the psychiatrist's assessments approximated to the description of the man as a "cold calculating psychopath".[5]

On 26 March, four members of healthcare staff attended the review. They decided to close the form. The review was recorded by a healthcare officer who signed off the closure of the form. There was no-one from the segregation unit or any other residential unit present. None of the participants was of senior officer or equivalent rank.

[5] The man's family have expressed concern about this note. They suggest that this perception of the man led to him being returned to the segregation unit, rather than to normal location. However, none of those responsible for that decision made any reference the man's character – only his problems with other prisoners on the wing.

Overall the entries in the F2052SH while the man was in the healthcare centre were of a very poor standard, containing almost no quality records of interaction or observations of mood or behaviour evidenced through conversation.

PART 3

Examination of the issues

Family concerns

The family was critical that the man had been held in the segregation unit for such a long period, particularly as their understanding was that the decision to segregate him was based solely on an argument between the man and his cousin. They took the view that he should have been moved to another prison. They said they were shocked to learn that he had been moved back to the segregation unit from the healthcare centre on 13 April. The last time they had spoken to him, about a week before he died, he told them that his state of mind was improving because he was in the healthcare centre.

The man's family were angry about the fact that he had been punished for tearing up bed sheets in his cell in the segregation unit at the beginning of February 2004. They said that the punishment had included the removal of his radio, writing materials and magazines. They thought that this episode was the trigger for a deterioration in his state of mind.

In addition, the letter from the the man's family's solicitor that I received in February 2006 set out a range of concerns. Some of these arose in part at least from changes that were made between my draft and 'final' reports. They include:

- changes of emphasis, making the report less critical of the Prison Service;
- removal or dilution of specific criticisms in relation to:-
    - ♦ efforts to secure a transfer;
    - ♦ use of safety algorithms;
    - ♦ medical appointments;
    - ♦ record keeping;
    - ♦ the lack of stimulation for the man;
    - ♦ a failure by the wing manager to arrange a meeting with the man;
    - ♦ aspects of the clinical review; and
    - ♦ use of the expression 'sale or return' in connection with transfers.

They again challenged the reasonableness of keeping the man in segregation, suggesting that there was no evidence as to the accuracy of information about threats to the man or their likely severity. They said the review board merely rubber-stamped previous decisions to segregate and that the paucity of the regime was detrimental to the man's mental health. They were critical that insufficient account was taken of the impact of segregation on the man's mental health. They were concerned about the failure to follow up on the recommendation that the man should be considered for the DSDP

unit and that the man's discharge from healthcare to the segregation unit appeared to have resulted from a shortage of beds in the former.

Referring to a letter from a prisoner to the Coroner, in which he referred to two suicide attempts around the time of the man's death, the family's solicitor suggested that those two attempts might be relevant to my consideration about the environment in the segregation block at the time.

The family challenged my conclusion that steps taken to transfer the man had been reasonable and appropriate, and were critical of the delay in following up the decision to transfer him.

They also suggested that the care afforded to the man in the healthcare unit was inadequate. They said that assessments of his mental state were inconsistent and complained that the risk of suicide and self-harm was not taken seriously enough. They thought healthcare took insufficient account of the effect of segregation on the man's mental health and noted that records were disjointed and inadequate. They suggested that the visiting psychiatrist had been at fault for apparently not writing to the SMO about the DSPD referral until March 2004.

Generally, the family was critical that I had drawn many conclusions from the evidence of non-independent witness evidence "without having documentary proof to back it up or making enquiries to test the veracity of this evidence". They suggested that this applied especially to evidence from staff that it would have been unsafe for the man to return to the wing. Finally, they suggested that I should have interviewed more prisoners in order to determine the man's state of mind and the likelihood of a return to the wing being unsafe.

I have sought to explain or address all these points in this revised report.

Concerns expressed by other prisoners

A prisoner in the healthcare unit at the same time as the man said he was surprised when the man was discharged, as he "knew" that he was very low, depressed and suicidal. He said a nurse told him that the man had requested the move himself.

In an undated letter to my colleague, Mr Truffet, the prisoner said that he had overheard a conversation between (unidentified) staff on the night shift in the healthcare centre following the man's discharge. The prisoner said that he heard one of them say words to the effect:

> "has there been any change in [the man's] behaviour situation and if not is there anything we can do to prevent it?"

The prisoner said that someone replied, "No", at which point the staff discovered that he was listening. They then allegedly told him to go away. He also claimed that, after being told of the man's death, he asked staff to

explain why the man had been moved out of the healthcare centre to the segregation unit despite the fact that he was depressed and confused.

The prisoner said he had also asked why the man was not put on a F2052SH. He claimed in his letter that the staff to whom he spoke told him that they either did not know or could not answer his questions. Mr Truffet asked the prisoner to submit a supplementary statement, identifying the staff to whom he spoke. No further submission was received.

Miss McMurray interviewed the prisoner and pressed him on precisely what he had heard and what he thought the significance of it was. He repeated what he had told Mr Truffet. He identified the officer in question as a [named] Healthcare officer and suggested that it was clear from her questions that there were real concerns about the man's state of mind, but that he had been put in the segregation unit even so. (I do not consider that the words the prisoner has quoted readily lend themselves to such an interpretation, however.)

Another prisoner in the segregation unit at the time of the man's death, was on exercise with the man on the two days before he died. He said the man should not have been sent back from the healthcare unit as it was clear from the way that he was talking that he "wasn't right" and was suffering from paranoia. The prisoner thought the man had been sent back to the segregation unit because staff "had the hump" with him over a complaint made by two other prisoners about a member of staff.

The prisoner also said he heard the man ask a nurse about his medication on the night of his death. He said he could not hear clearly what was said, but he thought someone said, "don't be a child" or "don't be a kid". He did not hear the man's reply. The prisoner said it was some time later that the man's death was discovered.

Another prisoner in the segregation unit was also critical of the decision to discharge the man from the healthcare centre given his state of mind. He said he thought the man had asked to be allowed to attend the gym whilst he was in the hospital. He had been eating better, his condition had stabilised and he was bored and needed something to do. However, the response of staff was that if he was fit enough to go to the gym, he was fit enough to return to the block. The prisoner thought it was also the case that the man's face simply did not fit in the hospital. He said most of the prisoners in there were not sick, but were simply needy and looking for someone to mother them and were extremely compliant. The subject of this report did not fit this mould and was taking up space, so they got rid of him.

In a letter to my office on 30 April 2004, another prisoner held in the segregation unit at the same time as the man raised the following issues:

- The man "had committed suicide as a result of his extremely poor and untenable mental condition as well as of a lack of qualified medical

attention in the surroundings of a totally depressed and isolated segregation unit";
- he should have been placed on a 15 minute watch;
- he had been held in "a totally normal and not a suicide cell complete with camera etc…"; and
- he was "deliberately moved out of the prison hospital which was the appropriate medical location for him, considering his well-known history of mental problems".

The justification for the man's segregation

The man spent three months in the segregation unit because of staff concerns for his safety were he to return to the wing. His family do not believe there was such a risk or, if there was, that it was properly reviewed by staff.

The man was originally taken to segregation following an altercation with his cousin. Once he was there, however, staff decided it would not be safe to return him to the wing. They were apparently concerned that an argument the man had got into over a foodboat the previous July might re-surface now that he no longer had the protection of his cousin. An SIR relating to the foodboat argument dated 3 July 2003 recorded that the reporting officer had overheard the man on the telephone, when he "kept making reference to a falling out on the 'food boat'". It said he was in a different mood on the phone from what he normally was. The SIR went on:

> "[The man] also stated that "the lad is big, about '18 clem' [sic] and has a reputation about him, but if he keeps going on I will take his reputation off him".
>
> Also that if he kept going on he will ask him into the showers to sort it out properly.
>
> I have spoke to the G wing management and can confirm [the man] is of the food boat which contained [three named prisoners and the man's cousin] and the description is that of [one of the named prisoners].
>
> [The man] is not a big person but sounded as though he may attempt to do something to [the named prisoner] so not as to lose face."

The other four prisoners are described in the summary of supporting/related intelligence as "some very influential prisoners". Staff were to be briefed and security would monitor relevant calls and report any further occurrences.

There is little further evidence of staff concerns in this respect in the available documentary evidence before 13 December. The man's wing history sheets thereafter record that:

- although the man often appeared to be quiet, his activities with other prisoners needed to be monitored (July);
- The man was spending most of his time in bed (September);

- on 26 September, he lost his temper and threw a table across the landing;
- no further events of note during October, but the man was a moody individual who mixed with very few people; and
- he attended a week-long course in the gym in November and seemed to enjoy the experience.

No other comments were recorded.[6]

There are a number of security information reports (SIRs) relating to this period:

- 29 June – drugs retrieved from the man following a visit;
- 3 July – a phonecall by the man was monitored in which he repeatedly referred to a falling out on the foodboat and suggested he would sort out another prisoner if he kept going on as he was;
- 25 September – letter suggesting addressee might receive a parcel for the man and to drop it off at his brother's;[7]
- 5 October – money sent outside believed to be payment for drugs;
- 11 October – a parcel was received for the man containing cannabis and heroin;
- 17 November – an officer reported finding a letter from the man telling the addressee to sort out his priorities, suggesting the man had put out a contract on someone and containing an apparent threat;[8]
- 30 November – the man observed asking about a prisoner who had that morning been found in possession of unidentified tablets;
- 12 December – the man was seen selling heroin to another prisoner.[9]

Two SIRs were submitted on 13 December. The first reported that a prisoner had told an officer that the man had become very unpopular on G wing since his assault on his cousin. The prisoner stated that the man had now pushed his luck too far and if he entered the wing he would be seriously hurt. The second SIR reported that the cousin had told the man's father on the phone that the man had threatened and eventually attacked him, apparently as the cousin had reacted to a threatened 'straightener', by saying, "Come on, then". The cousin also mentioned that the man had been offering 'straighteners' on the wing and that he had fallen out with another prisoner (thought to be the same incident as that reported on 3 July).

[6] The Prison Service commented that it was not surprising if information about tensions between the man and the other prisoner was not included on the wing history sheets, since they are subject to open reporting and are disclosable to prisoners. They suggested, however, that the reference to the need to watch the man's activities with other prisoners suggested that staff were in fact watching him.
[7] The man's family have noted the inference that the parcel may have been drugs. They stressed that the man's brother has never been involved in either taking or supplying drugs.
[8] The man's family have expressed their disbelief of this and suggested that the prison would have followed it up if it was considered a serious threat.
[9] The man's family have stressed that the man had absolutely no history of drug dealing before his imprisonment and that he was very much against heroin in particular.

The first SIR dated 13 December assessed the source of the information as unreliable and the information not known to be true to source but corroborated. It was considered to have a low probability of consequences with low security implications. The Intelligence Officer noted that the prisoner, "has given this sort of information to staff before and this time appears correct." The Security Manager commented, "It does not appear that it is safe for [the man] to return to G wing."

The second SIR dated 13 December was assessed as "Very reliable" and "True without reservation". It was assessed as having a high probability of consequences with low security implications. The Intelligence Officer commented:

> "The suggestion that this is not over is very apparent. [The man] appears to have not forgotten his falling out with [named prisoner] and that his own relative (cousin) … would not back him up and has fallen out with him. In the call,]the man's father said to [the cousin], "He is my son but he has it coming to him and watch your back as you know what he's capable of." Almost an agreement that [the man] should not be allowed to get away with threats/actions."

(Before his death, the man's father denied making this comment.)

The Security Manager commented:

> "[The man] appears to be out of his depth and his bottled up resentment appears to be getting him into trouble with more established prisoners. It also appears that he has no support on the wing, and it may be unwise for him to return."

I am satisfied in light of the two SIRs dated 13 December, and particularly that deriving from the cousin's phonecall, that the initial decision to retain the man in the segregation unit was reasonable and indeed responsible.

Whether it remained so, however, is less certain. The extent to which there was ongoing ill-feeling towards the man that would make a return to the wing unwise once the immediate heat had gone out of the situation is unclear. The falling out over the foodboat apparently happened in late June/early July. There is no further reference in either the wing history sheets or SIRs relating to tension between the man and other members of the foodboat or the particular prisoner highlighted in the SIR. It is difficult to gauge therefore what the feeling was on the wing. Unfortunately, I have been unable to obtain evidence from either the cousin or the other prisoner on this matter.

One prisoner told Miss McMurray that he did not believe that the man would be in any danger, as his cousin was a member of a well respected criminal family, which meant that no-one would trouble the man. (I have been asked to make clear that the man's immediate family are respectable people and that they had absolutely no involvement in the cousin's alleged activities.)

The man apparently maintained that there would be no difficulty with him returning to the wing – he wrote in a statement for the review board that talk of a possible assault on him by other prisoners was "news to me and I would say it is nonsense. I have had one argument with one person in 8 months on G wing (my cousin) ... The matter is being blown out of proportion."

A number of members of staff referred during interview to the question of returning the man to the wing. The governor charged with arranging a transfer for the man said he was not aware of an altercation over the foodboat. He said that the information he had had was that the man had been acting 'a bit cocky' on the wing and that this had not gone down well with some of the older prisoners and had caused some friction between him and his cousin. The governor confirmed that the man had originally been located in the segregation unit because of the assault but,

> "It then transpired and I think security clearly had taken the temperature in terms of what was happening on the wing and it was felt [the cousin] in some way had withdrawn his support from [the man] and that had resulted in possibly these other individuals involved with the foodboat potentially seeing [the man] now as a legitimate target and if they were upset with him that would have placed him at risk. So the segregation continued on that basis."

The governor acknowledged that the man did not consider there to be any risk but said that, "certainly the first couple of months when we actually went back and revisited the situation and checked with either security or with the wing managers to see if there was any prospect of him coming back … Each time … we came back to the same point that we felt that given the information that we were getting back from prisoners and what I was getting from security and from the wing management was that he would have been at serious risk".

The governor referred to having gone through the review process on "several occasions".

.

The G wing governor (until mid January 2004) said at interview that he recalled conversations with the other governor, his (the G wing governor's) line manager and the G wing principal officer about whether the man could return to G wing, or even F wing (the other 'normal location' wing in the prison). He said he also recalled a conversation on the same subject when the new G wing Governor arrived, but that the meeting was not minuted. Finally, he thought the man would have been offered the opportunity to go to the vulnerable prisoner wings.

The segregation unit Principal Officer said at interview that he thought "there were several attempts to review [the man's] position as to regards could he return back to G wing. There was a lot of work done in that area and it became evident it couldn't happen."

There is little contemporaneous evidence of staff reviewing the position, however. An entry by the PO in the Record of Events noted on 17 December

that the G wing governor would “make enquiries as to [the man’s] safe return or not to ‘G’ wing.” On 31 December, a target set for the man at the review board was that he should move back to normal location. At a segregation review board on 14 January 2004, it was noted that the man would be interviewed by wing management who were considering his return to normal location (there is no record of such an interview taking place). The final contemporaneous record of the question of the man’s return to normal location was another note by the segregation unit Principal Officer dated 15 January which says, “After enquiries with security it would appear that intelligence would suggest that his safety would be in jeopardy if he were to return to the wing.” A note dated 16 January records that a Principal Officer interviewed the man’s cousin and explained the concerns noted the previous day. This suggests that there was dialogue between staff and those most likely to know the likely repercussions of the man being returned to the wing.

However, there are no SIRs after 13 December 2003 reporting on feelings on the wing towards the man. Accordingly, it is not possible to know whether the information on which staff relied in making decisions to retain the man in segregation was based on ongoing intelligence or on the SIRs submitted in mid December.

The man’s cousin apparently confirmed to the original investigator, Mr Bell, that he had offered the man a level of protection and support. This suggests that staff were right to be concerned once there was reason to suppose that this support was removed (as recorded in the SIR of 13 December. The cousin apparently also told Mr Bell that, even though he and the man had resolved their personal differences, it would not have been advisable the man to return to the wing. This seems to be corroborated by the fact that the cousin was informed on 16 January of the conclusion that the man would be in jeopardy if returned to the wing and that it would be appropriate to seek a transfer for him. His response is not recorded, but it is perhaps significant that the prison did not alter its view as a result of that interview. This suggests that the cousin was in agreement.

I have seen nothing to persuade me that the matter was actively reviewed after this point. This is of particular concern, given that the prisoner with whom the man had fallen out over the foodboat was transferred to another prison on 26 January. The man referred to this in a letter (undated but apparently written while he was in the healthcare centre). He said that his cousin wrote to him a lot, “but I think he’s trying to sweeten me up for some reason. Ulterior motive. His commander in chief has been moved on so he wants to be my pal now. Hmm …” I note the man’s own reservations about his cousin’s approaches, but it seems likely that the threat to the man on the wing must have been much reduced following the other prisoner’s transfer. I have seen no evidence to suggest the man’s position was re-assessed in light of this change of circumstance, however.

I turn now to the question of whether it was appropriate, notwithstanding considerations about the likely impact on his mental health, to return the man to segregation following his discharge from the hospital.

The governor who authorised the man's return to the segregation unit said that she was aware of the history of the man being held in segregation and that, when he was discharged from healthcare, the segregation unit Senior Officer reaffirmed the situation with regard to possible reprisals from prisoners on G wing. She added that, "On the basis of my knowledge and on the basis of the information that I was receiving from the senior officer in the segregation unit, I signed [the man] up in the unit for the Good Order Or Discipline of the establishment." She said she made "an informed decision" in this respect.

The line manager of the governor charged with effecting the man's transfer said in relation to healthcare contacting him about arrangements for the man's discharge that, "the information that I'd been receiving over a number of weeks from the security department and G-wing was that the problems he had with [his cousin] hadn't been resolved and that it was unsafe to send him back to normal location so the only obvious answer was to put him back into segregation". I have some doubts about the currency of this information in mid April, especially in light of the transfer of the other prisoner. The man had by that time been away from G wing for four months and his cousin would no doubt have relayed back to the wing that the man was to be transferred to another establishment. It is difficult to imagine that the man would have been the subject of any (fresh) intelligence from the wing by this point.

In late March/early April, the man told healthcare staff that he was happy, having made things up with his cousin. He asked if they could have a visit. Staff apparently asked the cousin about this and he agreed. This suggests that he too was willing to forget what had gone before. A Healthcare Officer also said during interview that a number of prisoners on G wing had signed a card for the man. The man's family sent me a copy. It is signed, inter alia, by the man's cousin and another of the four members of the foodboat, over which there had been the falling out. I have not been able to ascertain whether the fourth member signed the card or indeed if he was still in the prison at this time. At any rate, the sending of the card suggests that any animosity was much reduced, if indeed it continued to exist.[10]

I have considered whether proper account was taken of the apparent reconciliation between the man and his cousin. A governor said, when asked, that prisoners who had been segregated often said that the problem had been resolved but that, "Unfortunately our experience is that on most occasions it's not and on this occasion the evidence to suggest that there would be further trouble far outweighed the chance of putting him back safely." (It is worth noting that Mr Bell reported that the man's cousin considered a return to the wing would have been ill-advised, even though he and his cousin had resolved their differences.)

[10] Commenting on a draft of this report, the former Governor of Frankland suggested that the card might not be a reliable barometer of feelings on the wing towards the man, however.

The lack of contemporaneous records of reviews of the man's position and of security information make it difficult to form a judgement as to whether it was necessary to retain the man on the segregation unit between December and March and then again following his discharge from the healthcare centre. Staff refer to there having been several discussions on this matter, but there is no documentary evidence to show that the information on which they relied was up to date as opposed to deriving from the SIRs submitted in mid December.

Much seems to have relied on Prison Service experience in such matters – that is, that whatever appearances might suggest, it was unlikely that old hostilities would simply have gone away. (Arguably, the man's fragile mental health and paranoia would also have made him more vulnerable on the wing.) It seems to me that staff are entitled to draw on their experience when making decisions on matters that are not always susceptible to copper bottomed truth. Indeed, much of the safe running of prisons depends on them doing so and staff would have been rightly criticised if they had returned the man to the wing and he had been assaulted or worse. Nevertheless, the family remains unconvinced that the man would have been in any danger on the wing. I think the family are also entitled to draw upon their experience of the man and I share their concern about his continued segregation, especially in the period from late January onwards.

Commenting on a late draft of this report, the Deputy Director General of the Prison Service commented:

- "I challenge the conclusions regarding [the man's] return to segregation rather than G wing. It is apparent the investigator has been significantly influenced by new evidence – that another prisoner, [named], who had been identified as a threat to [the man] had left Frankland in early 2004. Whilst I do not dispute its relevance, it is reasonable that this should be presented in balanced way. It is far from clear that this prisoner was a significant factor in the minds of those actually making the decision in 2004. Indeed there is clear evidence that [the man] had fallen out with several prisoners, not just [named prisoner] (see the SIR of 3 July 2003, the interview with [a governor] and the SIRs of 13 December 2003). In addition it is noteworthy that in the new evidence (the letter written by [the man]) it goes on to highlight [the man's] lack of trust in [his cousin] and suspicion that there was an ulterior motive behind [his cousin's] attempts to 'sweeten [him] up'.

- In considering the prospects of a successful return to G Wing by [the man], in addition to his problematic history on G wing and the probability of ongoing tensions (as identified above), staff would also have to consider the problems of his apparent immaturity, lack of anger management and well-established pattern of institutional violence. In his interview, [a governor] refers to such broader considerations as contra-indicating a successful return to normal location at Frankland - we ask that these broader factors also be considered.

- Consequently, whilst it may be fair for the investigator to raise questions about the decisions made regarding [the man's] location, I argue it is not possible, based on the evidence available at the time, to conclude … that there was no danger in returning [the man] to G wing. This appears to be a test of a decision in the light of hindsight, rather than a reflection on whether the decision was reasonable in the light of the evidence and circumstances prevailing at the time. As a result I ask that necessary changes be made to the draft report to reflect our concerns."

As is my normal practice, I have considered the Deputy Director General's representations carefully. In dealing with any matters relating to prisoners – whether it be a death in custody or resolving a complaint – it is important to bear the context in mind. Prison is a very different environment from anything most people will be familiar with. Apparently straightforward matters may become complex and difficult because of the many issues around security and good order, the character of the population and the special responsibilities the Prison Service has to those in its care. For that reason, and as I have suggested above, there are many situations in which it is right that I should defer to the professional judgment - borne from experience - of staff.

I have considered what view I would have taken of the man's prolonged segregation and then his return to segregation following his spell in healthcare if it had come to my attention as the result of a complaint rather than the man's death. I would certainly have taken seriously the professional judgments of staff with regard to the man's character, prison history and the need for good order. In this case, however, the absence of contemporaneous evidence that the situation was kept actively under review and professional judgments brought to bear throughout the period of his segregation, mean it is likely I would have been very sympathetic to the complainant. Segregation is a serious matter. Its initial and continued use should be considered extremely carefully in light of current information. In the absence of contemporaneous records, I cannot be convinced that consideration of the man's segregation was afforded the necessary degree of care – especially from late January onwards. It is for this reason that I share the family's concern.

I also have concerns about the man's return to the segregation unit from the point of view of his mental health. (I consider separately below the question of the man's fitness to be discharged from the healthcare centre.) There is little documentary evidence as to his state of mental health before he went to the segregation unit in December 2003. His reported paranoia was first recorded on 4 April 2003, at Durham, but there is no further reference to his mental health until January 2004 when segregation unit staff became concerned about his behaviour and mental deterioration. They described him as 'not being the same person'. The writer noted that the man thought someone was controlling his mind and it was causing him anxiety. On 2 and 8 February, the segregation unit staff noted that the man was very withdrawn. In the history sheet on 6 March, he was described as "very withdrawn but

coming out of it". On 16 March, a segregation safety algorithm was completed which identified him as unsuited for segregation. The duty governor organised his transfer to the healthcare centre as soon as possible.

The deterioration in the man's mental health was therefore quite rapid. One of the prisoners in the segregation unit at the same time said the man did nothing to occupy himself whilst he was in the unit, despite attempts by other prisoners to encourage him to read or do crosswords. He said the man mostly just lay on his bed staring at the ceiling. He described him as a happy/jovial 'pest' when he first came on to the unit, but said his head was "totally fucked" after a period in the segregation unit. He said the man was very depressed, always had his head down and was uninterested in anything. He thought the problem was exacerbated by staff continually telling him different things about his transfer. The prisoner said that the man was not at all well when he was taken to the hospital. The deprivation he experienced in the segregation unit meant his "head had gone". (I consider later in this report the adequacy of the segregation unit regime.) The man himself told his brother in a letter that he felt much better in the healthcare centre and that, "Block was making me think far too much".

A safety algorithm was completed soon after the man's return to the segregation unit. The instructions on the form say that it must be completed within two hours of the prisoner being placed in the segregation unit. However, given that the man's move to segregation was planned, it would have been good practice for the assessment to have been carried out beforehand. As it is, it is difficult to avoid the suggestion that the form filling was a mere formality, and that its finding was a foregone conclusion.

I recommend that, where a transfer to the segregation unit is being considered, a safety algorithm is completed before a decision is made.

I was initially critical of the failure to refer to the earlier safety algorithm (on 16 March) when completing the later one. It seemed to me that concerns that were present on 16 March might at least have rung a few alarm bells on 13 April and caused the nurse to approach the assessment with more careful consideration than is required by the simplistic tick box approach. However, I accept the former Governor's advice that, "Each completion of a safety algorithm should be done on its own merits, based on the circumstances that prevail at that time." The then Governor suggested that the logical extension of my point was that the algorithm completed in December 2003 (which concluded that the man would cope with segregation) should have informed that completed in March. I accept that this would have been inappropriate. The Governor also advised that the nurse who carried out the safety algorithm in April was the same one who had completed it in March. As well as being aware of the man's general condition from his time in the healthcare centre, he should have been aware of the circumstances that led to him being transferred out of the segregation unit on 16 March.

I am reassured to some extent by this, but remain anxious that the gateway to consideration of whether the prisoner's mental health would deteriorate

significantly if segregated is only via a history of self-harm, an open F2052SH or the prisoner currently being on anti psychotic medication. Because none of these applied in the man's case, the form does not require the assessor to consider the impact of segregation on the prisoner's mental health. (I am not sure that the separate question of whether the prisoner would be able to 'cope' with segregation necessarily gives rise to the same considerations.)

However, at the time of his discharge, the man's demeanour was stable and he had apparently told staff that he was content to go to the segregation unit (although his letters from this period clearly show that it was his wish to go back to the wing).

The timing of the rapid deterioration in the man's mental health, together with evidence of the other prisoner and the man's letters, suggests that segregation was largely the cause of it. Whatever his fitness to be discharged and the efficacy of the medication he was on, I question whether it was appropriate to return him to an environment that had previously had such a detrimental effect on his state of mind. This concern is substantiated by the immediate return of clinical symptoms of anxiety following his transfer back to the segregation unit.

Within three days of his discharge from the healthcare centre, confirmation of a transfer to Rye Hill during the week commencing 19 April 2004 was received at the prison. It is clear therefore that steps were already in hand to secure a transfer for him. Indeed, given the timing of the confirmation, it seems entirely likely that staff knew of an agreement in principle to transfer the man. They therefore knew that his stay in the segregation this time would be short. With the undoubted benefits of hindsight, I believe the better course of action would have been to retain the man in the healthcare unit pending his transfer. However, I am aware of the problems caused by bed-blocking and it is clear that, by this time, the man was considered to be fit and well. I also note that HM Chief Inspector of Prisons had been critical of Frankland for not controlling the problem of bed-blocking in healthcare.

Nevertheless, and notwithstanding unresolved concerns about the need to keep the man in the segregation unit, I do consider that more thought could and should have been applied to his management upon his return there, in terms of giving his day some structure and keeping him stimulated.

The extent to which the provisions of Prison Service Order 1700 (The Management of Segregated Prisoners) were followed

The quality of segregation review boards

The man's family have complained that the segregation review boards simply rubber stamped the original decision to segregate the man for his own protection.

Prison Service Order 1700 makes clear that all periods of segregation should be properly authorised and that a segregation review board should be

convened within 72 hours of the initial segregation. Thereafter, subsequent review boards should be convened at intervals no longer than 14 days. Boards must comprise a chairperson and a healthcare representative. The prisoner should be invited to attend. Ideally, boards should also be attended by a segregation unit personal officer, a chaplain, a psychologist and a member of the Independent Monitoring Board (IMB). Each board is expected to consider and review:

- the reasons for the initial segregation;
- the extent to which the prisoner has met targets set at previous reviews;
- any concerns that may have come to light about how the prisoner is coping with segregation;
- what the prisoner needs to demonstrate in order to be considered for a return to normal location;
- the privileges or incentives that might be awarded or removed;
- the option of transferring the prisoner to another establishment.

A form entitled "Segregation Review Board - Governor's Continued Authority for Segregation" should be completed and signed by an Operational Manager.

Initial review board - 17 December 2003

The first segregation review board took place on 17 December. This was within the 72 hour period prescribed by the PSO. The board comprised an operational manager, the unit principal officer, and representatives from the IMB, the security department and the healthcare centre. The man was present. The correct form was used to record the business of the review. It said that the man had been compliant with the unit rules and regulations. There were no specific concerns about his mental health. The fact that he was not on an open F2052SH was noted. No privileges or rewards had been awarded or removed at that stage. The behaviour targets set were that he should conform to the unit regime and communicate with staff. He made written representations to the board in which he claimed that, because he was innocent of the charge of assault and was not a control problem, his segregation was pointless. Nevertheless, the board decided to authorise his segregation for a further two weeks. He was to have access to the whole range of activities and facilities available in the unit, including education and library, but not work, PE, television or association. The next review was to take place on 31 December.

On this occasion, most of the procedures laid down in PSO 1700 were properly followed. However, the targets set were not imaginative and they were not geared towards keeping the man occupied in constructive activity.

Review board - 31 December

The next review board took place on time on 31 December. It comprised two senior managers, a doctor, a senior officer and a nurse. Once again, the man was present. In the general notes box on the review proforma, it was noted that the man could appear immature at times, that he had poor social skills

and could not maintain eye contact. It was minuted that he was complying with the unit regime. His segregation was to continue for a further two weeks. He was set two targets - to conform to the regime and to be interviewed by wing management. The regime activities to which he was to have access remained unchanged. The next review was to take place on 14 January.

Review board - 14 January 2004

The paperwork presented to the investigating team in relation to this review is confusing. Only part of the correct review board proforma was included in the documents available and there were no details of who attended. Although it is likely that the man attended the review, the paperwork does not make this clear. The man submitted a very detailed paper to the board in which he set out his arguments against segregation. Nevertheless, the board decided that he was "To remain segregated until interviewed by wing management who are considering your return to the wing." (It seems likely from the Record of Events that this target was superseded by information from security the next day that it would not be safe for the man to return to the wing. Certainly, there is no record of such an interview having taken place.) His segregation was authorised until 28 January 2004. The man was to have access to the same regime facilities as set out in previous reviews. He was told that he was being considered for a transfer to another establishment.

Review board - 28 January

The minutes of this review are recorded on the correct proforma. The review was attended by a multi-disciplinary team of four staff and by the man himself. The board recorded that he had been experiencing chest pains which were diagnosed by healthcare staff as panic attacks. The man was described as being concerned about his move now that he knew he was to be transferred. Surprisingly, despite this last observation and the fact that segregation unit staff had reported to the healthcare centre their concerns about the man's mental state, no mental health issues were identified. There is no reference to the planned interview, either to show the target no longer applied, that it was yet to be met or that it had been met. The man's segregation was authorised for a further two weeks until 11 February and he was set targets that required him to comply with the regime and to build positive relationships with staff. No targets were set that were likely to keep the man's mind occupied in constructive or stimulating activities. Of the regime activities available in the unit, the man was not to have access to work, television or association, although he was allowed access to education and library facilities. (One of the prisoners interviewed was very critical of the limited number of books available in the segregation unit 'library'). The 'exercise' box was also ticked as being disallowed, but I understand that this was an administrative error and that the man was in fact allowed exercise.

Review board - 31 January

Although the next segregation review board was scheduled for 11 February, some segregation review paperwork was raised just three days later. On this

occasion, part of the correct proforma was used to record the business of this review. On one side of the form is recorded a comment that the man's history sheet stated that he was still not attempting to communicate with staff but that he was conforming to the regime. On the reverse side of this form are details of the review that took place on 14 January. This may be evidence of nothing more than a photocopying error. It is therefore difficult to comment on this particular 'review' beyond highlighting the manner in which the paperwork was assembled.

Review board - 11 February

This review was attended by a multi-disciplinary team and by the man himself. The correct review proforma was used. It recorded that the man had been quiet during the previous two weeks, that he seemed to have no future at Frankland and that a move to another establishment would be beneficial. No mental health issues were identified, even though the man had been described by staff as very withdrawn and lethargic. He was to remain segregated for a further two weeks, to comply with the regime and to communicate with staff. The record shows that he was to be transferred to another establishment. The man was to have access to work, exercise, education, and library, but not to the gym, television or association. The next review was to take place on 25 February.

I am concerned about the continuing lack of any stimulating and imaginative targets that might have kept the man's mind occupied in constructive activity. In addition, although the record makes clear that the man was allowed access to education and library facilities, there is no evidence to show that he took up any of these options. The segregation history sheet did not provide a comprehensive record of what the man did each day (contrary to guidance in the PSO). In addition, the efforts being made to transfer him should have been discussed at, or between, review boards and a record of that discussion ought to have been made during the review.

Review board - 25 February

This review was attended by a multi-disciplinary team and by a representative of the IMB. The man was also present. On all previous reviews, the 'Initial reasons for segregation' had been given as, "He was segregated until the outcome of the adjudication for alleged assault on another prisoner." On 25 February, however, the wording was inexplicably changed to, "[The man] is alleged to have assaulted another prisoner to remain segregated until outcome of adjudication." This is worrying, since it suggests a recent assault. (There was none.) The report goes on to say under 'General notes about behaviour and attitude since last review', "Has been placed on report since last review and punished 4 days cc." Following as it does from the previous entry, it suggests the four days cellular confinement (cc) was given for assault. In fact, the man was adjudicated upon for damaging a bedsheet. He was not given four days cellular confinement, but four days loss of privileges (I say more about this below). In the section for recording concerns about mental health is written, "No problems", despite ongoing and documented

concerns by segregation unit staff about the man's mental health. He was to remain segregated for a further two weeks. The only target set for him was to conform to the regime. He was denied access to work and the gym.

There is no record of clear and detailed communication with the man about transferring him, and no meaningful targets were set. Again, the segregation history sheet did not identify how he spent his days.

Review board - 10 March

At this review, which was again attended by a multi-disciplinary team, the IMB and the man, it was noted that he appeared withdrawn and subdued while awaiting transfer. Despite this comment, it is recorded that no mental health issues were identified. The man was told that it was unsafe for him to return to a wing and that he was therefore to remain segregated. Again, his only target was to comply with the regime and he was denied access to work gym, television and association. No detailed history sheet was evident.

The paperwork gives the impression that, by this time, the review process had become little more than a "tick-box" exercise. In this respect, I share the family's concern that the periodic reviews had become a rubber-stamping exercise. I am also very concerned that, with the exception of the review on 10 March which noted that the man was withdrawn and subdued, there is no evidence that the review board was aware of, and therefore considered, his mental health issues when agreeing his continued segregation.

I recommend that review boards convened to consider a prisoner's continued segregation specifically consider questions relating to the prisoner's mental health and ability to cope with segregation.

It is disappointing that, despite the length of time that the man was segregated, more imagination, thought and energy was not invested in his reviews. By 10 March, the man had been segregated continuously for nearly three months. There is no evidence that, during this period, he had engaged in any purposeful activity, or that he had been encouraged to do so. This makes the absence of detailed information about how he used his time particularly significant. Had the board been aware that he did little but lie on his bed staring at the ceiling, they might have applied themselves more effectively to setting challenging and meaningful targets.

It seems that a decision to transfer the man was probably taken in the second half of January. This appears originally to have resulted from the conclusion that it would not be possible to return him to the wing. Arguably, this was not an unreasonable conclusion to reach - even after allowing two months for tensions to ease. Nevertheless, one might have expected staff to have kept the question of a return to normal location under active consideration whilst efforts were made to secure a transfer.

However, during the period in which the man was in segregation, staff had come to the conclusion that he simply was not suitable for Frankland. He was

considered to be too immature to be able to settle well with a population which was mostly older and serving long sentences. The governor charged with effecting a transfer said during interview:

> "Given his age and what we observed of his temperament … he didn't strike us as terribly mature in the way he conducted himself at times, and so we felt that probably he would be better located outside the dispersal system and that might give him more of an opportunity to cope better and get on better …"

In light of this and a possible expectation that a transfer would be achieved fairly promptly, it is perhaps not surprising if the board ceased to give proper thought to whether the man could be safely returned to the wing. But this did not in any way detract from the responsibility of staff and the various boards to ensure that the man's safety was not compromised in a different way – that is, as a result of an impoverished regime in the segregation unit.

Segregation period: 13 to 15 April 2004

I now turn briefly to the man's final period of segregation that followed his discharge from the healthcare centre on 13 April. On that day, a segregation safety algorithm was completed. It suggested that there were no healthcare reasons against segregation. The man's segregation was formally authorised at 2:10 pm, when a Governor's authority for initial segregation up to 72 hours was completed. The operational manager who completed the form noted that the man was to be segregated for the good order or discipline of the prison following an assault on another prisoner. It also noted that the man was "pending transfer". The form that indicates what regime activities the man could access was left blank. On this occasion, a segregation history sheet matrix was evident, but it does not record any information about how he was to spend his day. Although the date on which the form was completed is correct, the date of the 72 hour review is shown as 16 March instead of 16 April. The man died the day before this review was due.

Overall, I am satisfied that the boards convened to review the man's segregation were appropriately programmed and, that they were, for the most part, properly constituted. However, I am concerned at Frankland's apparent failure to set and monitor imaginative targets that might have helped the man to engage in constructive activities and thereby safeguard his mental health.

Promoting and safeguarding the mental health of those who are segregated

Included in PSO 1700 is a list of measures staff can employ to promote and safeguard the mental health of prisoners who are segregated. These include:

- increasing the level of medical support;
- increased staff observations;
- encouraging prisoners to keep in touch with family and friends through letters, phone calls and visits;

- encouraging prisoners to take exercise, including PE;
- relaxation: watching television, reading;
- education/hobbies;
- talking to someone.

I make the following observations in respect of the subject of this report:

- *increasing the level of medical support*

The man was appropriately referred to a psychiatrist before and during his segregation. The psychiatrist considered that he was suffering from a personality disorder that could be treated by his allocation to a unit for prisoners with such a disorder. He asked for the man to be assessed for that unit.

Segregation unit staff liaised with healthcare staff at times when the man showed signs of mental deterioration.

- *increased staff observations*

There is no evidence that this measure was specifically applied at any time during the man's segregation. There was a clear and pressing need to consider this option after the referral made to the healthcare staff on 20 January.

- *encouraging prisoners to keep in touch with family and friends through letters, phone calls and visits*

There is no evidence that staff in the segregation unit actively encouraged the man to keep in touch with his family and friends. No targets in this respect were set at any of his review boards. In fact, the man sent only two letters during his entire period in segregation – one to his brother and one to a friend on 23 and 24 February respectively. He had three visits during January – two from a friend and one from three family members – but none subsequently. The man did, however, in general make telephone calls every couple of days or so.

- *encouraging prisoners to take exercise, including PE*

The man was not allowed access to the gym at any time during his periods of segregation.

On 29 December, the man's requests to be allowed to exercise were refused. In a draft of the earlier report, I was critical of this refusal and of the suggestion (implied by the need for prisoners to apply for exercise) that exercise was treated as a privilege rather than a right. The then Governor explained that the application system (which applied also to other facilities such as showers, access to the telephone etc) existed to enable staff to plan the day effectively, given that they had to cater for each activity by each prisoner to take place separately from any other. He suggested that, in light

of the impact the man's change of mind might have had on others, the refusal might not have been unreasonable. He also pointed out the suspicion that the man wanted exercise to enable him to traffic drugs. I accept his comments. Nevertheless, I hope that staff respond flexibly where possible to spontaneous requests from prisoners and do not adhere blindly to the application system.

- *relaxation: watching television, reading*

No in-cell television was available at the time the man was segregated because no electrical sockets had been installed in any of the segregation unit cells. Despite the fact that the segregation review board records show that the man was routinely permitted access to library facilities, it seems from the evidence of another prisoner who was in the segregation unit at the time, that he simply was not interested. The prisoner also said that, in theory, prisoners were allowed to have in their cells whatever they would have on normal location. This was not always the case, however. He said they were allowed a radio, but not CDs. They could have two or three tapes at a time, but would then have to put in an application to exchange them. This could take weeks, depending on how staff felt. He said the batteries in the man's radio only lasted an hour and a half and that he would then be impatient for the next canteen so that he could use his radio again. It is significant that this prisoner referred unprompted to prisoners encouraging the man to do something. They, at least, seem to have been alert to the dangers of complete inertia.

- *education / hobbies*

The segregation review board records show that the man was normally allowed access to education facilities, but there is no evidence that he made good such an opportunity or that he was actively encouraged to do so. No targets were set for him in this respect.

-
- *talking to someone*

The segregation review board records show that the man was given continual targets to communicate with staff.

However, the prisoner referred to above described the segregation unit as quite tense. He said staff were only really comfortable when everyone was locked up. He said some staff would tend to "get in the faces" of the young, weak or small prisoners and would harass them, hurrying them along at whatever they were doing so as to get them locked up again as soon as possible. He said there tended to be two 'firms' of staff. There were those who took the 'care bear' approach and those who were macho and overbearing. Much depended on who the Senior Officer was on a particular shift. The prisoner said a couple of officers "got on [the man's] case" because he would not "kowtow" to them. (The prisoner could not identify or describe either officer, however, so I have not been able to investigate this allegation. No other prisoners corroborated it.)

Arguably, the questions relating to the appropriateness of keeping the man in segregation would have been much less important if active steps had been taken to promote and safeguard his mental health during his three months there. That the segregation unit at Frankland fell short in so many ways of the provisions of the PSO in this respect gives genuine cause for concern. It is this, rather than the decisions to keep the man in segregation of which I am most critical.

I recommend that the Governor ensures that the full provisions of PSO 1700 are met in respect of any segregated prisoner. Specific measures that need to be taken include:

- **ensuring that segregation review boards set prisoners targets that seek to promote their engagement in purposeful activity;**

- **ensuring that segregation review boards consider the suggestions listed in the PSO for the promotion and safeguarding of prisoners' mental health, and implement appropriate measures.**

Adjudication

The man's somewhat barren existence in the segregation unit was exacerbated following an adjudication on 14 February for allegedly damaging a bedsheet. The details of the offence were that two officers conducting kit change the previous day noticed that his sheet was damaged.

The man's family are critical that the man was put on a charge for this when it was possible that he might have damaged the sheets whilst trying to make a ligature. There is evidence in the adjudication papers that the adjudicator inquired into the nature of the damage. However, he did not record his findings. Miss McMurray made enquiries to establish what the damage was. The then Governor advised that the reporting officer did not recall the offence or the adjudication at all, whilst the adjudicating governor had a vague recollection that the sheet had been unpicked to make a line (to move items between cells). However, he could not be certain of this.

The then Governor's view was that the damage was not the result of the man making a ligature. The reasons for his view were that:

- there was no evidence to support any suggestion to the contrary;
- the fact that staff could not recall the detail of the incident suggested it was entirely routine. He said that damage to sheets, particularly to make lines, was quite common in the segregation unit; and
- it is not practice at Frankland to charge a prisoner where prison property is used to make a ligature (as had happened from time to time). The Governor added that, "in the highly unlikely event that an officer did lay a charge in such a situation, I do not believe an adjudicating governor would find the charge proven." (The fact that the adjudicator specifically asked about the nature of the damage tends to support this.)

The man said he did not damage the sheet himself and that it was damaged when he got it. (This of itself suggests that the damage was not such as might be expected had the man torn it intending to use it as a ligature, since a sheet so damaged would not have been given to him.) He said that, when he received his kit, he had not realised he was signing to confirm that it was in good condition. He was found guilty and punished with loss of canteen/use of private cash, association, tobacco, publications, radio, occupations in cell and possessions in cell for four days.

I have a number of concerns about this adjudication. I am a little surprised that the medical officer found the man fit for cellular confinement, in light of the detrimental effect on his mental health of the impoverished segregation regime. Similarly, it seems to me that depriving the man of any means with which to occupy himself for four days would be harsh in any circumstances. In the particular circumstances that obtained (the decline in the man's mental health brought on in part at least by inactivity), the punishment was inappropriate.

Although the record of adjudication makes the punishment quite clear, it is worrying that the punishment was recorded in the man's history sheets and on the segregation review board papers as four days cellular confinement. Since these entries would have been made by those responsible for implementing the punishment, it seems likely that, notwithstanding the adjudicator's intentions, the punishment actually served would have been four days cellular confinement. If that was the case, it was an unacceptable mistake and one that was likely to have been detrimental to the man's state of mind.

Was the threat of self-harm taken seriously enough?

The man's family expressed concern that the risk of the man self-harming was not taken seriously enough by prison staff.

In a draft of this report, I suggested that an early opportunity to re-assess the risk of self-harm had been missed, when there was no follow up by staff to the man contacting the Samaritans on 15 December and speaking to a Listener on 16 December. However, the then Governor, advised by a member of the NOMS, Safer Custody Group, pointed out that a balance needed to be struck between intervention and the need to provide prisoners with free access to support agencies, without the risk of deterring them by asking them questions afterwards. The then Governor said, "The very last thing we want to be doing is inhibiting prisoner contact with Listeners and Samaritans by making some of them think that to do so entails the risk of being subjected to what are often perceived as obtrusive methods of supervision." I agree. Nevertheless, I would hope that staff would at least offer the prisoner the opportunity to talk to them about any problems or issues.

On 12 March, the man's father rang the prison to say he had spoken to his son and was worried about him. He said his son said he could not cope with his sentence. The message was relayed to a Principal Officer, who in turn asked for an F2052SH to be opened.

A review was carried out the next day. The doctor reported that the man had said he was not suicidal in any way and that he had just been trying to manipulate his father. The doctor concluded therefore that the F2052SH could be kept open for a further 24 hours and then closed.

The segregation unit Senior Officer said that, from what they had observed of the man (his acting withdrawn), segregation unit staff had "niggling concerns" that there might be more to it. The Senior Officer was a psychiatric nurse and said he was aware that depressed people hid their feelings. He had therefore sought the advice of the duty governor. It was agreed to keep the F2052SH open for the full 72 hours as a precautionary measure and to enable staff to get a better picture of the man's mood and ideation in the interim.

The man was present at the 72 hour review at which staff tried to explore with him why he was feeling so low. He apparently said he was feeling depressed and paranoid and was having interrupted sleep. He said he was hearing voices telling him to do things – but not to self-harm. As a result of concerns arising from this review, he was transferred to the healthcare centre. He remained on F2052SH measures for a further 10 days. (The clinical review looks at healthcare management of the F2052SH procedures.) The F2052SH was finally closed following a review on 26 March. The man said again that he was not suicidal and had no thoughts of self-harm. He also said the medication he was then on was working. The decision to close the F2052SH was unanimous.

I do not agree with the man's family that the threat of self-harm was not treated seriously. On the contrary, and despite the man's assurances that he was not contemplating self-harm, staff opened and kept open for two weeks an F2052SH. The detail on the support plans indicates the seriousness with which they viewed the matter.

Several prisoners were critical that the man should have been on F2052SH procedures and located in either a cell with a camera or a safe cell following his return from the healthcare unit. It is difficult to know to what extent their views were coloured by subsequent events. Did they genuinely feel at the time that the man was vulnerable or was it the case that he "must have" been suicidal because he went on apparently to kill himself?

The fact is that a decision was made by experienced staff that the man was no longer at risk. Clearly, it would be wrong of me to second-guess that decision, as I was not there, did not know the man in question and have no practical expertise. The outcome of the final review rendered the measures advocated by the other prisoners unnecessary. In addition, there is no evidence to suggest that a further F2052SH should have been opened thereafter. The man manifested no obvious signs that might have led staff to believe that he was at a heightened risk of self-harm or suicide, or that he needed to be observed more frequently than he was.

In light of subsequent events, however, I have considered the mechanics of the decision to close the F2052SH. Only nurses and healthcare officers were present at the final review. None of them was of management grade. (This was contrary to the guidelines which say, "When deciding on closure, the chair of the case review must be a minimum grade of SO or Nurse Grade F".) I am also concerned that there were no residential staff (or indeed managers) present when the decision was made to close the F2052SH. It is difficult to judge the significance of this. Manifestly, a differently composed group might have made a different decision - and segregation staff, in particular would have been able to offer a different perspective. On the other hand, segregation unit staff had had little, if any, contact with the man in the intervening period and would therefore have had little to offer on his state of mind at that time. Nevertheless, the fact that guidance on the constitution of final review panels was not followed is a cause for concern.

Local guidelines state that newly closed F2052SHs should be passed to the Safer Custody Manager. The purpose of this is to ensure information relating to the support plan is cascaded to relevant staff and to enable the Safer Custody Manager to conduct appropriate post-closure reviews of the support plan. I am concerned that this did not happen in this instance. As a consequence, the extent to which the targets set out in the man's support plan were communicated and followed was not reviewed. I regard this as particularly significant in light of the fact that the man had been returned to an environment where he had not previously thrived. In those circumstances, I would have expected the Safer Custody Manager to monitor progress especially rigorously.

I recommend that:

- **The Governor ensures that closed F2052SH documents are passed to the Safer Custody Manager so that post closure reviews can be held.**

- **The Governor ensures that F2052SH case reviews convened for prisoners in the healthcare centre who are likely to be discharged to the main prison are attended by an appropriate representative from the unit to which they are likely to be allocated, as well as by healthcare staff.**

Clinical review

Health screening

Ms Frances concluded that the conduct of the man's initial healthcare assessments at Durham was lacking in rigour, failing to follow the instructions on the printed form. She noted discrepancies between the assessment by the healthcare worker and the doctor. For example, the man had admitted to the healthcare worker that he had been drinking 12 cans of lager per day and the healthcare worker ticked the box indicating the reason for referral to the doctor was 'DETOX'. However, the doctor found no evidence of heavy drinking and there was no evidence of any follow up on the man's alcohol consumption.

The man had stated that he was depressed and reported taking an antidepressant, Trazodone. Ms Frances suggested that this should have triggered a referral to a CPN. The doctor also noted that the man needed to see a CPN. In the event, he was not seen by a CPN until 4 April 2003 and only then as the result of a referral by discipline staff because they were concerned about his behaviour and expressions of anger.

The man was comprehensively assessed by the visiting psychiatrist on 7 April 2003. The psychiatrist diagnosed a probable severe conduct disorder since childhood. He recommended consideration be given to transferring the man to the DSPD unit at Frankland, adding that he must be considered to present a high risk of violence to other prisoners. The man was moved to Frankland within three weeks of that consultation, yet on reception at Frankland he was recorded as having no psychiatric history.

Ms Frances noted that the form used by the reception healthcare staff at Frankland to assess 'Risk factors associated with suicides in dispersal prisons' asked questions about previous or current psychiatric history and current or past anti-depressant medication and that both were answered erroneously in the negative. She said that whether the fault lay with the man or the member of staff cannot be determined, but that a simple scrutiny of the man's records would have shown that he was positive for both these factors.

Ms Frances concluded that the flaws on reception at Frankland hindered an early assessment of the man's mental state. She suggested that the forms in use at Frankland at that time were not fit for purpose but that the situation was exacerbated by poor information gathering. Ms Frances said the man should routinely have had a mental health assessment given his history, but this should have been prioritised given the possibility of him being a candidate for the DSPD unit. Ms Frances commented that, in light of the delay between the events and this report, it is doubtful how useful any recommendation might be. Nevertheless, she made a recommendation which I endorse:

When a prisoner is transferred to Frankland with a recommendation for consideration for the DSPD unit, this information should be conveyed to

healthcare staff at the earliest possible opportunity, preferably in the form of a written note.

Psychiatric care

On 20 January 2004, a doctor saw the man at the request of discipline staff in the segregation unit who were concerned about his behaviour and mental deterioration. The doctor arranged for the man to be discussed by the MHT. The team agreed, on 21 January 2004, that he should be referred to the visiting psychiatrist (who had seen the man at Durham). The contemporaneous record from that meeting stated that the psychiatrist would see the man the following week. In the event, the visiting psychiatrist assessed him on 3 March and conducted a further review on 24 March. (When the psychiatrist saw the man on 3 March, he said he would review him in one week. An entry on 6 March mentioned that the man 'now agrees' to see the psychiatrist. The psychiatrist did not see the man until 24 March, but this particular entry suggests that the man may have initially refused his next appointment.) the visiting psychiatrist concluded that the man was a good candidate for either the DSPD unit or Grendon and a referral was made on 25 March.

Ms Frances was concerned that, despite the psychiatrist's recommendation when he saw him in Durham that the man be considered for the DSPD unit at Frankland, the man was at Frankland for almost a year before that referral was made. She said this represented an unfortunate and avoidable delay in giving his candidacy due consideration.

Ms Frances commented that it was difficult to frame a recommendation that could inform the general issues of referral, and noted that the man's case was no doubt made more complex because there were operational reasons for his transfer as well as the recommendation by the visiting psychiatrist.

She judged that the assessments and review by the psychiatrist were of a very high standard. She said his contemporaneous reports directly into the CMR were an example of best practice in communication and continuity of care.

In-patient care and records and record keeping

When the man was admitted to the healthcare centre at Frankland, a 'Short Stay Care Plan' was opened. After a few days, it was apparent that this was inappropriate. However, the form did not allow for a full assessment of the man's physical or, more importantly, mental health. Ms Frances concluded that the short stay care plan was not fit for purpose and should have been replaced by a full care plan after a maximum 48 hours.

Ms Frances noted that part of the care plan was to maintain the man's regime as it had been in the segregation unit, where he had been on a restrictive regime under the auspices of PSO 1700. She concluded that the plan to maintain that regime in the healthcare centre was outside the remit of the

Rules and was inappropriate and unacceptable in a therapeutic setting. Ms Frances said managers should have picked up on what was happening and stopped it. What happened was not in line with either local or national policy. I share Ms Frances' view that it was wholly inappropriate that a 'punishment' regime was applied in healthcare.

Records about the man were being kept in the care plan, the CMR, the healthcare centre log and the F2052SH. Ms Frances commented that this led almost inevitably to duplication and, more significantly, shortcomings in the comprehensiveness of any one record on its own. Ms Frances suggested that the burden of recording in so many places is great. She commented that the use of a number of recording documents at the same time should have been monitored for continuity and comprehensiveness by managers.

She added that, in general, record keeping was flawed in respect of keeping entries in chronological order. This applied at both prisons as did the "all too common failure" to time entries (except in the F2052SH) and sign legibly or, where the signature is unclear, add the name in capital letters.

Finally, Ms Frances commented that the maintenance of the healthcare centre log on separate sheets of paper designed for another purpose altogether was unacceptable.

Ms Frances made a number of recommendations, all of which I endorse:

The healthcare manager must review and revise policies for records and record keeping, including completing care plans and the use of the short stay care plan and ensure the healthcare log is maintained in an appropriate ledger or diary.

The Governor must ensure that healthcare staff are aware of the limits on the implementation of Prison Rule 45, Good Order or Discipline.

The Governor should, in conjunction with his local Primary Care Trust, remind staff who make entries in medical records of the need to identify themselves clearly.

Suicide and self-harm

Ms Frances advised that the suicide and self-harm documentation presented a number of areas for concern. The first was that there was no record in the CMR that an F2052SH had been opened for the man, despite a nurse undertaking a health assessment and completing page 5 of the document. She said it was a common and recommended practice that the healthcare staff should be made aware of and record which prisoners were on suicide and self-harm monitoring. Annex B of Prison Service Order 2700 refers:

> "A doctor, nurse or healthcare officer must, where the F2052SH has been raised by non healthcare staff:

- Obtain the IMR and discuss prisoner's needs with the Residential/Wing/Unit Manager, checking for any medical risk factors.
- Record the raising of any F2052SHs in the IMR (whether or not referred) and in the F2050A, together with any advice given or assessment of the prisoner."

The second concern was that the four times per hour observations were recorded as being carried out, in the healthcare centre, at regular 15 minute intervals from 9:15 am on 17 March to 7:15 am on 18 March. Ms Frances noted that this breached the guidance for checks to be made randomly. The wording in PSO 2700 is:

> "The checks must not be spaced at regular, and therefore predictable, intervals. In the past, prisoners being checked at predictable intervals have killed themselves between supervision times."

The third concern was the poor standard of entries in the Daily Support and Supervision Record. PSO 2700 gives clear guidance on what is required:

> "Report any further observations (including at night) and contacts with the prisoner and subsequent follow up action in the daily supervision and support record, including any change in mood or behaviour, failure to collect prescribed medication (as informed by healthcare staff) and any information received from outside the establishment. Bring any concerns to the attention of the manager of the unit where the prisoner resides.
>
> Ensure all F2052SH entries are legible and dated - print name (not signature) next to all entries - and that whenever possible entries demonstrate meaningful interaction, e.g. conversation, with the prisoner."

Ms Frances advised that this guidance had not been met.

Related to this, the fourth issue Ms Frances identified was the quality of management checks in the F2052SH. This was a breach of the guidance on quality control in Annex B of PSO 2700:

> "A Residential Manager or duty Governor must audit the quality of F2052SH entries at least twice a week, draw deficiencies to the attention of line managers, monitor the response, and record that they have made these checks."

While management checks had been made and recorded on a locally produced separate sheet in the F2052SH, there was no evidence that staff's attention had been drawn to the insufficiency of meaningful entries in the daily supervision and support record.

Finally, Ms Frances noted that the man's F2052SH was closed by a healthcare officer. No-one from the segregation unit or any other residential unit was present and none of the participants was of senior officer or equivalent rank. This too was a clear breach of PSO 2700:

> "The F2052SH will be closed at a case review when the prisoner appears to be coping satisfactorily. When deciding on closure, the chair of the case review must be a minimum grade of SO or Nurse Grade F. The case review will agree after-care or follow-up requirements."

In the light of the above concerns, Ms Frances concluded that standards of implementation of PSO 2700 were poor in several respects. She recommended that:

The Governor should take steps to ensure that all healthcare staff and their managers are fully conversant with PSO 2700 (or as now applicable the ACCT procedures) and have been trained in suicide prevention and self-harm management to the same standard as required for discipline staff.

I endorse that recommendation.

Mechanics of discharge from the healthcare centre

A Short Stay Care Plan was opened when the man was admitted to the healthcare centre on 16 March. Ms Frances said this suggested that the admitting nurse, a healthcare officer, expected him to stay 48 hours or less. His discharge from the healthcare centre was first mentioned by the writer of an entry on 20 March who noted that the man felt he was well enough to leave the healthcare centre.

On 21 March, in the same handwriting, an entry stated that the man was:

> "For GP review re discharge and possible medication review tomorrow am, seg informed of possible discharge."

An entry in the CMR on 22 March, over an illegible signature, but from the content probably that of a doctor, stated:

> "Staff feel he is calmer but he says is still a little agitated and having 'bad thoughts'. Increase CPZ to 100mgs bd. If settles can move to seg."

On 7 April, the writer of an entry in the CMR, which could have been by a nurse or a doctor, noted that the man appeared to be 'fit to be on wing'. The next entry in the CMR was by the healthcare officer on 13 April. During interview, the healthcare officer agreed that the entry read 'Fitted return to Seg'. She told the interviewers that this meant that "the doctor would have

seen him and fitted him for to return". Ms Frances noted that there was no entry from a doctor to corroborate this.

On 14 April at 10:30 pm, the man told another healthcare officer that he was experiencing the same kind of chest pain as when he was in the segregation unit previously and associated the pain with being 'wound up'. The healthcare officer reassured him and told him he would be seen by the MHT on 15 April.

Ms Frances concluded that there was no evidence of a managed and co-ordinated approach to the man's discharge from the healthcare centre. His initial management was short term, but in the event he was in the healthcare centre for 28 days. There was no written record of a systematic approach to his discharge by doctors or nurses in either the CMR or the care plan. Ms Frances suggested that his swift return to a state of agitation, and physical symptoms such as chest pain, might be construed as evidence that he was not fit to return to the segregation unit when he did.

Ms Frances recommended that:

The doctor discharging a patient from the healthcare centre in-patient unit to another location should make a clear statement of any issues s/he has considered of relevance to the patient's fitness for discharge and any continuing care in the continuous medical (now clinical) record.

I endorse the recommendation.

Discharge from the healthcare centre

In light of suggestions from some of the prisoners to whom she spoke that it was not appropriate for the man to have been discharged from the healthcare centre on 13 April because he was depressed and paranoid, Miss McMurray considered the contemporary documentation. The healthcare records show that the man was first considered to be fit for discharge on 7 April. However, he was not actually discharged until 13 April. There is no contemporaneous account of why he was not discharged on 7 April or why he was discharged on 13 April. The records that were made are ambiguous, in that a nurse wrote in the man's IMR that he was "Fitted return to seg" but "Fitted" has been crossed through with a zigzag line.

Miss McMurray asked the (now) healthcare manager,:

- why the man remained in the healthcare centre after he was apparently judged fit to be discharged on 7 April;
- why he was subsequently discharged on 13 April in particular;
- who actually fitted the man for discharge on 13 April and why the word "fitted" had been crossed through; and
- what the man's state of (mental) health was on 13 April.

Prolonged stay in healthcare

The healthcare manager advised that the segregation unit admissions book showed that there were relatively high numbers of prisoners in the unit around the time of the man's being fitted for discharge. He said he also understood that there were some difficulties with complex relationships between some of the prisoners in the segregation and healthcare units. He said the then segregation unit governor was on annual leave and it was likely that a decision might have been delayed until his return. The segregation unit governor had advised the healthcare manager that the man's continued stay in the healthcare centre (as a lodger) might have aided his transfer (in view of the reluctance of category B prisons to accept prisoners from dispersal segregation units). The healthcare manager suggested that the decision to keep the man in healthcare appeared therefore to have been aimed at supporting or expediting his transfer to another location.

Discharge on 13 April

The healthcare manager said it was unclear from the paperwork why the man was moved to the segregation unit on 13 April particularly, but believed there was some pressure on healthcare beds. (This is supported by unrecorded evidence to Mr Bell from a nurse.)

Who fitted the man for transfer and why was "fitted" struck through?

The healthcare manager advised that it was standard practice for the GP to do a healthcare round every morning, and he therefore had no reason to doubt that the man was seen by the duty GP and fitted accordingly by him. He explained that, on occasion, the nurse would write in the IMR on behalf of the doctor, owing to time restrictions on the GPs. This was why the entry was made by the nurse rather than a doctor (this is in line with the nurse's evidence to Mr Bell). The healthcare manager added that there had been discussions surrounding nurses writing 'fitted for discharge' in medical records and that the nurse and the doctor had suggested the word 'fitted' may have been removed, owing to the nurses' fear in relation to accountability. Finally, the healthcare manager advised that fitting someone for the segregation unit was based on a safety algorithm and that prisoners were not fitted for the segregation unit directly from healthcare, but merely fitted for residential location.

State of (mental) health on 13 April

The healthcare manager told Miss McMurray that the man had been seen by the mental health team, psychiatrists, nurses and GPs all around the time of his discharge, and that the general consensus was that it was appropriate for him to leave healthcare. He added that staff who were around at the time of the man's admission stated that he appeared to function very well in healthcare and none had any particular concerns about his mental state during his time there.

The healthcare manager also noted entries made by a healthcare officer in the IMR after the man complained of panic attacks/anxiety, from which there

was no evidence upon investigation of tachycardia. The healthcare manager suggested that this might cast doubts over the man's self-reported symptoms. (I would note, however, the doctor was sufficiently concerned when she saw the man on 15 April that she referred him for the next available GP appointment, the following Monday.)

Finally, the healthcare manager (a mental health professional) said he believed that the man suffered from personality disorder, and that it would not have been appropriate for his immediate needs for long-term intervention to have taken place in healthcare.

Notwithstanding the fact that the man's condition apparently took a downward turn very soon after his return to the segregation unit, I have no reason (other than the evidence of non-medically trained prisoners) to suppose that the decision to discharge the man on 13 April was wrong. However, like Ms Frances, I am concerned about the apparent lack of a systematic approach to his discharge and that key decisions relating to his management were not recorded at the time. It is not satisfactory in determining whether the man was appropriately managed to have to rely on the recollection and interpretation of events of those involved.

I have noted above that I consider the decision to return the man to segregation was far from ideal. I am disappointed, moreover, that no further assessment of the safety of retaining him in the segregation unit was carried out in light of his reported symptoms.

Transfer

I turn now to consideration of whether prison staff did enough to effect a swift transfer for the man, thereby removing him from the segregation unit regime at the earliest possible opportunity.

The governor charged with arranging a transfer explained to the investigators that transfer to another prison was not immediately considered as it sometimes happened that, following altercations of the sort the man had with his cousin (and others), prisoners were able to negotiate their return to normal location. Clearly, this was desirable. The governor said it was necessary to allow a little time to see if that happened in this case. However, once it became apparent that it was not going to happen, it was decided that the best option for the man would be to transfer him.

At draft stage of the earlier report, the former Governor wrote of the "professional obligation" of the prison "to exhaust or at least explore all reasonable options for managing the man within Frankland before concluding that a transfer was necessary". He also argued that, in order for a transfer to be a success, the man would have needed to be sufficiently stable and willing to co-operate. Whilst the man continued to believe there was no problem with him returning to the wing, this was not the case.

Although the man's record does not contain a comprehensive narrative of every development where the question of his transfer is concerned, there is evidence to show that the option of a transfer to another prison was under consideration from mid January onwards and that, on more than one occasion, a move had actually been arranged.

The first reference to a transfer was made on 15 January 2004, a little over a month after the man was segregated following his assault on his cousin. A member of staff made an entry in the man's core record in which he stated that it would be appropriate for the man to transfer to another prison because his safety would be in jeopardy if he were to return to the wing.

On 28 January, another entry in the man's core record shows that, during a review board, he was asked about transferring and that he replied that he was willing to go anywhere. (There had been no mention of a transfer at the review board on 14 January.)

On 2 February, another entry in the man's record stated that he might benefit from a transfer because he was very withdrawn.

On 25 February, a governor was asked to investigate the possibility of moving the man to Lowdham Grange "on a sale or return basis", after the man had asked to be moved there.

A list of anticipated movements dated 12 March for the week commencing 15 March lists some 12 prisoners who were due to move on 17 March. The man is shown as being due to transfer to Rye Hill, travelling via HMP Garth. However, on 16 March, he was admitted to the healthcare centre. The governor remembered that the man was showing signs of mental illness at this time and that it was felt that his admission to the healthcare centre had to take precedence over a move to another establishment.

I have considered whether a two month delay (between mid January when a transfer was first identified as being the way forward and mid March) is indicative of a lack of effort by staff at Frankland to secure a transfer. Unfortunately, there is no documentary evidence to show definitively at what point this activity started and of what it consisted. The notes of interview do not shed any light in either respect, other than that a healthcare officer said efforts to transfer the man had "been ongoing for some time so [Population Management Unit] were very much aware of it." Frankland's PMU themselves, however, had no record of action in this respect and none of the prisons specifically referred to by staff or in the documentation (Rye Hill, Dovegate and Lowdham Grange) had any record of contact from Frankland in relation to the man. (Perhaps not too much should be read into this, however, since the prisons concerned have no record of even the proposed transfers and a letter from the man to Lowdham Grange was not recorded.)

The governor spoke of some of the obstacles to securing a quick transfer. He told the investigators he took the view that, because of the man's age and relative immaturity, he would be better suited to an establishment outside the

high security prison estate. He advised that it took some time to arrange a suitable transfer for the man, as category B establishments were cautious about taking prisoners from segregation units in high security prisons. (He added that he and his staff made it clear to potential receiving establishments that the man was only segregated because of the threat they felt he would have been under, rather than because of his own violence.) He also referred briefly to population pressures and to it having become more difficult over the previous two and a half years to arrange transfers. These were worse in relation to transfers from the high security to the general prison estate.

The former Governor pointed out that Prison Service HQ's cancellation of a later proposed transfer due to population pressures was evidence of the circumstances that prevailed at the time. He suggested that to arrange a transfer within eight to nine weeks of deciding on this course of action was "a highly effective piece of work" given the "considerable systemic problems" they faced.

I have to say that my work in investigating complaints from prisoners tends to support the former Governor's point. I receive numerous complaints from prisoners who have been waiting some considerable time for moves, often in the face of quite compelling grounds for them to transfer. Set in this context, eight to nine weeks does not appear excessive.

On the other hand, the line manager of the governor charged with arranging the transfer said during interview that managing the man was the latter's responsibility and that he would only go to him (the line manager) if he was having difficulty moving prisoners on. In such cases, he would either speak to Headquarters or perhaps speak Governor to Governor, which he said he had done on a number of occasions to try to speed up a transfer. He did not suggest that he had done this - or been asked to do so - in this case, however. Of course, such intervention by a senior manager would be de-valued if it was to occur in any but exceptional circumstances. It should not be something to which managers routinely have recourse. I also readily acknowledge that no-one could have known how things would eventually turn out. Nevertheless, I am concerned that, in light of staff concerns about the man's mental health (albeit that he was not considered at risk of self-harm until mid March), the matter was not escalated to the line manager.

Efforts to transfer the man were (correctly, in my view) suspended whilst he was in the healthcare unit. The governor arranging the transfer said, however, that he sometimes talked to the man in his role as liaison officer between the healthcare centre and the segregation unit. During these discussions, he kept him up to date on the question of his transfer. He specifically remembered speaking to the man on 5 April when he told him that he was going to "put the transfer back on".

The evidence presented to the investigating team consists of two documents that provide clear evidence that arrangements were in place in April to move the man. The first is an undated communication from the Population Management Unit at Prison Service Headquarters that notified Frankland that

the man's transfer to Dovegate in the week commencing 19 April 2004 had been cancelled because of population pressures. The second is a computer print-out of a form entitled "Proposed outgoing movements for week commencing 19/04/2004". According to the form, the man was due for collection at Frankland at 9 am on 21 April and Rye Hill was to be the receiving establishment.

(Just two other documents relating to the question of transfer are also on file. The first is a copy of an undated letter written by the man himself to the Governor (Director) of Lowdham Grange, in which he asked to be transferred there as soon as possible. The second is a copy of the reply sent to the man from the Observation Classification and Allocation (OCA) Unit at Lowdham Grange, dated 8 April. The letter advises him to apply for a transfer through the OCA Unit at Frankland.)

These documents, together with the evidence that was given in the interviews conducted during the investigation, make clear that a transfer to Dovegate had been arranged, and that a further transfer to Rye Hill was arranged by Frankland to take place on 21 April. In view of the difficulties faced by staff, I have to agree with the Governor's assessment that to arrange two transfers within the space of 11 days was a "highly effective" piece of work.

In conclusion, I am uncertain whether sufficient was done by staff between mid January and mid March to secure a transfer. On the one hand, I acknowledge the very real problems faced by staff in securing transfers. On the other, I wonder if the urgency in the man's case (albeit that he was not considered to be at risk of self-harm until mid March) was sufficiently recognised. It is arguable that the matter should have been escalated as soon as staff became concerned about his mental health.

I am satisfied that the action taken after 5 April to secure a transfer was sufficient and timely.

I have considered whether I should make a recommendation with regard to documenting actions taken to bring about a transfer. On balance, I have concluded that this would not be appropriate. Thankfully, it is rare that such actions are of such critical importance and I hesitate to tie the Prison Service up in unnecessary bureaucracy.

Summary of observations and conclusions

Little of the evidence in this investigation is concrete or compelling. In many instances, I have had to rely entirely on the recollection and interpretation of events by those involved, in some cases many, many months after they occurred. This is not satisfactory and inevitably impacts on my ability to form evidence based conclusions. I acknowledge that these conclusions have changed in the light of comments from the Prison Service and the family, and as additional information has come to light. Much of what I have concluded has been on my assessment of the balance of probabilities.

It is clear that prison staff were unhappy in the early stages of the man's segregation about returning him to the mainstream. Some of their unhappiness derived from experience of how prisons and prisoners operate, rather than directly from the man's particular circumstances. Even so, I am not persuaded that there were compelling grounds to keep the man in segregation so long after the altercation with his cousin. Nor am I certain that the matter was kept under constant review, referring to up to date information.

I have considered carefully suggestions from the man's family and from prisoners that the man should have remained in the healthcare unit. A variety of reasons for his discharge have been suggested. However, I am satisfied that, at the time the decision was made, there was no clinical reason for him to remain in healthcare. Given the pressure on healthcare places (and the unit at Frankland holds only 18 in-patients), decisions must be based on clinical judgement, rather than on questions of more general vulnerability. Even supposing the man was suicidal (and there is no contemporaneous evidence to suggest that he was), suicidal ideation is not a clinical condition requiring only medical input. Most prisoners considered to be at risk of self-harm or suicide are (rightly and properly) managed on normal location.

It is easy with hindsight to identify things that might have been done differently. In conducting my investigations, it is important that I remain firmly grounded in what was reasonable based on the information available at the time – that is, without being able to foresee the future. In this context, and in light of the pressures on spaces throughout the Prison Service estate at that time (as now), I do not criticise the 'delay' in arranging the man's transfer. In normal circumstances and whilst not ideal, I would not uphold a complaint that a transfer had taken eight weeks to arrange.

However, three months in segregation is a long time and segregation itself is stressful and demanding. I have been very concerned therefore by the evidence uncovered by my investigation that the provisions of PSO 1700 were not fully met, particularly as they relate to safeguarding prisoners' mental health. I say in the foreword to this report that I have become increasingly concerned about deaths in segregation units. The number of such deaths alone argues strongly for the need to adhere rigorously to the terms of the PSO.

There is also a need for segregation unit staff to be constantly alive to the experience of those segregated and to be alert to the psychological consequences of segregation for all prisoners, particularly the already vulnerable, and especially when they are not engaged in activities to occupy their minds. It follows that staff must engage regularly and proactively with prisoners if they are to discharge their duty of care effectively.

Recommendations

I make the following recommendations:

I recommend that, where a transfer to the segregation unit is being considered, a safety algorithm is completed before a decision is made.

The management of segregated prisoners

I recommend that review boards convened to consider a prisoner's continued segregation specifically consider questions relating to the prisoner's mental health and ability to cope with segregation.

I recommend that the Governor ensures that the full provisions of PSO 1700 are met in respect of any segregated prisoner. Specific measures that need to be taken include:

- ensuring that segregation review boards set prisoners targets that seek to promote their engagement in purposeful activity;

- ensuring that segregation review boards consider the suggestions listed in the PSO for the promotion and safeguarding of prisoners' mental health, and implement appropriate measures.

Suicide prevention

I recommend that:

- The Governor ensures that closed F2052SH documents are passed to the Safer Custody Manager so that post closure reviews can be held.

- The Governor ensures that F2052SH case reviews convened for prisoners in the healthcare centre who are likely to be discharged to the main prison are attended by an appropriate representative from the unit to which they are likely to be allocated, as well as by healthcare staff.

Clinical matters

- When a prisoner is transferred to Frankland with a recommendation for consideration for the DSPD unit, this information should be conveyed to healthcare staff at the earliest possible opportunity, preferably in the form of a written note.

- The healthcare manager must review and revise policies for records and record keeping, including completing care plans and the use of the short stay care plan and ensure the healthcare log is maintained in an appropriate ledger or diary.

- The Governor must ensure that healthcare staff are aware of the limits on the implementation of Prison Rule 45, Good Order or Discipline.

- The Governor should, in conjunction with his local Primary Care Trust, remind staff who make entries in medical records of the need to identify themselves clearly.

- The Governor should take steps to ensure that all healthcare staff and their managers are fully conversant with PSO 2700 (or as now applicable the ACCT procedures) and have been trained in suicide prevention and self-harm management to the same standard as required for discipline staff.

- The doctor discharging a patient from the healthcare centre in-patient unit to another location should make a clear statement of any issues s/he has considered of relevance to the patient's fitness for discharge and any continuing care in the continuous medical (now clinical) record.

I am pleased to report that the Prison Service has accepted all these recommendations.