Investigation into the circumstances surrounding the death of a man at HMP Rye Hill in June 2006

Report by the Prisons and Probation Ombudsman for England and Wales

January 2009

This is one of the most worrying reports I have issued in nearly five years of investigating deaths in custody.

The man was 33 years old when he died at HMP Rye Hill on 10 June 2006. He came from Ukraine and, after a sentence of imprisonment, was awaiting deportation. His time in custody had taken him to eight different prisons. In the period leading up to his death, the man had been repeatedly blood-letting.

After extensive efforts by my investigators, the Coroner's office, the British Embassy in Kiev, and the Ukrainian Embassy in London, the man's father and family were traced. My report will be extremely disturbing for them to read, and I offer my sincere condolences.

Two of my investigators carried out the investigation. I also asked a clinical review of the healthcare and treatment received by the man whilst he was in custody, and I am grateful for the assistance of the clinical reviewer and that of her colleagues.

All in all, this has been an extremely complex investigation to which we have needed to devote much time and effort to understand what happened. The earlier drafts of this report resulted in many comments from the parties, and we have considered very carefully everything we have been told. A variety of amendments have been made and new material added. I believe that what follows is an authoritative account of the circumstances that culminated in the man's death. However, the scale of the investigation has meant a delay in issuing my report for which I must apologise.

An important part of any investigator's work is the examination and questioning of available documentation and evidence. Unfortunately, the prison records are incomplete which means that the chronology prior to the man's arrival at Rye Hill has been difficult for my investigators to follow. However, they have been able to piece together the most significant events. These show that there were times when the man was a difficult man to manage, but other periods when his behaviour was settled. Although my report concentrates on the months the man spent at Rye Hill, it would be wrong to exclude the salient points from this earlier time in custody. To do so might suggest to the reader that his problems only manifested themselves after his arrival at Rye Hill.

As part of my report, I have included the most important conclusions of the clinical review and its recommendations, together with my own. In a report in which there is much to cause alarm and anger, one of my recommendations concerns members of staff whom I believe should be commended.

For the last few months of his life, the man was monitored under the Prison Service's suicide and self harm monitoring and support arrangements because of his serious self harming behaviour. The last four months were spent at Rye Hill, and I have been distressed to learn of the conditions the man lived and died in. This report reflects a tragic catalogue of self harm and abuse. Sadly, Rye Hill did not provide sufficient care to protect him.

An additional issue in this case was the man's immigration status. It seems that the man was almost certainly not held with proper authority between 29 March 2006 and 12 May 2006.

Stephen Shaw CBE
Prisons and Probation Ombudsman **January 2009**

Note on report structure

My report is divided into several sections, a list of which can be found in the contents on page 5. The initial sections explain how the investigation was carried out, identify the different prisons where the man was held, and present background information about him. Additionally, there is a section which explains relevant prison and clinical terminology.

The Key Events section informs the reader of the factual information in a chronological order from the date the man was first received into prison. Although the report covers the full length of the man's imprisonment, the main findings, issues and recommendations concentrate on the period he spent in Rye Hill.

There are a number of significant dates where I identify issues relating to the man's care and treatment whilst at Rye Hill. These dates are sub-headed within the Key Events section.

The report names a number of individuals who had contact with the man and identifies several members of staff whose actions have raised concern. However, I recognise that other people were also responsible for the man's care and for this reason have made a recommendation for Global Solutions Limited (GSL) – now part of Group 4 Securicor (G4S) Care and Justice Services - to investigate key dates separately. Only in this way will GSL be able to ascertain clearly who was responsible for actions and inactions.

Issues, concerns and areas of good practice are discussed in greater detail in the Issues section. Recommendations which result from issues or concerns are made at this point and are also listed separately in the final section of the report.

As with all my reports, I refer to the deceased by the name indicated by the next of kin, unless no preference is suggested.

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SUMMARY

The man arrived in the United Kingdom from Ukraine on 30 April 1998 on an employment visa. In December that year he applied for asylum, but this was refused in 2001.

In April 2002, the man was remanded into custody charged with burglary. He was released in June that year. After being charged with further burglary offences, he was returned to custody in September and sentenced in June 2003 to seven years imprisonment. As a result of his conviction and sentence, the Immigration and Nationality Department (IND) of the Home Office (now the United Kingdom Border Agency (UKBA) but for ease and consistency with the prison records at the time referred to as IND in this report) was informed and proceedings to deport the man back to Ukraine were started.

During the early stages of his sentence, the man appeared relatively settled but for a variety of reasons he would ask to transfer to other prisons. He was described in various documents as "manipulating" situations to obtain a transfer, and this would take the form of refusing food and minor self harm. He told prison staff that he had been in hospital in London after apparently feeling mentally unwell, but said he had not had a mental health assessment. He also told prison staff that he would be killed by members of the Russian Mafia if he returned to Ukraine because they believed he was a police informant.

Due to the food refusal, the man began to lose weight and it was deemed necessary to transfer him to a prison where he could receive appropriate medical care. After a while the man was given a place at a suitable prison and, after assessing his needs, he was given food supplements to build him up. At the same time, he became eligible for presumptive parole. However, although the process began, the rules were not applied correctly and parole was not granted.

In January 2006, the man agreed to transfer to Rye Hill. On 23 February 2006, staff from Rye Hill arrived at HMP Norwich to collect him and the transfer took place. Once again he appeared to settle down and engage positively with the prison regime. However, this changed soon after the initial decision not to grant parole was reviewed and found to be wrong. After the review, parole was correctly granted and the man became more challenging in his behaviour, increasing his level of self harm and food refusal.

Such was the increase in the man's self harm that special meetings were held to determine the appropriate level of care and support required. Unfortunately, what was agreed for his medical care and assessment was not carried out and the man's mental health was never formally assessed. The man was dealt with in the main as if he were refusing treatment. However, the only signed treatment refusal form dated from his first period in prison custody (2002) and by then was no longer applicable.

The man's level of self harm increased such that on one occasion staff described his cell as having been covered in blood from the early hours, through to the night time. It appears that he was only moved to healthcare after

a senior manager received complaints from a chaplain and heard threats that prisoners would not return to their cells to be locked in for the night.

On the day he died, the man was being observed constantly by officers. There are notes showing that he had been in great distress, lying on the floor of his cell and experiencing great difficulty in moving because he was so weak. When he asked for water, neither prison staff nor the duty nurse went into his cell to assist him, and he had to struggle to a hatch in the cell door to collect it.

Shortly before midnight on 9 June 2006, the man was seen kneeling at the end of his bed, with his arms and head laid upon it. The officer watching him became concerned that he could not hear the man breathing and asked for medical assistance. He had died and there was nothing that staff were able to do to save him.

THE INVESTIGATION PROCESS

1. When my office was notified of the man's death, the Deputy Ombudsman at the time and one of my investigators opened the investigation at Rye Hill on 12 June 2006. They met the prison's Director at the time, and he briefed them about what had happened. After the meeting the investigation was allocated to two of my investigators.

2. On 19 June, HM Chief Inspector of Prisons gave the Deputy Ombudsman copies of three letters which she had received from Rye Hill. Two were from a member of Rye Hill staff, a Prison Custody Officer (PCO) – PCO A and the other was from the man himself. One of the PCO's letters referred to her own experience of Rye Hill's healthcare arrangements, whilst the other referred to her concerns regarding the man's care. In his letter, the man referred to his wish not to be deported to Ukraine and also touched on his self harm. All three letters were handed to my investigators for their consideration.

3. I am aware that GSL, the company responsible for Rye Hill, commissioned an internal investigation into the matters raised by the PCO. I am grateful to GSL for their agreement to annex their report to my own.

4. One of my Family Liaison Officers (FLOs) telephoned the prison's Deputy Director on 23 June 2006. My FLO asked for details of the man's next of kin and whether the prison had informed the Ukrainian Embassy of the death of one of its citizens. The Deputy Director said there was no known family and it was not within the prison's remit to inform the Embassy.

5. On 3 July, the investigators and one of my Assistant Ombudsmen, now Deputy Ombudsman, returned to Rye Hill to continue the investigation. During a search of the prison records, a telephone number was found that was believed to be for a member of the man's family. The number was later passed to the Coroner's Officer, for him to follow up. The following day, the investigators met members of the prison's Independent Monitoring Board (IMB) to discuss the investigation process.

6. My investigators were given access to the man's prison records. They examined the documents and used them to inform their decisions on whom to interview. The interviews did not include everyone who had contact with the man whilst at Rye Hill, but concentrated on those who had the more significant dealings with him. Unfortunately, one of the managers they wished to speak to had been suspended from work on an unrelated matter and so could not be interviewed.

7. On 6 July, the investigators went to the home of PCO A to interview her about her letter to the Chief Inspector of Prisons, and to see what information she had relating to the man's care and treatment at Rye Hill.

8. Five days later (11 July 2006), the clinical review was commissioned. At a meeting with my investigators and the clinical reviewer to discuss the investigation's findings to date, my Deputy Ombudsman confirmed that she

would be requesting a panel review to assist the clinical reviewer with her work and that she would oversee the clinical review report including the conclusions and recommendations. Additionally, the clinical reviewer agreed to lead the investigation interviews with medical staff. These began on 7 August.

9. On 8 August, my investigators met the then Detective Chief Inspector (DCI) in charge of the police investigation into the man's death. At that meeting the investigators told the DCI about their concerns regarding the man's care. The DCI told them that he would refer the case to the Crown Prosecution Service (CPS) for advice.

10. Six days later, on 14 August, the DCI told my investigators that the CPS wanted to meet the investigation team in September at their office in York to discuss the initial findings.

11. As per my office's guidance on feedback to institutional heads, the investigators met the prison Director on 18 August and gave further feedback about the progress of the investigation. This was subsequently confirmed in writing.

12. Following the referral to the CPS, my investigators, a registered mental health nurse on the clinical review panel and the DCI met on 8 September with a CPS lawyer. The outcome was that the police were taking no further action at that stage. However, it was left open that, once my report was completed, the Coroner might wish to consider directing the police to reconsider the information.

13. After carrying out further interviews, the investigators met the then Deputy Director of Rye Hill, on 26 September. They provided him with more details about their findings and concerns. As previously, the investigators confirmed this in writing to the then Director.

14. After consultation with my then Deputy Ombudsman, my investigators wrote to the prison Director to request a meeting to discuss the initial findings of the clinical review. The Director was asked to invite a senior member of staff from Primecare's headquarters. The meeting was arranged for 19 December. A copy of the clinical findings was sent in draft to the Director for him to share with all parties attending the meeting. The clinical findings were shared on the understanding that the report covered the important points of concern, but was still in the investigative stage and subject to amendments.

15. On 19 December, my investigators, then Deputy Ombudsman, the clinical reviewer met the prison Director, the Deputy Director, the Managing Director, Offender Management and Immigration Service, GSL, the Regional Offender Manager, the Primecare Service Director, a doctor from Primecare and the Home Office Controller. The outcome was that Primecare – the company contracted by GSL to provide healthcare at Rye Hill at the time – commissioned its own inquiry into members of Rye Hill healthcare staff.

16. Primecare's report states that their inquiry team was made up of three independent clinical professionals experienced in general and mental healthcare in a secure environment and a Primecare employee with a prison background. A report on the findings of the internal inquiry was completed and a copy sent to my Deputy Ombudsman in April 2007. After reading the Primecare report, my Deputy Ombudsman remained satisfied with the findings of the clinical review panel which my office had commissioned and advised my investigation team that no amendments needed to be made to the clinical review as a result. At the request of Primecare, I have annexed their internal inquiry report to this report. Additionally, I have added a brief note regarding their report findings and recommendations at the end of my own Recommendations section.

17. On 21 December, due to the lack of progress in finding the man's family, my investigators telephoned the British Embassy in Ukraine and asked for their assistance. A scenes of crime officer based at the Embassy agreed to circulate details to other agencies. Additionally, the investigators were able to provide details of a possible address for the man's relatives that they had obtained through the immigration service.

18. The following month, on 2 January 2007, my investigators were told by the Coroner's officer that the man's father had been traced a few days earlier and informed of his son's death.

19. One of my investigators was contacted by a member of staff from an International Funeral Directors. They had been appointed to repatriate the man's ashes back to Ukraine. The investigators contacted the Deputy Director who agreed to contribute up to £3,000 towards the cost of the cremation and repatriation.

20. As my family liaison officer had by then left my office, another FLO, wrote to the man's father in Ukraine explaining my role and inviting him to contribute towards this report. The letter was translated and sent on 10 January. On 1 February, one of my investigators received a telephone call from the Ukrainian Embassy in London. They had been contacted by the man's father who wanted my investigators to know that he would like to meet them at his home in Ukraine. After agreeing to the request, my investigators arranged to travel at a later date to meet him and his lawyer, which they did in May 2007. (Additionally, at the request of the family's legal representatives in the UK, my investigators returned to Ukraine to discuss the draft report in August 2008.)

21. At the same time as this investigation was ongoing, a separate unconnected criminal trial was taking place at Northampton Crown Court relating to the death of a prisoner at Rye Hill. The trial judge was aware of this investigation and directed me to send him the file relating to the man. After seeking legal advice, I did so.

22. Following the criminal trial, BBC Panorama broadcast an investigation into Rye Hill. As part of the documentary, they referred to my investigation into the man's death and interviewed the man's father at his home. On the same day, the Home Office Controller at Rye Hill rang one of my investigators to ask

when my report would be ready as he was responding to a request from the Home Secretary.

23. On 28 March, my investigators contacted IND because they were concerned that the man might not have been held lawfully during his final months in custody. They requested that a senior official re-examine his immigration files. The following month, on 24 April, one of my investigators met the senior official at IND. The official agreed to examine the files further and report back his findings.

24. By this point, the then Director of Rye Hill, had retired and his line manager, (the managing director) had asked that all further communication regarding the man should be directed to him personally. My investigators wrote to the managing director on 18 May outlining additional concerns to those raised previously. These related specifically to two prison managers, and to two members of staff whom they felt ought to be commended for their actions.

25. On 25 May, my investigators travelled to Ukraine to meet the man's father, his lawyer, daughter and son in law, at their home. The man's father and his family welcomed my staff and they told him about the investigation and their concerns, and the man's father shared his. The investigators used the services of a local translator.

26. After returning to the UK, my investigators were contacted by a member of staff from IND. She told them that the man might not have been held in prison lawfully.

27. In the event of my reports making criticism of an individual or organisation, I issue the draft report in advance under my disclosure policy. This allows for any individual or organisation named to correct any factual errors or identify any omissions. In line with the disclosure policy, the draft report was advance disclosed on 8 October 2007 to GSL.

28. Following advance disclosure, I received feedback from various individuals who were criticised. I have noted their comments and have made amendments where I consider it necessary. A second draft report was issued with 14 days advance disclosure on 18 February 2008. As noted, at Primecare's request I have also annexed their internal inquiry report which they commissioned following the meeting with my investigation team on 19 December 2006. Prior to the draft report being published to all interested parties in April 2008, an application was made by the Medical Defence Union (MDU) by way of Judicial Review to prevent this. The application was withdrawn by MDU after the Judge refused to grant an injunction.

29. One of the members of staff my investigators wished to interview was being investigated over another unrelated matter and suspended from duty and was therefore unavailable for interview. Following the advance disclosure of my draft report, my investigators made further attempts to interview the staff member. They wrote to the staff member to invite her for interview and sent the letter via the new Director of Rye Hill. The Director told my investigators that the staff member was on sick leave and not available for interview but she would hand the letter to the staff member on her return. My investigators have

had no further response from either the Director or the staff member and are therefore unable to include her version of the events on 23 May 2006.

30. Since my draft report was disclosed to GSL, I have received feedback from the prison via the Prison Service's Safer Custody and Offender Policy Group. I am pleased to note that all of my recommendations referred to GSL have been accepted with the exception of two which have been partially accepted. Their response to the recommendations is noted in the final section of this report. Before issuing the final report my investigators invited the Director to update them of any changes and progress since the man's death. The offer was accepted, and on 5 January 2009 my investigators met with the Director and Rye Hill's Head of Safer Custody. I have summarised the meeting at the end of the Recommendations section of this report.

THE MAN

31. On 30 April 1998, the man arrived in the UK having travelled on an employment visa. He claimed asylum in December of that year. He was refused asylum in September 2001 and appealed against the decision the following month. A few months later (February 2002), the man, who was now regarded as an "overstayer", signed an appeal waiver that would allow him to be removed from the UK back to Ukraine. (Overstayer is a term used by the immigration service to describe someone who has remained in the country longer than authorised.) Arrangements were made for the man to travel to Ukraine on 25 February. He was supposed to make his own way to the airport but failed to appear.

32. The man was remanded into custody to HMP Brixton, charged with burglary, on 26 April 2002. He had no other police records on file except for a driving offence for which he had been banned from driving and given a fine. The man returned to court in relation to the burglary charges on 21 June and was discharged. The prison records relating to this period of custody have been destroyed (I understand this is normal procedure), and therefore I do not have an explanation for the man's discharge from court.

33. According to later prison records, the man told prison staff that he had been in hospital once before he was imprisoned. He said that in June 2002 he attended the Accident and Emergency Department at Charing Cross Hospital, saying that he was 'feeling crazy'. He told prison staff that he was not admitted and was assessed as not having a mental illness.

34. The man was arrested and charged with further burglary offences, and on 20 September 2002 was again remanded into custody at Brixton. The immigration authorities were notified by the prison that he had been arrested. As well as being remanded in custody, the man was served with a deportation order which meant that he was also being detained as an "overstayer".

35. On 6 December, the man returned to court and was then taken to HMP Wandsworth rather than to Brixton. Whilst at Wandsworth, he was interviewed by police officers (this is not unusual for any remand prisoner). Although he did not say so at the time, later in his sentence he told prison staff that he was worried that other prisoners thought he was a police informant. As a result, the man believed his life would be in danger from members of the Russian Mafia if he were to return to Ukraine. He also said that he owed money to people in Ukraine. The man's father told my investigators that, in his opinion, this was not true.

36. On 12 June 2003, the man was sentenced to seven years imprisonment for six counts of burglary, with a court recommendation that he should be deported at the end of his sentence. (The long sentence reflected the commercial nature of the burglaries and the value of the items stolen.) Two months later, the man's asylum appeal was dismissed by the immigration authorities. It would appear from immigration records that, even though he had signed the appeal waiver in 2002, his application had continued.

37. Whilst in prison, the man completed several educational courses - including levels one and two in literacy and numeracy - and was undertaking an Open University course in mathematics. During his time at HMP The Verne (one of the prisons he spent time in), the man joined an educational course in building and construction. Prison records show that the man's tutor described him as a good learner, keen to make changes and with a proved commitment in completing the course.

38. After leaving The Verne in February 2005, the man never spent more than a few months in any one prison. During his time in custody, the man went to eight different prisons, and at each one made requests to transfer to somewhere else. The reason for the requests varied from wanting to be closer to London for ease of people visiting him, to better gymnasium facilities, improved regimes and workshops. The man also frequently asked to be transferred to a segregation unit or to a prison with an in-patient healthcare centre.

39. On a number of occasions the man refused food in order to obtain a transfer. In November 2005, he refused food for 28 days, telling staff that he wanted to go to a prison with in-patient healthcare facilities. Prison records indicate that the man would "manipulate" a situation in order to obtain a move, but none of the records gives reasons why. On many occasions the evidence suggests he would self harm so that he could get a transfer or a move to a healthcare centre.

40. The prison records show that from 16 October 2005 the man was regularly monitored under the Prison Service's self harm procedures until his death in June 2006. Prior to this, the only recorded incidents of self harm were when he appeared at court in April 2002 and September 2002.

THE PRISONS WHERE THE MAN WAS HELD

HMP Brixton

41. The original buildings date from 1819, and there are four main residential units and a healthcare centre. 'A' wing houses 264 prisoners in 143 cells, the majority of which are for two prisoners. 'B' wing has 86 cells, some of which are shared, and is mainly used for foreign national prisoners. 'C' wing has 69 double cells and operates primarily as a centre for drug treatment programmes. 'G' wing has 151 cells, 61 of which are double cells. Additionally, it has a first night centre and induction unit. 'D' wing has a 26 bed in-patient facility, concentrating on acute mental health care.

42. The prison's primary role is to serve the local magistrates' courts and Inner London and Southwark Crown Courts, and it holds remand and trial prisoners. It is intended that convicted prisoners should be allocated to another prison with facilities appropriate to their sentence and needs.

HMP Wandsworth

43. Wandsworth is a large prison in south west London, with a separate vulnerable prisoner unit. It currently holds 1,650 prisoners and is the largest prison in the UK and one of the largest in Western Europe. The prison was built in 1851, and the residential areas remain in the original buildings. There has been extensive refurbishment and modernisation of the wings, including in-cell sanitation, privacy screens for cells occupied by more than one prisoner, and installation of in-cell electricity.

HMP The Verne

44. The Verne is a category C training prison for adult men on the Isle of Portland in Dorset. The original buildings date from 1873 when it was built as a citadel fortress to overlook Portland Harbour. It was taken over as a prison in 1949, using the existing citadel defences for dormitory accommodation and workshops. A number of purpose built houseblocks were constructed in the early 1970s. The prison takes a wide range of prisoners, including 50 life sentence prisoners.

HMP Guys Marsh

45. Guys Marsh opened in 1960 as a Borstal and became a Young Offender Institution (YOI) in 1984. After completion of perimeter fencing in 1992, it became a closed establishment and started to accommodate adults. It is now a category C prison and closed YOI, holding up to 578 prisoners. There are currently nine living units, one for young offenders, and the remainder for adults.

HMP Wayland

46. Wayland is a category C adult male training prison in Norfolk. Since opening in 1985, the buildings have been expanded on three occasions, and the prison is now made up of eight residential units with an operational capacity of 709. The accommodation is mainly single cell, although there is some shared accommodation. The prison has a healthcare centre, but there are no in-patient facilities and any prisoner who requires in-patient care is transferred to HMP Norwich.

HMP Highpoint

47. Highpoint is situated in Suffolk and built on a former Royal Air Force base. The prison opened in 1975 as a category C prison. There are eight units with cellular accommodation, and the operational capacity is 816.

HMP Norwich

48. Norwich prison is situated within the city of that name in Norfolk. It is a local prison taking remand prisoners, but also holds category C convicted adults, and young offenders. At the time the man was there, the operational capacity was 824, with the vast majority of accommodation being in single cells. The prison has a healthcare centre, providing a 28 bed in-patient facility for those with physical or mental health needs, and in-patient facilities for Wayland and HMP Blundeston.

HMP Rye Hill

49. Rye Hill is a contracted out prison, privately managed by Global Solutions Limited (GSL) – now part of G4S. It opened in 2001 as a purpose built training prison for sentenced adult men with a minimum of 18 months left to serve. It has an operational capacity of 660 prisoners, and the accommodation is in eight units.

50. All private prisons have a Controller who links the prison to the Home Office/Ministry of Justice and oversees the contract to ensure the company is delivering its contractual obligations. Much of the terminology in private prisons differs from that in the public sector prisons. For example, the Governor is known as the Director, and prison officers are called prison custody officers (PCOs).

51. Healthcare at Rye Hill at the time of the man's death was provided by another private company, Primecare Forensic Medical Ltd (PFM). The healthcare centre is staffed 24 hours a day by qualified nurses and healthcare assistants. Visiting specialists, based on need, include a doctor, dentist, optician, chiropodist and psychiatrist. There are eight beds for prisoners requiring in-patient care.

52. The staffing structure at Rye Hill is as follows:

- **Director**

  The Director is in overall charge of the prison.

- **Duty Director**
  Members of the senior management team take on the role of Duty Director on a rota basis. The Duty Director is in charge of the operational management of the prison on a day to day basis.

- **Oscar 1**
  This is the code for the Orderly Officer, a middle manager discipline grade. The managers rotate responsibility for managing the prison on a daily basis and report to the Duty Director.

- **Duty Security Manager (DSM)**
  A first line junior manager (discipline). They assist Oscar 1 and are responsible for tasks such as moving prisoners and rostering staff duties. In public prisons this post is known at Oscar 2.

- **Residential Managers**

  Residential managers are responsible for the day to day running of a unit.

- **Prison Custody Officers (PCOs)**
  PCOs are front line officers working on the units directly with prisoners. In public prisons they are called prison officers.

53. In April 2005, Her Majesty's Chief Inspector of Prisons, Dame Anne Owers, carried out an unannounced inspection of Rye Hill. In the introduction to her report, the Chief Inspector wrote that: "the prison had deteriorated to the extent that we considered that it was at the time an unsafe and unstable environment, both for prisoners and staff … So great were the concerns that I immediately informed Ministers and urged the Chief Executive of the National Offender Management Service to take immediate and decisive action."

54. In her introduction, the Chief Inspector went on to say: "Staff were inadequately supported by managers and were sometimes surviving by ignoring misbehaviour or evidence of illicit possessions." She added: "Managers were not a visible presence on the wings, we were told by prisoners and staff that they rarely made an appearance when prisoners were unlocked."

55. The Chief Inspector was impressed by the enthusiasm of the officers and their positive approach to their task and to prisoners. However, her report said it was evident that some critical systems, such as suicide prevention and personal officer work, were suffering because staff were unable or did not know how to engage with either prisoners or the appropriate systems.

PRISON AND CLINICAL TERMINOLOGY

Buddies/Listeners

56. Buddies are prisoners who have been selected to support other prisoners who may be feeling vulnerable. They work alongside the safer custody manager and receive training to help them support prisoners who could be suicidal. Listeners provide a similar service but receive training through the Samaritans.

Clinical Panel Reviews

57. Clinical panel reviews are made up of a group of medical specialists able to give an informed professional opinion about the level of medical treatment and to assess medical care.

Emergency Codes

58. To ensure a correct response from healthcare as to what type of emergency medical equipment to bring to a patient, Rye Hill uses a code which is transmitted over the local prison radio system. A code one alerts the medical team of the danger of immediate death. A code two alerts the medical team of the need for urgent medical assistance in a less life threatening situation than a code one.

First Night Risk Assessment

59. First night risk assessment documents have been developed to ask a series of questions designed to gather as much information as possible about the prisoner. They cover areas such as accommodation, employment, courses and family. They also deal with the prison rules, disability and public protection.

Food Refusal

60. Under prison rules, the refusal of food is not officially recognised until three days of not eating have elapsed. After this, healthcare staff will monitor the prisoner and take observations including weight.

Incident Reports

61. When an event occurs in prison that affects security or the safety of a prisoner or member of staff the details are recorded on an incident form. The information is analysed and any action required then taken. If necessary, the reported incident is passed to Prison Service Headquarters for their information.

Independent Monitoring Board (IMB)

62. Each prison has its own IMB who are independent and have access to all parts of the prison. They may report directly to Ministers.

Mental Capacity

63. Individuals who are mentally capable are entitled to refuse treatment. The Mental Health Act (2005) states that:

> 'a person lacks capacity in relation to a matter if at the material time he is unable to make a decision for himself in relation to the matter because of an impairment of, or a disturbance in the functioning of, the mind or brain.'

In this case, prison healthcare staff decided that the man was capable of determing whether or not to accept treatment.

Mental Health In-reach Team (MHIRT)

64. The team provide support and continuous care to those prisoners whose lives have been disrupted by symptoms of serious mental illness.

Night State

65. Night state is when all prisoners are locked into their cells and staffing levels are at the minimum. Access around the prison is restricted to the few people on duty who have keys. Additionally, movement in and out of the prison is restricted to essential moves only.

66. Before unlocking a cell door at night, consideration has to be given to how the prisoner is reacting or is likely to react. It is for this reason that, unless the prisoner is in a life threatening situation, cell doors are not normally opened without sufficient officers being present.

67. At Rye Hill, the night manager has the authority to open a cell during the night in an emergency situation. At other times, the night manager should seek the permission of the on call director.

Personal Officer Scheme

68. The work of personal officers is central to the care of prisoners and the security of the establishment. A personal or group officer scheme and/or a shared working arrangement is required in each prison so that particular staff get to know particular prisoners, and prisoners can turn to them for advice and assistance.

Prison Service Orders (PSOs)

69. Prison Service Orders are long term instructions from the Prison Service and issued to all prisons. Each has a title and unique reference number. Any mandatory instructions to Governors or Directors of contracted prisons contained within a PSO are written in italics. Since the man's death a number of PSOs will have changed, and my report refers to the guidance given in the PSOs in effect at the time.

PSO 0500 Reception Screening

70. PSO 0500 concerns reception procedures and sets out the standard actions to be completed in the first two to three hours after a prisoner arrives in an establishment. One requirement is a first reception health screen assessment

which should identify any immediate physical or mental health problems, significant drug or alcohol abuse, and risk of suicide and/or self-harm.

71. Whenever a prisoner is transferred to another prison, all of the prison records should accompany them. In this way, the receiving prison has a full record of significant information available.

PSO 1025 Prisoner Escort Form (PER)

72. In England and Wales, the majority of prisoner movement to and from prisons is carried out by private firms specialising in escorting prisoners using secure vehicles. The Prisoner Escort Record (PER) is a standard form used by the police, escort companies and the Prison Service. It contains information which is shared about the risks posed by prisoners moving within the criminal justice system. The form highlights and assesses the risks posed by prisoners, and their vulnerability, and is also a record of events during a prisoner's movement.

PSO 1301 Handling a Death in Custody

73. All prisons have local contingency plans for dealing with a death in custody. The purpose of the plans is to guide staff in the immediate actions to take following the discovery of someone who has died. The plans give additional information on how to support staff, prisoners and the bereaved family.

PSO 1600 Use of Force

74. The PSO states that force is only to be used when necessary and the minimum force must be used. Wherever possible, nursing staff should be present or asked to attend before force is used.

75. Rye Hill officers who use force on prisoners are referred to as the First Response Team.

PSO 1700 Prison Rule 45 Segregation (Good Order or Discipline)

76. When it is desirable for the maintenance of the good order or discipline of the prison, or in the interest of the prisoner, that they should not associate with others the Governor or Director may arrange for the prisoner to be segregated and removed from association. (Association means a time when prisoners are allowed to meet each other and watch television together, play games or simply relax.)

77. As part of the admission procedures to a segregation unit, a segregation safety algorithm is completed. The document assesses the suitability of placing a prisoner in the unit depending on health and risk to themselves and others. It is completed by a segregation officer, and nursing staff, and signed off by a senior manager.

PSO 2000 Adjudications

78. Discipline procedures are provided for by Prison and Young Offender Institution Rules which set out all disciplinary offences and punishments. The rules empower Independent Adjudicators, Governors and Controllers to

investigate the charges. Prisoners have the opportunity to hear what the allegations are and to present their case. The aim is to provide fair and just treatment for prisoners and victims by ensuring that all adjudications are conducted in accordance with the principles of natural justice and without unfair discrimination. Should the allegation be equivalent to a serious criminal offence, the police may be asked to investigate and consider prosecution.

PSO 2700 Suicide and Self harm Monitoring

79. This sets out the procedures for monitoring prisoners considered to be at risk of harming themselves. The original procedure, the F2052SH, has been replaced by the Assessment, Care in Custody and Teamwork document (ACCT). The document can be opened by any member of staff who is concerned about a prisoner having thoughts of self harm, or who is suspected to be vulnerable. The PSO lists the type of monitoring and support that is to be provided.

80. It is not desirable to place anyone on a F2052SH/ACCT into the segregation unit. The practice is not banned but is positively discouraged by the Prison Service.

81. In Rye Hill's case, suicide and self harm monitoring is referred to as SASH. SASH reviews are usually held weekly, although more frequently if necessary. The meeting is multi-disciplinary and designed to obtain a cross-section of opinion, and should include the prisoner under discussion.

82. The PSO requires that a residential manager or a Duty Director/Governor audits the quality of entries in a F2052SH/ACCT at least twice weekly. The local policy at Rye Hill for monitoring open SASH records is that the Duty Director is required to check the documents on a daily basis

83. In addition to the SASH record, Rye Hill has developed its own document – the 'unit special watch record' – which is intended to record observations at ten minute intervals.

84. PSO 2700 states: "Routine case reviews are not required when a prisoner is located in healthcare on a regular scheduled basis in recognition of the fact that the prisoner will in this circumstance have a nursing care plan. However, it is good practice to do so when possible, and a nursing care plan must not be used in place of the F2052SH." It goes on to say that a case review must be conducted in healthcare:

    - When a prisoner harms themselves (unless an alternative review level in the event of further self harming is specified in the support plan).
    - Prior to the prisoner's discharge to normal residential accommodation.

85. The PSO also contains the following mandatory instruction, at paragraph 4.2.6: "When an at risk prisoner is in the HCC [healthcare centre] or under intermittent supervision or constant observation elsewhere in the establishment, a doctor or nurse must be consulted before any news known to be unfavourable to the prisoner is communicated to him or her."

86. Prisoners placed under constant observation should be urgently referred for mental health assessment. Their case must be reviewed as soon as is practicable, and certainly within 24 hours. Case reviews must be held at least three times during the establishment's core working day.

87. Safer custody officers oversee the suicide and self harm monitoring procedures on behalf of the Governor or Director.

88. In addition to PSO 2700, Rye Hill and Primecare have their own local policies for suicide and self harm.

PSO 3050 Continuity of healthcare for prisoners

89. PSO 3050 was implemented in February 2006 and contains guidance to improve the continuity of healthcare received by prisoners. It gives guidance on reception, transfer and discharge of prisoners, with a particular focus on those with ongoing health needs.

PSO 3845 Blood borne and related communicable diseases

90. Chapter two of this PSO outlines the management of risk situations and offers procedures to minimise risk. Although I do not list every detail of the PSO, I do identify the more salient sections of the instructions below. The sections I refer to are sections one, three, five and routine precautions. I make no suggestion that the man was suffering from any communicable disease; the assumption is that the prison should comply with the instructions contained within the PSO.

91. Section One: Risk Management:

- Some aspects of Prison Service work may expose staff to communicable diseases. This part of the order gives instructions on how to keep the risk of infection to a minimum and details the recommended procedures for dealing with risk situations.

- Under the Management of Health and Safety at Work Regulations, governors in prison establishments must ensure that assessments are carried out to determine the level of risk associated with work activities, and decide if any additional precautions are required. The Control of Substances Hazardous to Health Regulations 1994, which cover micro-biological agents, will also apply to these situations. The procedures form an integral part of the control measures required under both these sets of regulations.

- A description of routine precautions is given in the section 'Guidelines for Cleaning up Blood and Body Fluid Spillages'. All incidents involving the spillage of blood and body fluids (including saliva, vomit and urine) must be treated with care because of the possible risk from blood-borne infections including Hepatitis B and C and HIV. Routine precautions are simple and sensible. They assume that all body fluids from all friends, relatives, colleagues, clients and prisoners could be infectious.

- The main operational risk to prison staff occurs if blood from an infected person comes into contact with an open wound, rash or sore, or if the skin is punctured by a contaminated needle or other sharp object. This is most likely to occur during searching, whilst dealing with violent or self harming prisoners, or in incidents involving major blood and body fluid spillages, for example suicide attempts or bloody fights.

92. Section Three: Precautions to be employed during a violent incident:

    - In a violent incident, the main risk of infection is from being hit, spat at, bitten, struck with a needle or sharp object, or from being drenched with urine. It is important to remember that, although risk of infection with HIV from a needle stick injury or a bloody fight may be low, it is not non-existent. There is a risk of Hepatitis B and C from contact with contaminated saliva or blood. It is known that Hepatitis B can be transmitted by urine, but it is not known whether the same is true for Hepatitis C. Examples of incidents requiring medical advice:

      An incident involving a great deal of blood, such as a suicide or suicide attempt.

93. Section Five: Guidelines for clearing up blood and body fluid spillages (bio-cleaning):

    - It is likely that, whilst at work, prison staff will come into contact with blood and body fluid spillages. It is always important to take sensible precautions when there is a spillage of this nature, and to treat all such fluids as if they were infected, whether they are from a colleague, relative, friend or prisoner. Observing these precautions, known in this document as ‘routine precautions’, will help safeguard against infections which are carried in the blood or other body fluids.

94. Routine precautions, procedures to prevent infection from blood borne viruses that might be present in any spill of blood or other body fluid:

    - Avoid direct contact with blood and body fluids. When dealing with these fluids, wear disposable gloves and apron. Use disposable towels and tissues, and other equipment where appropriate.
    - Dispose of all waste and contaminated material in yellow plastic bags, to be collected in accordance with local arrangements.
    - When dealing with the large amount of blood associated with suicide or serious self injury by ‘slashing’, more elaborate safety measures must be taken. Staff dealing with this type of spillage must first seal off the area, which must be closed to all but essential personnel.
    - Employing the principles of routine precautions, staff must attempt to avoid contact with spilt fluids, and wear protective clothing.
    - A footbath containing bleach solution placed at the threshold of the contaminated area will help to stop waste matter from being spread elsewhere on footwear.
    - Contaminated clothing and other waste must be sealed into yellow plastic bags and collected for safe disposal.

PSO 4400 Incentives and Earned Privileges Scheme (IEP Scheme)

95. All prisons operate an IEP scheme for prisoners to encourage responsible behaviour, participation in constructive activity and to progress through the prison system. There are three levels, basic, standard and enhanced. Basic prisoners are given the minimum regime and facilities, and standard and enhanced prisoners have higher wages, additional visits, in cell television and other facilities, depending upon the resources available. Enhanced level provides the most rewards.

PSO 4630 Immigration and Foreign Nationals

96. PSO 4630 describes the legal status of immigration cases as follows:

    - An immigration detainee is a person detained under the Immigration Acts. Foreign National Prisoners may be subject to immigration control whilst on remand, convicted but unsentenced or serving a custodial sentence. They are held in what is commonly known as 'dual detention', but their status is the same as that of any other prisoner. This means that a subject is detained sequentially; first by remand or conviction by the courts and then upon expiry of their custodial sentence under:

      A court recommendation for deportation or

      A warrant served by the Immigration Service.

97. Persons recommended for deportation by the court, but who would otherwise be eligible for immediate release because of time spent on remand, may be detained on the court's recommendation only (Schedule 3 to the 1971 Immigration Act) unless the Immigration Service or court directs otherwise.

98. When a prisoner is held beyond their release date and is located in a prison which does not normally hold unconvicted prisoners, they must be informed that they will be held with convicted prisoners and their agreement must be recorded. Annex C is the document used for this purpose.

99. The UK Border Agency (UKBA), formerly IND, is the responsible authority for immigration matters.

PSO 6000 Early Removal Scheme (ERS)

100. All foreign national prisoners serving a determinate sentence of three months and over must be considered for eligibility for removal from the UK under the ERS. Those serving a determinate sentence of four years or more, and who should be released under the provisions of the Criminal Justice Act 1991, must also be considered for early release on presumptive parole. They are eligible to be considered for early release on presumptive parole once they have served half of the sentence and are automatically released at the two thirds point. Unlike other prisoners, those subject to deportation and fit the criteria for ERS cannot opt-out of the presumptive parole process.

PSO 9000 Categorisation

101. Categorisation and allocation of prisoners is a critical task. Effectively assigning prisoners to the correct security category and allocating them to an appropriate prison helps to ensure that they do not escape, abscond or threaten the control of establishments. It also means that prisoners are not held in security conditions which are higher than necessary.

102. Categorisation, recategorisation and allocation are also vital to the sentence management of prisoners. Combined with balancing security issues and the needs of the prisoner, this helps prisoners to use their sentences constructively, to tackle their offending behaviour and to prepare for release.

103. There are four security categories:

- Category A prisoners are held in the highest security. Their escape would be highly dangerous to the public, the police or the security of the state.
- Category B prisoners do not require the very highest conditions of security.
- Category C prisoners cannot be trusted in open conditions, but are unlikely to make a determined attempt to escape.
- Category D prisoners can reasonably be trusted in open conditions.

Her Majesty's Chief Inspector of Prisons

104. Her Majesty's Chief Insector of Prisons for England and Wales runs an independent inspectorate that reports on conditions for and the treatment of those in prison, young offender institutions and immigration removal centres. It promotes the concept of 'healthy prisons' in which staff work effectively to support prisoners and detainees to reduce reoffending or achieve other agreed outcomes.

105. The Chief Inspector is appointed from outside the Prison Service. The current incumbent is Dame Anne Owers.

KEY EVENTS

25 April 2002

106. Under the terms of the Police and Criminal Evidence Act, anyone detained in police custody and considered to be either physically or mentally unwell should be interviewed and assessed by a doctor in the first instance. The doctor is required to complete a Forensic Medical Examination (FME) form, which is given a unique serial number. The form includes their medical findings and instructions, such as monitoring individuals considered to be at risk of harming themselves. The doctor assesses the individual's suitability to be interviewed and gives or withholds their consent to the interview, and any charges or transfers. If the person arrested is not assessed as sufficiently mentally well to be interviewed alone, the doctor can recommend that an appropriate adult is present.

107. At 3.10am on 25 April 2002, whilst in police custody, the man was interviewed by a police doctor. The police doctor completed the FME form, serial number 413568, and noted that the man was at risk of self harm and should be in a cell with closed circuit television coverage (CCTV). Although the copy of the form given to my investigators is difficult to read, I believe the doctor recommended a MHT review prior to interview, and presume that this refers to a mental health team.

108. A further FME form, serial number 413572, was completed by a different doctor 40 minutes later. The second doctor recorded that the man had no current medical problems, and was not taking medication. He described the man as being in a difficult personal situation, and depressed because of it. The doctor wrote that the man needed to be assessed by a psychiatrist as he had tried to kill himself on more than one occasion, and had cut his wrists with a razor blade at court. The doctor assessed the man as coherent and rational, but wanting to kill himself and having said he had nothing to live for. The doctor recorded that the man was fit to be detained by the police, and should be in a cell with CCTV as he was a suicide risk. The doctor also said that the man was fit to be interviewed with an appropriate adult, but the report does not explain the details of his difficult personal situation or the requirement for an appropriate adult to be present. My investigators have been unable to determine whether an appropriate adult was present or not.

109. Later that day at 7.54pm, a third FME form, serial number 413574, was completed by the police doctor. The doctor recorded that the man had a clean wound to the mid to lower palm side of his left forearm, which had had eight sutures inserted at hospital. (This appears to be referring to the cut made earlier that day.) The man told the doctor that he did not want to talk about the wound. There was also an old injury on his right wrist which had scabbed over. The doctor wrote that the man knew why he had been arrested, and had been interviewed and was waiting to be charged. The doctor also noted that the man did not make eye contact, and was uncooperative but alert.

HMP Brixton: 26 April 2002 – 6 December 2002

110. On 26 April, the man was taken from the police station to Horseferry Road Magistrates Court, from where he was remanded into custody at Brixton prison. When he arrived at the prison, he went through the normal prison reception procedures.

111. During the First Reception Health Screening interview, the man's weight was recorded as 66.8kg and his height as 1m70. The man told the person carrying out the assessment that he had deliberately cut his wrists in an attempt to commit suicide. Although there is no record of when or where the incident took place, it would appear to refer to the injury when the man was in police custody. The assessor asked the man how he currently felt, and circled the "yes" option on the reception form in response to the following questions:

    - Have you ever deliberately harmed yourself?
    - Have you ever attempted suicide?

    In response to the following questions, the assessor has circled the "no" option:

    - Do you feel like hurting yourself at the moment?
    - Are you feeling suicidal?

    The assessor noted on the form that the man was excessively withdrawn and anxious, but there was no indication that he had a history of mental health treatment. From looking at the prison record, it appears that a F2052SH document was opened and the man monitored under its procedures.

112. That day the man was seen by the prison doctor. The doctor's entry in the medical record notes that the man was drunk and wanted to kill himself but does not say when this conversation took place. Although the prescription chart shows that the man was then prescribed Amitriptyline for 'anxiety and alcohol', the doctor's written record notes that the man only used alcohol socially. The notes also show that there was evidence of self harm and a cut wrist.

113. On 13 May, the man was referred to the mental health outreach team because he was on an open F2052SH document, but he refused to co-operate with healthcare staff. He was seen and assessed 11 days later by a member of the outreach team who noted that the man appeared depressive and uncooperative. The man refused to give any information to the assessor, but was offered outreach support should he require it.

114. The following month (6 June 2002), the man signed a medical treatment refusal form which, although it should have been, was not countersigned by a witness. The man signed to say that he was refusing an appointment, medication and treatment prescribed by a doctor. He also acknowledged that the consequences of his actions had been explained to him.

115. The man returned to court on 14 June. Whilst there, a medical examination showed that he had cut his left forearm in two places, but does not note where he was when the injuries occurred. (I assume that this refers again to the cuts made at court.) The man returned to Brixton later in the day, and was admitted to the prison healthcare centre where his injuries were treated. Antibiotics and anti-depressants were prescribed. Two days later, he signed a second treatment refusal form. On this occasion it was countersigned, albeit with an illegible signature.

116. After another court appearance on 21 June, the man was discharged from court. My investigators have been unable to determine from any records why the man was discharged.

117. The man's personal circumstances after his discharge from court are not known. However, he was rearrested by police in September.

118. On 20 September, the man appeared at West London Magistrates Court on burglary charges, and was again remanded in custody. As it was a new period of remand, the man was given a new prison number, and a further First Reception Health Screen assessment was carried out. The form indicates that concerns were expressed whilst he was at court, either by police, probation or another agency, and noted that an F2052SH document had been opened on 20 September.

119. The mental health section of the form shows that the assessor has circled "no" to the questions which received an affirmative answer five months previously when the man first arrived at Brixton.

120. In preparation for the man's next court appearance, a specialist registrar and a registered mental health nurse (RMN) from West London Mental Health NHS Trust wrote a confidential psychiatric report on 26 September. The doctor wrote that the man had cooperated with the assessment and, as his command of the English language was good, an interpreter was not required. The man told the doctor that his mood was "okay", but that he no longer cared about anything. He expressed some suicidal ideas and said that, on a daily basis, he wanted to kill himself because of his personal circumstances. The man told the doctor he cut his forearm whilst at Horseferry Road Magistrates Court because he was angry. The doctor noted that during the interview the man did not express any intention to harm himself or take his life.

121. It was the specialist registrar's opinion that the man had no history of mental illness or other psychiatric disorder, and he noted that the man had once attended a psychiatric hospital when he was assessed as having no mental illness. The doctor wrote that the man was distressed by his predicament, but there was no evidence to suggest any mental disorder. He concluded that the man was fit to stand trial, should not be diverted from the criminal justice system, and required no further psychiatric assessment or treatment.

122. On 10 October, the open F2052SH document was reviewed and closed. The man remained at Brixton until 6 December, and there are no records of further significant events.

HMP Wandsworth: 6 December 2002 – 19 December 2003

123. After being taken from Brixton to appear at court, the man was transferred as a remand prisoner to Wandsworth on 6 December. He appears to have settled down to prison life, and there are no records of further injuries.

124. Whilst at Wandsworth, the man was visited by police officers. This is not uncommon for prisoners with outstanding court matters or charges. The man is not known to have said anything about this at the time, but referred back to it later in his sentence when appealing against his deportation (he was to claim that others believed he was a police informer).

125. On 12 June 2003, the man was taken to Middlesex Guildhall Crown Court and sentenced to seven years imprisonment, after which he returned to Wandsworth as a convicted prisoner. In September, he was re-categorised from B to C, and arrangements were made to transfer him to a suitable prison in line with his categorisation. On 19 December, the man transferred to HMP The Verne.

HMP The Verne: 19 December 2003 – 4 February 2005

126. Staff at The Verne repeated the standard reception processes. The man told the reception officer that he had not previously been on an F2052SH.

127. The man appears to have cooperated with the induction process, and signed the wing compact. The incentive file also shows that the man settled well into the prison. At the monthly incentive review on 8 January, records show the man was working regularly in the construction workshop and had been upgraded to the enhanced level. The next review, later in the month, also noted that the man was settled. The wing history file shows that, with the exception of removal of his radio for a week in February as he had been playing it loudly, the man was settled in his new environment for the first four months.

128. At approximately 10.50pm on 19 March 2004, the man and another prisoner had a fight and were injured. The man was bitten on his face and forearm. He asked to be tested for Hepatitis and other blood borne diseases and was referred for antiviral therapy and blood tests. The Hepatitis vaccination was offered on 21 March. The medical record notes that the man refused to attend. He later changed his mind and started the vaccination course on 23 March. Both men were charged, and the man's records show he was taken to the segregation unit pending adjudication. The adjudication record shows that a Governor opened the hearing the following day and the man pleaded not guilty to the charge. The Governor adjourned the hearing and referred the case to the police as a possible assault. The record does not show which prisoner the Governor considered to be the assailant, although the man subsequently stated that he had been attacked.

129. The segregation and wing history records do not show whether the man remained in segregation or returned to his own wing pending the outcome of the police enquiries. However, it appears that he returned to his wing.

130. The man's medical record for the beginning of April 2004 notes a request by healthcare for a psychiatric referral because of concerns that he was depressed. He was described as pale, withdrawn and having lost weight. The man was not taking food from the hotplate, although he had told officers that he was eating items purchased from the prison shop.

131. On 20 April, the man was seen by a RMN but refused to allow the nurse to carry out clinical observations and said he would not come out of his cell until he was transferred. He was described as difficult to engage in conversation or with any form of healthcare.

132. The police decided to take no further action regarding the fight in March and referred it back to the prison to be dealt with under normal disciplinary rules. On 28 April, the Governor reopened the adjudication and found the man guilty of fighting. He received a punishment of three days cellular confinement, suspended for three months. Despite the fight and adjudication, the next month's IEP review on 18 May shows that the man was still considered suitable to remain on the enhanced level.

133. However, the following month's IEP review on 5 June records that the man was "going down hill", and it was suggested that his IEP level be re-assessed. The suggestion was based on the man's failure to tell officers when he returned to the wing by booking in at the office. The next two reviews show that the man had not come to the attention of staff again, and he appears to have attended work as normal and associated with other prisoners. The assessor decided that no change was required to his IEP level. The prison records describe the man as a recluse who did not leave his cell or have anything to do with anyone else.

134. The man submitted an application to transfer to HMP The Mount. He had not received a response to his request one month later and therefore submitted a complaint form. The response was that his application was being considered. After a further two months without an answer, he submitted another form. The man was told that he had been accepted at The Mount and his transfer would be arranged.

135. Over the next four months the man made several further complaints as he had not been transferred. In the complaint dated 8 November, he said that another prisoner he knew had gone to The Mount and so he [the man] no longer wanted to move there as he did not want to meet the other prisoner. The man asked instead to go to HMP Guys Marsh.

HMP Guys Marsh: 4 February 2005 – 9 August 2005

136. On arrival at Guys Marsh, the man was interviewed by a member of the healthcare team. The reception health screen document was completed and recorded the man's weight as 85kg. When asked if he had ever harmed himself or attempted suicide, the man said he had not.

137. The following week (11 February 2005), an officer recorded in the man's wing history record that he had introduced himself as his personal officer. He wrote on 26 February that the man attended education classes in the mornings, and worked in the gardens in the afternoon. The officer considered that the man had made a good start at the prison.

138. From then until June, the man's record is extremely positive and there were no concerns about his behaviour. He remained on the enhanced IEP scheme, attended work regularly and used the gymnasium at every opportunity. On 10 April, he asked to transfer to a prison nearer to London, as he said he wanted to be closer to his family and friends.

139. Two months later, on 16 June, another officer recorded in the man's history sheet that he was not his usual self and had missed work as he was ill. The officer referred to a problem in the workshop, but did not explain what it was. The same day, a different officer recorded that the man had been seen by a member of healthcare staff who advised that he should rest for the day and not eat anything. However, the man did not take the advice and did eat a meal.

140. From then on, and with little in the way of explanation, the man's behaviour deteriorated to the point where he was placed on the basic IEP regime because he refused to go to work. He began to disengage from officers and would not talk to them, simply responding to their questions with a grunt.

141. On 25 July, another entry in the history sheet noted the man's request to be taken to the segregation unit as he said that he did not feel safe on the wing. The officer noted that the man very rarely left his cell and preferred to sleep, read or write. The investigators have found no evidence of the nature of the man's anxieties, or whether they were ever investigated.

142. The prison segregation unit history record, although not comprehensively completed, shows that the man was taken to the unit at 8.10pm on 2 August. The records do not make it clear why he was moved although there is an entry the following day showing a pending adjudication. The segregation algorithm has not been completed correctly and does not make clear the initial reason for segregation. Five days later an entry was made in the records showing that the man continued to be held in the segregation unit for failing to comply with the prison regime and not returning to normal accommodation. The record shows that the man did not communicate with staff, was withdrawn and did not take all of his meals.

143. As a result of his earlier request to transfer to a prison closer to London, the man left Guys Marsh to go to HMP Wayland. (Wayland is in Norfolk and is in fact little closer to London than Guys Marsh.) The length of the journey is such that he stayed one night at HMP Wormwood Scrubs on the way.

HMP Wayland: 10 August 2005 – 15 September 2005

144. When the man arrived at Wayland, he went through the customary reception procedures. Despite being downgraded at Guys Marsh to the basic IEP level, the officer recorded that he was an enhanced prisoner.

145. An officer completed part of the reception documents and noted that there was no evidence that the man had previously been monitored by an F2052SH. The officer recorded that the information was obtained from prison records, and assessed the man as low risk and suitable for multi cell location.

146. The man's wing history sheet records on 16 August that a report was submitted to the security department saying he had refused to return to his cell. Later that day an officer reported that, together with a Senior Officer (SO), he had spoken to the man to try to help him with his problems. The man was offered a change of cell and access to a computer to assist with his education studies. He refused the cell move as he wanted a single cell. From then on, and again without a recorded explanation, the man's behaviour deteriorated.

147. By 22 August 2005, the man had completed the induction period and was required to move to a normal cell on D wing. He refused to leave and was placed on disciplinary report. The man told staff that he did not smoke, but when offered a no smoking cell he changed his mind and said that he was a smoker. Once again staff found him a suitable cell, which he also refused. There was an adjudication hearing on 24 August. The man was found guilty of refusing to relocate to D wing. He was punished with five days stoppage of earnings, suspended for one month.

148. On 26 August, the man again refused to move to D wing and was once more placed on disciplinary report. The adjudication was heard the following day and, in addition to activating the previous punishment, the adjudicating Governor imposed 14 days loss of canteen and association. An IEP review was held on 29 August when the man was downgraded to a standard regime. He was also warned that he would be downgraded to basic regime if his behaviour deteriorated further.

149. At the beginning of September, the man refused a third time to move location and was again placed on report. He pleaded guilty at the next day's adjudication and was punished with 21 days without privileges, including the loss of the cell television. The man was placed on report again on 5 September after refusing to leave an office on A wing. This time he was punished with 14 days cellular confinement in the segregation unit, a severe punishment.

150. The man's behaviour continued to deteriorate. The segregation unit history record shows that he began to refuse food but does not explain his reasons. Officers logged which meals were refused and also informed the healthcare department. The food refusal log shows that, between 6 and 9 September, The man refused some but not all of his meals. He was allowed to select his meal beforehand, and then agreed to eat it.

151. An officer talked to the man about transferring to another prison. The entry made in the wing history sheet notes that the man was willing to move to the south of England. He asked to transfer to HMP Coldingley so that he could earn higher wages and send money home to his family in Ukraine. There is no evidence to show that he had ever previously sent money home. The officer also noted that the man said that his mother had recently died, but that he had not been told. The officer added that it appeared to be due to a breakdown in communication at a previous establishment.

152. In the meantime, the transfer clerk at the prison wrote a note to the man confirming that his application to transfer to HMP Coldingley had been sent. The man must have also asked about a transfer to Wandsworth, because in the note to the man the clerk told him that if he wanted to return to Wandsworth he should submit a new application.

153. From then on, the man's behaviour improved, and there were no other occasions at Wayland when he refused meals or caused problems. He asked for Open University books to be supplied, although it is not clear whether his request was ever granted at Wayland. I can confirm, however, that later in his sentence he was undertaking an Open University mathematics course.

154. During the period the man was at Wayland, he reached the date when he had served half his sentence, and under PSO 6000 the prison should have started the parole process under the Early Release Scheme (ERS). My investigators could find no evidence in the prison records to show that this happened.

155. Although the records do not show a date, it appears that the man was granted a transfer to Coldingley, but on the day of the transfer he refused to go. Instead, on 15 September, the man transferred to HMP Highpoint.

HMP Highpoint: 15 September 2005 – 4 January 2006.

156. The man was interviewed in reception. On this occasion the officer said that there was evidence in the prison records that the man had previously been on an F2052SH. Additionally, and for the first time, the officer noted that the man said he was concerned about sharing a cell because sharing with a prisoner who smoked would affect his health. The officer assessed the man as low risk, which was confirmed by the healthcare officer who completed the third section of the form. Section four was completed by another officer, and the man was allocated to a cell on the induction wing.

157. The man settled in well to the prison routine and positive comments were made in his wing history record. He left the induction wing without incident, and was allocated a single cell on B wing. At the IEP review on 9 October 2005, he was re-graded to standard regime. The same day the man was described in the wing history record as a quiet prisoner, but one who at times was arrogant.

158. The following week, on 16 October, the man rang his cell call bell and an officer went to see him. He had a cut to his left forearm, but there is no record of how the injury occurred. The medical record notes that the man was not very communicative with healthcare staff, and asked to go to the segregation unit. He accepted healthcare treatment and an F2052SH was opened. The next day, an officer recorded that the man was being checked five times an hour. The medical notes for the rest of the month indicate that the man continued to be uncommunicative and said that he wanted to be transferred to segregation or another prison. The possibility of a language barrier was identified on 22 October, but the healthcare manager had a good rapport with the man and was confident that he could understand English.

159. During the morning of 26 October, a F2052SH review meeting was held. The man refused to attend. It was agreed that the psychiatric nurse would assess the man that day and, if no concerns were raised, the F2052SH would be closed. The medical record for the same day notes that the man was assessed by a member of the Mental Health In-reach Team (MHIRT), but it was not possible to assess his mental health as he refused to talk to the member of staff. He continued to say that he wished to be segregated, and it was noted in the F2052SH record that he was "controlling the situation" and "manipulating" the officers. Despite this, the F2052SH document was closed.

160. Two days later (28 October), the man rang his cell bell again. An officer answered the call and found the man with another cut to his left arm. The officer reported that the man wanted to go to the segregation unit, and added that the man said he had spoken to staff about his problems, although no details of their nature were recorded. A registered mental health nurse (RMN) attended, and saw a large cut on the man's left forearm. The man refused to go to healthcare for treatment, and a second F2052SH was opened. This required him to be observed at least five times per hour. A nurse saw him again later in the day, and he was offered more treatment and counselling but refused both as he still wanted to move to the segregation unit. The clinical review has found that a thorough assessment of the man's condition was documented in the medical notes.

161. A senior officer wrote in the wing history record that, on the instructions of a senior manager, the man was to be relocated to the segregation unit. My investigators could find no explanation for moving the man to the segregation unit other than it is what he asked for.

162. The man was taken to an outside hospital the next day (29 October) so that the injury to his left arm could be stitched. The Prisoner Escort Record (PER) indicates that he cooperated with the escort officers and allowed the doctor to treat his arm.

163. The following day an F2052SH case review was held at which the man attended. It was recorded that the man was very defensive and accused staff of working for the police. The man was apparently angry at being asked questions, and told the meeting that he had been fine at Guys Marsh and now wanted to go to Coldingley. The review decided that the level of monitoring was to remain the same.

164. A further review was held the following day, 31 October. The man attended but was described as uncooperative. The man told the meeting that he was happy to be in the segregation unit and had no thoughts of self harm. The meeting noted that he was eating well. The F2052SH was to continue, but the level of observations reduced, and the prison psychology department were to be told.

165. On 1 November, the man was seen by a member of the prison psychology team. He engaged in conversation, but apparently with limited eye contact. The man acknowledged that he had harmed himself to get to the segregation unit, and wanted a transfer to Coldingley. He told the psychologist that he was not suicidal, but was prepared to harm himself to get what he wanted.

166. Three days later (4 November), a further case review was held. The meeting agreed that the man was not displaying any signs of self harm, and decided to close the F2052SH.

167. Sixteen days later (20 November), for the first time at Highpoint, the man stopped taking food. On 23 November, as part of the monitoring procedures, he was seen by the prison doctor. The doctor requested that the man be assessed by a member of the MHIRT. The following day, the man was seen by a nurse from MHIRT, but he refused to communicate except to say that he would not eat or drink unless he was moved from the prison.

168. On 29 November, due to the length of time the man had refused food, a new F2052SH was opened. A full case review meeting was convened, and was attended by a range of staff including the head of healthcare. The man was invited to attend the meeting, but refused. A comprehensive plan was prepared for the man's welfare and included the following instructions:

- F2052SH to be opened, with five observations per hour
- the man to be interviewed by a member of the MHIRT
- doctor to see the man daily
- healthcare to attempt clinical observations twice daily
- segregation unit staff to interact with him
- National Operations Unit to be informed
- healthcare staff to inform the man of the consequences of his actions
- food to be placed in his cell and removed after one hour
- care plan by healthcare and supplements to be offered.

169. The man was also seen by an RMN that day who recorded that he "appeared to be maintaining a high level of control and manipulation in his interactions

with staff. This would indicate that there is unlikely to be any psychosis present at this time. Belligerent, uncooperative with periods of non-compliance with regimes, appears to be his strategy of achieving whatever is his goal at the time."

170. The records show that the man continued to be generally uncooperative with staff, but on 30 November he agreed to speak to an officer the following day. The conversation included a reference to IND and the officer agreed to refer the man's case to them. The officer also agreed to contact the prison education department to seek their assistance with the man's studies.

171. A healthcare plan was drawn up on 1 December 2005 and the man remained in the segregation unit where he was observed five times per hour. The head of healthcare issued a notice to staff which clearly outlined the care requirements for the man and the responsibilities of staff.

172. On 3 December, the man's weight was recorded as 74 kg. This was more than when he was first admitted to prison. Between 1 and 9 December, the food refusal log shows that he was taking some meals. As a result the log was closed, and F2052SH monitoring stopped.

173. On 11 December, a senior officer recorded that at 4.20pm the man picked up his Bible and shouted, "time for round two. I will not take any food starting from next week." There is no record of what prompted the man to make the statement, but the following day he said that he would not eat as long as he was at Highpoint. The following day, due to his refusing food once again, the food refusal log was reopened. The man was weighed again on 13 December, and his weight had risen to 75kg.

174. Four days later (17 December), the man cut his left wrist in a number of places and an urgent healthcare response was requested by segregation unit staff. A member of the healthcare team assessed the man's wound, but he would not allow treatment to be administered. A dry dressing was given to him, but he threw it out of the window. The healthcare staff member advised the segregation staff that, if at any time the man changed his mind about receiving treatment, healthcare would attend.

175. Because of concern about the man's safety, the level of observations was increased to a constant watch. He continued to be uncooperative and refuse food. The prison doctor, visited at 11.00am and, following a long discussion, the man allowed him to dress his wounds. At 2.00pm, the man allowed the nurse to redress his wounds again, and said that he felt a little better. The following day, his care plan was re-written to reflect his changing care requirements.

176. On 21 December, the man received the results of his Open University studies. He had passed his maths exams.

177. One week later (28 December), the man completed a complaint form saying he had been held in the segregation unit for ten weeks. He wrote that staff were not looking after him and threatened not to eat until he was transferred to

a prison with 24 hour healthcare. He alleged that, because he was not British, he was not being treated fairly. My investigators have examined the records and are satisfied that the complaint and allegation of improper discrimination were dealt with appropriately in concluding that the man was held in segregation at his own request for his own safety. It was also explained to him that he would need to eat before a transfer could take place.

178. The following day, the segregation senior officer and the head of healthcare became more concerned about the man's deteriorating health. The head of healthcare shared her concern with a governor who in turn contacted the duty governor at HMP Chelmsford and requested a transfer for the man. The head of healthcare then contacted the head of healthcare at Chelmsford and gave a verbal handover. The Chelmsford head of healthcare was concerned about the man's "manipulative" behaviour. The head of healthcare, at Highpoint explained that it was his physical health she was worried about, and that it was no longer appropriate for the man to be in the segregation unit.

179. On 30 December, the man was escorted by the head of healthcare and prison officers to Chelmsford. It had been arranged with the healthcare manager at Chelmsford that the man was to be transferred to normal location and observed by healthcare. However, the initial meeting between the man, the head of healthcare from Highpoint and the Chelmsford doctor was not a happy one. The prison doctor subsequently wrote comprehensive notes of the day in the man's medical record. He wrote that the man had refused to talk to the doctor at Chelmsford during the assessment because he felt that the doctor was being aggressive towards him. The doctor at Chelmsford subsequently refused to admit the man and he was returned to the segregation unit at Highpoint. The man submitted a complaint form. A senior officer wrote in response to the complaint, telling the man that it was being dealt with at management level. I am unaware of the final outcome.

180. Upon the man's return to Highpoint, the F2052SH constant observations resumed. He continued to be uncooperative, although did allow his weight to be taken. It was recorded at 65kg, 10kg lighter than when the man was last weighed on 13 December. When staff tried to speak to him, he said only that he had no problems. He threw his food supplement drink out of the cell on one occasion, and continued to refuse food and drink. On 31 December, the medical records noted that he smelt of ketones[1], which indicated that his health was deteriorating significantly.

181. The head of healthcare considered that the man required an inpatient bed and enquiries were to be made to several prisons with the necessary facilities to see if they could take the man. In the meantime, the head of healthcare told

[1] Ketosis is a potentially serious condition in which excessive amounts of chemicals called ketones accumulate in the body. Ketones are normal products of fat metabolism, but are produced in excess when glucose is not available for the body to use as an energy source, for example in starvation or poorly controlled diabetes. Symptoms include sweet, fruity smelling breath, loss of appetite, nausea and abdominal pain. If left untreated the condition may result in confusion, unconsciousness and death. The treatment is the same as for diabetes unless it is due to fasting or starvation, in which case a nutritious diet is usually effective.

staff that if the man's condition deteriorated further he was to be admitted to West Suffolk Hospital.

182. On 1 January 2006, after 21 days of food refusal, the man swallowed a considerable amount of Eurax cream that had been given to him for a skin complaint. He later began to bang his head repeatedly on the wall. The clinical reviewers note that this behaviour differed from his previous deliberate self injury and was a possible indication that his mental health state was deteriorating. This was recognised by the prison doctor and the head of healthcare who arranged a transfer for the man to a prison offering 24 hour healthcare.

183. The man's behaviour led to bruising and external bleeding, but he would not allow healthcare staff to administer treatment. The prison doctor recommended that he should be monitored in case of internal bleeding or altered behaviour. The doctor recorded that he had told the man that his health was deteriorating, and he was at risk of kidney and heart failure as well as brain damage.

184. The following day, the man asked to see the prison doctor as he was suffering from abdominal and lower back pain. He told the doctor that he was worried that it was "very serious and that he might die". The diagnosis was that the man had a urine infection. It was treated appropriately.

185. By 3 January 2006, the man had refused food for 23 days and his weight had fallen to 61kg. In response to the head of healthcare' request for a suitable prison for the man to be transferred to, HMP Norwich agreed to take him. Arrangements were quickly dealt with and the man moved to Norwich the following day.

HMP Norwich: 4 January 2006 – 23 February 2006

186. When he arrived at Norwich, the man went through the usual reception procedures and was interviewed in reception by an officer. The interview was followed by a review of the open F2052SH. As Norwich no longer operated the F2052SH system, an ACCT form was opened instead. An entry was made in the history record that the man was eating, and the level of observation had been reduced from constant to hourly.

187. The officer was concerned about the man being allocated a shared cell as he had told the officer he would not share with anyone. The officer therefore considered that the man was not suitable to share a cell. A nurse from the healthcare team agreed with the assessment.

188. The nurse evaluated the man's nursing care plan, and his physical observations and a nutritional assessment were documented. She also took blood and urine samples for testing. The nurse noted that the man said he did not want anything to do with Russian or Ukrainian prisoners, although no reason was recorded. A care plan was prepared. It recognised the man's food refusal history, and aimed to improve his appetite and increase his

weight. He was to be reviewed and weighed each week, and offered a high protein diet with food supplements.

189. At some point, the Custody Support Manager at HMP Rye Hill, telephoned Norwich and asked if they had a prisoner who they could exchange for one who was causing problems at Rye Hill. He told them that his priority was to move the prisoner as he had been in the segregation unit at Rye Hill for some time and needed to be given a fresh start at a new prison.

190. A senior officer at Norwich spoke to the man on 10 January about transferring to Rye Hill, and recorded that he was happy about the proposal. The senior officer added that the man appeared fit and well, and was doing fitness training. He was weighed that day and his weight had risen slightly to 65kg.

191. A week later (17 January 2006), the ACCT document was reviewed and closed. On 24 January, a safer custody officer carried out a Post Closure Interview. The officer and the man discussed the ACCT monitoring and the care plan. The officer noted that the man's only worry was about completing an application for a further Open University course before the closing date. In the event, before the end of the conversation a member of the education department arrived to help the man complete the forms.

192. Through the normal prison administration procedures it was recognised that the man was subject to PSO 6000 (Early Removal Scheme) and that parole procedures had not commenced. The necessary documents were then completed and assessed by a senior manager at Norwich. The manager decided that the man was not suitable for parole, as he had not addressed his offending behaviour. However, the manager concerned had mistakenly applied the wrong rule. Under the terms of the PSO, he should have granted the man presumptive parole and arrangements made to deport him back to Ukraine. The man did not want parole but, under the rules of the PSO, he had no right to opt out.

193. An officer recorded on 18 February that the man was a quiet individual who was not causing any problems. Five days later, on 23 February, the custody support manager and Rye Hill prison custody officers arrived at Norwich to collect the man and take him to their establishment.

HMP Rye Hill: 23 February 2006 – 10 June 2006

194. During an informal discussion, the custody support manager at Rye Hill, confirmed to my investigators that Rye Hill had had a difficult prisoner whom they wished to transfer to another prison, and that he and a manager at Norwich had agreed to exchange one prisoner for another. The custody support manager told the investigators that Norwich identified two prisoners to him who were suitable for Rye Hill, and he agreed to take the man. He said that he was not aware at the time that the man was subject to deportation. He added that it did not make any difference, as the man was a serving prisoner and he wanted to move the other prisoner on.

195. The custody support manager told my investigators that the man did not cause any problems during the journey from Norwich to Rye Hill. After he arrived, a prison custody officer (PCO) completed the cell sharing risk assessment (CSRA) form, noting that the man had previously been on an ACCT and raising concerns about him sharing a cell. The officer assessed the level of risk as medium and added that, if the man was to be placed in a double cell, a further risk assessment would be required. The third section of the form was completed by nurse A who assessed the level of risk as low, and added that if the man was to share a cell it should be with a non-smoker. The officer also filled in some of the First Night Risk Assessment document. Although parts were omitted, it did include the man's history of harming himself.

196. Nurse A carried out the reception healthcare screen and recorded that the man had no physical, mental health, or substance misuse problems, and had no thought of suicide or self harm. Although it was not long since the man had begun to eat again, the nurse did not weigh him, refer him to the doctor or order a special diet. This was despite clear care plans from Highpoint and Norwich.

197. At interview, nurse A told the investigators that she had been busy on the day the man arrived at Rye Hill. She said that healthcare was short staffed and they did not always have time to read clinical notes from other establishments.

198. Contrary to the local reception policy which says that the medical officer will assess a prisoner's fitness to work and use the gymnasium, nurse A completed the assessment. She recorded that the man was fit for heavy work and the gymnasium and signed the form on the doctor's behalf. The review panel also note that there is no evidence in the man's medical records that the doctor assessed him.

199. Several of the prison's 'buddies' assist officers with the reception of new arrivals at Rye Hill. A buddy was in reception when the man arrived. He said that when they first met, the man talked about joining an education class and completing his degree in maths. The buddy thought that the man was fine and looked physically well. The buddy also assists with the induction procedure, and said that the man completed the two week process without any problems. He described the man as talkative and said that he was fully involved with the prison regime. Following reception, the man was located on Carling Unit.

200. At interview, PCO A told the investigators that she worked on Carling Unit in February 2006 when the man arrived. She described him as a quiet man who never had to be reminded to follow an officer's instruction and who conformed to the prison routine. She said he was small with a solid build and not emaciated. PCO A said the man was clean and neat in his ways, and ate and drank normally. However, she said that at one point in February she was worried that he was so quiet, and would look people in the face without saying anything, and did not mix much with other prisoners. She said she spoke to the unit manager about the man and was told that there were no problems.

201. As part of the normal checking of sentence calculation and the identification of prisoners subject to release on early licence a member of Rye Hill's custody team realised that the man's parole paperwork was incorrect. She believed that the decision taken at Norwich not to grant the man presumptive parole was wrong and not in line with the PSO. The custody team member brought this to the attention of senior manager A at the prison. On 29 March, the manager reviewed the earlier parole decision made at Norwich and agreed with the custody team member's assessment and granted the man presumptive parole. This meant arrangements could be made to deport him. My investigators are not sure if the man was told of this decision at the time.

202. The man's wing history record shows very little information following the first two months of his arrival at Rye Hill. However, it does confirm that, up until 3 April, the man went to the prison gymnasium regularly, and on occasions twice daily.

203. On 4 April, the man wrote to Buckingham Palace, the Prime Minister, the Independent Police Complaints Commission (IPCC) and to HM Chief Inspector of Prisons. The letters were similar in content. They reflected the man's belief that other Russian prisoners suspected him of being a police informant, and that he did not want to be deported for fear of repercussions back in Ukraine. At the end of his letter, the man wrote that he did not care about himself and had not eaten for six days. He added that he did not care if he lived or died.

204. The man sent the letters using recorded delivery to ensure that their receipt was signed for. My investigators found that Buckingham Palace and the Prime Minister's Office passed on the man's letter to the Prison Service but could not determine if the IPCC had done the same. The investigators have not been able to establish what if anything the Prison Service did with the letters. Unfortunately, the man's letter to the Chief Inspector was also not handled promptly. I understand that the Chief Inspector has subsequently taken measures to reinforce her policy that all prisoners' letters are responded to speedily and appropriately, although she is of course unable to investigate individual prisoners' cases.

205. My investigators checked the prison records to see if they could identify anything to verify that the man was not eating, as he had stated in his letters. They found no evidence of him refusing food at that stage.

206. On 11 April, the man completed a complaint form about a dental appointment that he said he had requested during the reception health screen, but which had not been facilitated. He was told that an appointment had been made for 20 April. The appointment was subsequently cancelled as the dentist was absent on sick leave.

21 April

207. On 21 April, the man refused to return to his cell after being unlocked to collect his lunch. An officer who was on the unit at time, PCO B told my investigators at interview that the man was sitting outside his cell, along with

his property, but would not tell staff why. The PCO B described the man as slim, pale and looking anaemic and ill. Permission was given by the Duty Director of the day and the Home Office Controller to use reasonable force to return the man to his cell. A unit manager, unit manager A, ordered the man into the cell, and explained that force might be used if he did not. The man did not respond or explain his actions. The unit manager instructed the officers to use force to return him to his cell.

208. According to PCO B's incident report, he took the man's right arm and used an appropriate control and restraint technique to relocate him in the cell. The PCO said, "The man did not resist, but his body became limp and he glided into the cell." He lay flat on the floor, still without saying anything, and was checked before the officers locked him in. The PCO said that he did not remember any evidence of self harm, and the cell looked bare, as the man's property was outside. There is no entry in the medical records to show that nursing staff were asked to attend this planned use of force, as per the guidance in the PSO.

209. Shortly afterwards, PCO C arrived at the unit to commence his duty. He told the investigators, during an informal discussion, that the man told him he wanted to be taken to the segregation unit. The officer told the investigators that he believed the request had been refused earlier in the day. The man said to the PCO, "watch what I do then", but the officer did not know what he meant.

210. Later that day at 2.29pm, the man pressed his cell call button and PCO C responded. When he looked through the door observation panel, he saw that the man had blood on his right sleeve. The man showed his right arm and the PCO could see two cuts. The PCO called for medical assistance using the local code 2 procedures, and nurse B came to the cell.

211. In the meantime, PCO C opened an F2052SH (SASH) document. He recorded in the SASH that the man was annoyed because the education department would not let him use a computer to complete his course work, and was apparently depressed about his parole and the thought of being deported. The investigators have been unable to establish what if anything was done to help him. (One of the education tutors has since told my investigators that the man, and other prisoners who needed a computer for course work, would check if there was space available in one of the classrooms. If there was space, they were able to go. Because it worked on an ad hoc basis, the man's name would not necessarily have been on the education list and therefore, the officer on education duty might have refused to let him attend. The education department would not have been aware of any refusal unless the prisoner told them when they saw someone from education again. The tutor did not recall the man ever telling her he had had a problem gaining access when she saw him on the wing. She recalls the man being an "exceptional" student with whom the tutor said she had a very good working relationship.)

212. The man refused to allow nurse B to treat him, and she later recorded in the SASH document healthcare assessment, section (1a): "called to see, has two

cuts to right arm, wants off the unit and go to segregation unit, won't say why. Refused healthcare treatment. 15.50hrs refusing to talk to any staff."

213. At section (1b) of the assessment, nurse B instructed that the man should remain in his cell and be observed six times per hour. She also gave interim instructions that he should be offered the support of healthcare, the chaplain, officers and counsellors as requested. The nurse signed the document at 3.45pm, and referred the injury to the doctor to assess him within 24 hours. Despite the dental appointment, this is the first entry in the medical notes since the man's reception at Rye Hill on 23 February.

214. Just over an hour later, at 4.50pm, PCO C noticed a small pool of blood in the cell when he was speaking to the man. The PCO asked whether he wanted medical treatment and recorded in the SASH document that the man refused to be seen in his cell. The medical record shows that healthcare was notified at the time but it is not clear whether they went to see the man or not. Another entry was made 40 minutes later by an unidentified member of staff who noted that the man refused his evening meal.

215. The medical record shows that a nurse telephoned the residential unit at 7.30pm to enquire whether the man would accept treatment and was told that he would not. It is not clear what, if anything, was done about this.

216. At 9.10pm, another PCO, PCO D who was carrying out the SASH observations, called a second code 2 for medical assistance for the man. The prison incident report states that the man's cell floor was covered in blood. nurse A came to the cell, and recorded in the medical record at 9.25pm that the man would not acknowledge her. She interpreted this as meaning that he refused to allow her to treat him.

22 – 30 April

217. On 22 April at 8.15am, unit manager B recorded in the SASH document that the man was moved to cell 22 because cell 33 was a health hazard. The Duty Security Manager (DSM) was asked to arrange for cell 33 to be biologically cleaned as soon as possible. The prison would have been in night state, but it is clear that the man had been left in a dirty cell for over 11 hours before being moved.

218. At what appears to be 9.32am, prison doctor A completed section 2a of the SASH document opened the previous day. He wrote that it was, "inappropriate for this man to be seen in healthcare in view of extreme aggression and non cooperation", and recommended that the man should remain on the unit. When interviewed for this investigation, the doctor could not remember how he had reached the conclusion that the man was aggressive, and thought that it might have originated in the records. My investigators found no evidence in any record of the man being aggressive before this date. The medical record for that day shows that the man refused to see a counsellor.

219. For the next two days, the majority of the entries in the SASH document describe the man as aggressive, and that he refused meals and medical care. However, one entry shows that the man apologised to an officer for the way he had spoken the previous day, and on another occasion it was noted that the man spoke calmly to staff.

220. A SASH review took place on 24 April at 11.00am. The man was asked if he would like to attend, but did not answer or take part. Healthcare staff did not attend the review either, but it is not known why. The review meeting decided that, as the man was withdrawn and had not attended the review, the SASH document was to remain open.

221. At 8.45pm that evening, another PCO, PCO E, (who was carrying out the SASH observations) called a code 2 as the man had a cut to his right arm. This was recorded as due to self harm. Healthcare staff attended, but again recorded that the man refused to allow treatment to be administered. The medical records show the time as 8.45am, and note that the injury was caused either by a cut or by opening an old wound. The prison incident reporting procedure shows the time as approximately 8.45pm, and I am satisfied that is correct.

222. Between 24 and 29 April, the SASH document records that the man ate bread, butter and jam, but did not take meals from the wing food servery. A further case review was held on 26 April. This noted his food refusal and recommended ongoing support, including seeing a doctor and a prison buddy. The man's food refusal was not entered into the medical records.

223. By 27 April, the man's behaviour on the wing had improved sufficiently for a member of staff to write that he was polite and talking to members of staff. However, the same day he refused to attend the doctor's appointment. A second dental appointment, in lieu of the appointment arranged for 21 April, was cancelled that afternoon as the dental nurse had gone off duty sick.

224. At 8.15pm on 29 April, a member of staff recorded in the SASH record that the man complained of pain and a swollen arm, and had asked to see healthcare. A note was made in the SASH record that healthcare staff did not want to go to the wing, and the man did not feel comfortable about going to healthcare. The medical record does not contain a record of this exchange, and no treatment was given despite this being an occasion when the man was requesting medical attention.

225. An hour later, at 9.20pm, the man showed his arm to the officer who noted that it was very swollen. He asked the man if he would like painkillers, but he refused. The officer also noted that the man was smiling and chatting during the night. However, at 6.30am the next morning (30 April) the officer noticed a cut to the man's right arm and blood on the floor. The man told the officer that he wanted to go to the segregation unit, but was unable to explain why he wanted to move until he got there. A code 2 was called and responded to by healthcare staff, but it appears that the man refused treatment. The sequence of events that followed is unclear, but resulted in him being taken to healthcare at 8.50am. The SASH documents note that the man was seen

picking at the cuts on his arm and had smeared blood across the observation panel, obscuring the view into the cell. The medical records state that the man's hygiene was poor. His right arm had two cuts which were not healing and contained pus, and his left arm had a deep cut which required stitching by outside hospital. The nurse who responded to the code 2 gave instructions to increase the level of observations to every five minutes for one hour, but if the bleeding stopped to return the level to six per hour. No treatment was given.

226. Whilst in healthcare, another of the residential unit managers, unit manager C, spoke to the man and noted in the SASH document that he had a number of issues which concerned him. They were that he was not able to use computers in education, his mother had died, and parole had been granted so he believed he would be deported. The man told the unit manager C that he wanted to make his own decisions, and was aware that no one else could help him. At the end of the conversation, the man agreed to have a bath, change his clothes and accept medical treatment. The medical records show that he allowed a nurse to take medical observations that morning.

227. That afternoon, the man was taken to St Cross Hospital for further treatment. However, within one hour of leaving the prison, he was taken back as he would not cooperate with medical staff. The SASH document shows that he was uncooperative, but does not explain why, or in what way. When he arrived back at the prison, the man was taken to healthcare briefly.

228. At 6.10pm, the man was taken to a different residential unit, Hastings unit, and his previous cell was bio-cleaned. His wounds had not been treated by healthcare or the hospital, and so were presumably still open. The SASH record notes that he was unhappy about moving units, but a buddy had spoken to him about it and walked over with him. The man was said to be afraid that other prisoners would call him names because he had cut himself, and was on a watch.

3 May

229. The man pressed his cell call button at 12.46am on 3 May. A PCO noticed blood on the floor, and called for medical assistance. The night manager and nurse C went to the cell, but the man again refused to allow treatment unless he was taken to either the segregation unit or healthcare. According to the clinical notes, there was a large pool of blood on the floor that the nurse thought had been mixed with water. The man refused to show his wounds to the nurse. A bandage was seen on the cell floor and removed.

230. The man told staff that he had not felt safe on his previous unit, Carling unit, but would not answer any questions and so his reason for pressing the cell bell was unclear. The night manager and nurse found a razor blade and a pack of razor blades in the cell, and removed them. It is not clear if the man took the razor blades with him, or if they had been left by a previous occupant. I am pleased to note that the manager took the appropriate decision to remove the razor blades from the man.

231. Healthcare was called again at 1.10am as there was more blood on the floor. Once again, nurse C who attended thought that it had been mixed with water.

A tourniquet was noticed on the top of the man's arm, but there are no records about any discussion or intervention. (Tourniquets are used to apply pressure to the veins to prevent bleeding.) The nurse and night manager went into the cell, but the man refused to allow treatment unless he was moved to healthcare or segregation as he said that he felt unsafe on the unit. He did not say why. The nurse remained in the wing office for the next hour whilst observations of the man continued. The medical records for that morning show that the nurse made repeated efforts to engage with the man.

232. The chaplain manager, Reverend A, at Rye Hill provides counselling, pastoral and spiritual care to prisoners and staff. As well as working at Rye Hill, he also works at an Immigration Centre. At interview, the Reverend A said that, due to his immigration experience, an officer asked him to speak to the man which he agreed to do. The SASH record shows he visited the man at 10.11am, remaining with him for approximately 20 minutes. Reverend A described the man as an intelligent and smart man, but unstable. For example, the man constantly changed his mind about what he wanted, particularly in relation to the deportation process. Reverend A felt that the man agreed to see him because he too is a foreign national. Reverend A said he started to build up a rapport with the man, sufficient to enable him to discuss accepting medical treatment. Additionally, he offered assistance in completing the man's deportation appeal documents.

233. At interview, Reverend A described how, when he arrived at the cell, he saw the floor and the man's duvet covered in blood. He explained to the man that he would need to accept medical treatment in order that his wounds would not become infected. The man agreed to this, providing that he could be seen in healthcare, but did not want a uniformed member of staff to take him. It was agreed that Reverend A would take the man to healthcare.

234. A case review took place at 11.30am, chaired by senior manager B at the prison. It was well attended by a cross-section of prison staff and a prison buddy, but not by the man who had refused. The summary of the review shows an agreed support plan and monitoring arrangements were put in place.

235. The SASH document records that the man was taken to healthcare at 12.45pm, and seen by nurse D at 12.50pm. He allowed her to look at the wounds on his arm, and she noticed that he was pale. The nurse took a blood test and sent it to a local hospital for urgent analysis.

236. The next entries in the SASH record are at 1.48pm, when the man was waiting in healthcare, at 1.54pm when he was waiting to see a second prison doctor, Dr B, and ten minutes later when he returned to the residential unit. Entries in the medical record show that the man refused to speak to the doctor and left the room to return to his unit. Apparently, he also refused to speak to the counsellor.

237. When the man returned to his cell, it was being bio-cleaned and an officer asked the DSM to locate him in healthcare, although the records do not show why. However the request was refused. (It is unclear whether it was the DSM

or healthcare that refused this move.) At 2.18pm, PCO B, who was carrying out the SASH observations, wrote in the SASH document that the man was "ghostly white" in colour, and he had told him to put his feet above his head to improve the circulation of his blood. The medical records state that the unit telephoned healthcare at 2.30pm, saying that the man had removed the dressings from his wounds and would not allow anyone to replace them. None of the records shows what action was taken.

238. At 3.00pm, nurse D received a telephone call from the laboratory with the results of the man's blood tests. They showed that his haemoglobin levels were 5.7 which is low. However, the written report showed that the level was even lower at 5 (the normal range is between 13 and 17). The nurse said that the information was passed to the prison doctor B, who instructed her to arrange for the man to go to outside hospital for a blood transfusion. The clinical review states that the man would have felt extremely weak and tired as a consequence of low haemoglobin levels.

239. Arrangements were made for the man to go for the blood transfusion that afternoon, but he refused. A Registered Mental Nurse (RMN), RMN A, went to see the man, but was unsuccessful in engaging him in conversation. The importance of having a blood transfusion was explained, but the man continued to refuse to go. The clinical review panel thinks it is likely that the man would have been so ill that he would have felt unable to undertake the journey without adequate support. It is not clear from the medical notes what arrangements were in place for transferring the man to hospital, and whether these had been explained in order for him to feel comfortable and able to attend hospital.

4 – 8 May

240. On 4 May, the man had a third dental appointment he refused to attend. However, there was reported to be some improvement to the man's attitude, as he talked more to staff than he had done previously.

241. Prison doctor A visited the man in his cell at 12.00pm, but the man did not respond. He also refused to allow his dressings to be changed by the nurse. In interview, doctor A said that he was made aware of the blood results from the previous day. He said he interpreted the results in the light of his knowledge of the man. He knew that the man was cutting himself, and that he was bleeding as a consequence. The doctor recommended that a psychiatric assessment should be arranged. In interview he explained that he was referring to a psychiatric nursing assessment which was dependent on the availability of a suitably qualified nurse. He said in interview, "I would certainly get a nursing assessment as a precursor to getting a psychiatric assessment, because our psychiatrist comes once a week".

242. Prison doctor A also said that the man's medical records contained no evidence that he was mentally ill, and he could not be treated without giving consent. He added that the man could be treated under common law, in his best interests, if he collapsed. He also said that the man, "wasn't going to accept treatment, wasn't going to hospital for a transfusion", and as a result thought that "there was nothing to do". The doctor said it was quite clear to

him that the man did have capacity to refuse treatment. He went on to say that he agreed a psychiatric assessment should have been done as a matter of course, but "was completely confident that the assessment would have said there was no mental illness".

243. Later, the man was given hot water but refused to accept his midday and evening meals. He asked to see the chaplain and a message was left on the chaplain's telephone. Another member of the chaplaincy team, the prison Imam, dealt with the message and went to see him at 6.00pm.

244. The next day (5 May), the man was called to healthcare to see the doctor or nurse, but he refused to attend and healthcare staff did not go to see him on the unit. The clinical records do not say why he was asked to attend healthcare.

245. Between 4 and 7 May, it appears that the man refused some meals, but there is conflicting information in the SASH record and communication room log. During routine checks of the wings, the Duty Director recorded in the SASH document that the man refused some meals, and added that it was unclear whether this was a protest.

246. Healthcare staff went to the unit to see the man on 7 May, but he refused to allow the nurse to treat him. The nurse gave him a dressing and a saline solution, and advised him how to clean and dress the wounds himself.

9 May

247. As the man was subject to deportation at the end of his sentence, form Annex C was issued to him by a member of the prison custody section. The prison file shows that the form was not returned to the custody section, and the records state that the man refused to acknowledge the form. (The SASH document does not refer to the form being issued.)

248. The clinical review shows that the man had a doctor's appointment scheduled at some point during 9 May, but did not attend. There is no explanation of why he did not attend in the medical records. However, an entry in the SASH record at 3.45pm written by PCO F records that the man wanted to see healthcare. The officer contacted healthcare and medical staff asked for the man to be taken there. PCO F told them that the man said he was unable to go to healthcare and asked medical staff to see him on the residential unit. The officer noted in the SASH record that healthcare refused to do this. The man's clinical record notes that healthcare staff did not go to unit because of his complex medical history, and he was not seen at all.

249. Because the SASH documents do not record the time that Annex C was issued to the man, it is difficult to establish whether his request to see healthcare was a direct result of the form being given to him. Equally, it is not known whether healthcare staff were told that Annex C had been issued.

10 May

250. The prison's Safer Custody Officer (SCO), went to see the man in the morning as part of the preparations for the SASH review. In interview she said that, as part of her role, she visited the man most days to see if he wanted anything. She noted that, as on previous occasions, the man did not reply when she spoke to him, refused to have his wounds dressed and would not attend the review.

251. The SASH review took place at 10.00am and considered 11 prisoners on open SASH documents, including the man. The meeting was attended by the Deputy Director, the SCO, the chaplain, a member of healthcare and prison staff. They were aware of the man's worries about being deported, and the Deputy Director asked the custody department, to put the man in touch with immigration advisory organisations and check that he had legal representation. The man was described by those at the meeting as being, "in a very bad way, his reluctance to get his wounds cleared up could make him very ill even though he is not self harming seriously". It was recognised that his reluctance to have his wounds treated could make the man very ill, even though his injuries were individually not serious. The review agreed that he should continue to be observed six times an hour, and should be required to respond at least three times per hour.

11 – 17 May

252. Nurse D contacted the residential unit to ask for the man to be taken to healthcare for treatment, but he refused to attend. The medical records note that the man had refused meals, but was eating bread and butter. The nurse asked the staff on the unit to try to observe the man's intake of fluids.

253. The man remained in his cell all day on 12 May, either asleep or watching television. At 11.30am, he acknowledged PCO G who was carrying out security checks, and agreed to have some lunch. At 12.20am, another officer, PCO H, recorded that the man accepted the meal and was very polite. At 6.40pm, another PCO, PCO I, also noted an improvement, and the man asked for his dinner.

254. The prison custody department received the 'Notice of Decision to Deport and Appeal', issued by IND, which should have been passed to the man. The notice was not handed to him until several days later.

255. The entries in the SASH record for 13 and 14 May are poor or missing and, with the exception of that made by PCO I at 5.00pm, give little information about the man's condition. PCO I wrote that the man was improving, eating and speaking to some staff. The officer wrote that she thought the man needed to develop the confidence to come out of his cell.

256. On 15 May, healthcare contacted the unit to offer the man treatment for his wounds, but he again refused. The clinical notes do not show whether any follow up action was made. The same day, the deportation papers received on 12 May were sent to the unit. There is no record to show that the man was issued with the documents until 17 May when unit manager D issued them

and the man refused to sign them. This event was not recorded in either the SASH or medical records.

257. A SASH review took place at 10.35am on 17 May, and again the man did not attend. The meeting heard that the man was eating and speaking to staff, but no reference was made to the deportation forms. My investigators found no evidence that healthcare was informed that the man had been issued with the deportation papers as per the instructions contained in PSO 2700. Although the receipt of the deportation papers was a potential trigger for self harm, as staff at the meeting were unaware of them they reduced the level of observations to twice per hour.

258. The SASH document shows that the man spent the majority of the day watching television in his cell. However, in the evening he went to the prison shop to collect goods that he had ordered previously. Unfortunately, the order was incorrect. It is not known how he reacted to the error, or what was done to correct it.

18 May

259. At 3.00am on 18 May, the man cut himself in his cell, and a code 2 was called and healthcare staff attended. It was recorded that the man responded to them, but refused to allow the injury to be treated, saying that he wished to be left alone. There was a large pool of blood on the floor and the level of observations was increased to six times per hour.

260. Later that morning, at 8.50am, a second code 2 message was issued as the man had harmed himself again. The SCO, prison doctor and the DSM went to the cell and found the man collapsed on his bed and a large pool of blood on the floor. The SCO said that the man refused to allow anyone into the cell, was abusive and refused all medical intervention. She described him as weak and looking unwell. He did not have a t-shirt on and she saw that he looked thin and underweight, and had a cut above the top of the waist of his trousers. There were more cuts on his arms, and she judged from the mark on the floor that he had lost a lot of blood. The doctor estimated the blood loss at approximately one pint.

261. The man later allowed observations of his pulse, blood pressure and breathing to be taken, and doctor A noted that he responded to stimulation but refused to allow any intervention. My investigators are aware that an ambulance was called, but it is not known why it was deemed necessary. At interview, doctor A could not recall whether he had requested the ambulance. In interview, he said that he asked the man to accept help saying "… no man deserves to die like this". He added that he was sure that the man knew he was going to die.

262. The SCO remained with the man until the ambulance arrived at 9.15am. She said he was virtually unconscious before he allowed anyone to touch him and the paramedics could move him on to the stretcher. She said that the man then seemed to gather some strength, and began to use abusive language and fight, as the paramedics lifted him into the ambulance. The clinical review panel's view is that, on this occasion, the man might have been treated without consent.

263. Prison staff took the man to hospital at 9.35am. He was sedated and preparations were made for him to have a blood transfusion. Two litres of blood were administered by 11.05am after which he was taken to an observation ward. The escort officers informed the communications room that the man would remain in hospital overnight. At 2.30pm, an escort officer recorded that the man had stopped complying with the treatment and pulled a drip out. A hospital consultant tried to speak to the man, but he refused to communicate. The man asked to see a counsellor and a mental health nurse came to his bedside. The escort officer wrote in the log, "refused to speak in the presence of officers", and there is no indication that a private conversation was offered. Arrangements were made for the man to return to Rye Hill, and he arrived back in healthcare at 3.40pm where he remained overnight.

19 May

264. On 19 May, prison doctor A made an entry in the medical record that he had attempted to assess the man who had refused. It is not documented in the clinical notes how the man communicated his refusal and whether he was capable of making an informed decision. The entry goes on to say that he [the man] was "clearly not mentally ill, no medical intervention indicated at present, nor any accepted by the patient. No need to be in healthcare, suggest he returns to Unit."

265. The clinical review panel are concerned that, despite being unable to assess the man, prison doctor A concluded that there was no need for him to be in healthcare. This is of particular concern to the clinical review panel as the man's haemoglobin level was still low having been recorded as 5.3 the previous day. Additionally, the blood transfusion had not been completed.

266. At approximately 9.20am, DSM A, and the unit manager D went to the healthcare centre to discuss moving the man back to the unit as suggested by the prison doctor. The man told them that he was being bullied on the unit, and so they left to discuss the matter with someone from the senior management team. Ten minutes later, the man harmed himself again. Nurse D saw him in his cell, but he would not let her treat him.

267. The SASH document shows that, at approximately 10.40am, the man went to the sink and collapsed onto the floor. Before healthcare staff were able to return, he managed to climb back onto the bed. When nurse D arrived she went into the cell and managed to take his observations. She noted that he was pale, his pulse was slightly fast and his blood pressure was dangerously low.

268. Nurse D told prison doctor A and noted in the medical record "Nil ordered", meaning that the doctor did not give any instructions for medical intervention or treatment. In interview, prison doctor A was asked about the entry in the medical record. He said that, "The man was determined to die … He was going to go on refusing medication or any medical intervention or any help of any sort … And when he had the opportunity he would cut again and he would die." Prison doctor A described the man as stable and not mentally ill. He said that it would be possible to administer treatment against the will of a

patient with such low blood pressure, depending on their state of collapse. He went on to say that there was nothing that anybody could do as the man had "made up his mind". An ambulance was not called on this occasion. Nurse D said at interview that this was because the man was refusing treatment, but there is no treatment refusal form.

269. The SCO spoke to healthcare staff and was aware that, if the man carried on losing blood, he could go into organ failure and die at any time. She spoke to the Deputy Director who decided to call an extraordinary SASH review. That day, the Deputy Director held two SASH reviews to look at the man's situation, neither of which were attended by the man.

270. The first meeting, at 1.00pm, primarily discussed the man's medical condition and noted that he had lost a large amount of blood through repeated self harm. Prison doctor A said that it was possible that the man could die in custody, especially if he developed organ failure. The minutes of the meeting note that no further medical intervention was deemed necessary. The meeting also noted the man's feelings about deportation, and decided to inform the relevant authorities of his situation. The level of SASH observations was increased to constant, and staff were required to obtain a response from him every ten minutes. If no response was obtained, healthcare was to be informed.

271. The second SASH review, at 3.00pm, produced a detailed action plan. The first action was to inform the Coroner's office. This was a precaution so that the Coroner was aware that there was a potential death at the prison. The head of healthcare, told the meeting that there was no requirement to inform the Coroner, and that the man should be treated as any other patient. Despite not having met the man, the head of healthcare told the meeting that there was no evidence that he had a current mental health diagnosis. Nevertheless, the Deputy Director requested an urgent psychiatric assessment.

272. At interview, the head of healthcare confirmed that it was the prison that insisted on the psychiatric assessment, rather than healthcare. However, the clinical review notes that the medical records show an entry made by the head of healthcare some 30 minutes before the first review meeting, in which she wrote that she had attempted to contact the psychiatrist. It is not clear why, if medical staff had decided there were no mental health issues and it was the prison that insisted on a psychiatric assessment, the head of healthcare appears to have tried to contact the psychiatrist.

273. The remaining action points from the second meeting were to contact IND, produce a chronology of events and contacts regarding the deportation, and produce a log of the man's self harm history. I am satisfied that the Deputy Director gave clear instructions as to what he wanted doing and what was expected.

274. Although the prison buddy could not recall the actual date, he told the investigators that he first became aware of the man harming himself about three to four weeks after the man arrived at Rye Hill. He had seen him occasionally beforehand as the man went about the prison. However, on 19

May, the buddy was asked to see the man on the residential unit. He said he was shocked when he saw the change in the man, describing his appearance as looking like a "zombie", and that he was depressed, unshaven and had lost a lot of weight. The buddy said the man had cut himself "quite badly". He stayed with him for about 45 minutes, during which time the man refused to accept any dressing for his wounds and would not explain why he had harmed himself. The man told the reception buddy that he did not want to eat and wanted to die quickly by cutting himself or by hanging. He said he was disappointed to still be alive despite cutting himself. The reception buddy said the man's problems were that he was unable to find his wife and child, and he was afraid that the Russian Mafia would kill him.

275. The reception buddy said he told the man that he would need to be fit and well if he was to appeal against deportation, and managed to get his agreement to go to outside hospital for a blood transfusion. At 5.08pm, healthcare staff were informed and prison doctor A arranged for the man to be admitted to an external hospital. The prison dealt with the arrangements quickly and staff were ready to take him at 6.10pm, but the man then declined, saying that he wanted to go the next day.

276. Contained within the documents obtained by the investigators was an undated memorandum written to the Deputy Director by the custody support manager (CSM), a senior manager at Rye Hill. The CSM told the Deputy Director that he had spoken to the man, together with the buddy. The CSM said the man told him he tried to take his own life, believing he would go to sleep and not wake up. He added that the man was concerned that, if he were deported to his home, he would be killed. The CSM also said that the man was concerned that, if he moved to London, members of the Russian Mafia would have him killed.

20 – 22 May

277. The SASH document for 20 May notes that the man ate and drank, was polite and did not present any control problems. Prison doctor A saw the man, and wrote in the medical record that he was asleep and had refused to have medical observations. It is not clear when the man refused to have any observations carried out. The doctor added that, in his view, there was no need for the man to be in healthcare. The DSM was informed that the man was fit to return to the residential unit, despite the man's dangerously low blood pressure which had been recorded the previous day.

278. The Duty Director of the day, senior manager B, saw the man and asked that he should remain in healthcare over the weekend. The medical record states that the Duty Director was concerned to avoid "antagonising him by returning him to the unit [residential]", where he might self harm and there would not be "enough staff to take him out". The investigators believe this to be a reference to taking the man to an outside hospital.

279. At 2.20pm, the man allowed a nurse to take nursing observations. He also asked to see a Roman Catholic priest, and a message was left on the chaplaincy answerphone.

280. Just over five hours later at 7.50pm, PCO J who was carrying out SASH observations noted that the man appeared unsteady on his feet and looked "ghostly pale and tired". There is no record of the action taken. The Duty Director, senior manager B, saw the man at 9.00pm, and made no mention of the man's appearance, the Duty Director noted that, when he spoke to the man, he said he was okay.

281. At 9.30pm, PCO K, now carrying out the SASH observations, noted that the man said that he felt very cold and shivery, and had a "funny tummy". The officer asked a nurse to see him, but the man refused to speak to healthcare. The medical records do not show any mention of this.

282. The SASH entries for the remainder of the night show that the man was restless. However, the following morning (21 May) prison doctor A again recorded that the man was stable and there was no reason for him to remain in healthcare.

283. On 22 May, the prison's management team began a two day meeting away from the prison, and at midday a senior manager, based at HMP Wolds arrived at Rye Hill to cover for the Director. The senior manager from the Wolds, had worked at Rye Hill previously and had some knowledge of its staff and routines. He told the investigators that, prior to taking over, he was briefed by Duty Director, senior manager C, and the Director who told him about the man's situation. The Director told the Wolds senior manager that the man was on a constant watch and, in the event of him being taken to outside hospital, documents were available which outlined his history over the previous months.

284. During the day, the head of healthcare provided the Deputy Director with the self-harm summary requested at the case review on 19 May. She wrote that there was no evidence, either anecdotal or assessed, of the man having any mental health history. Her summary said that since 2002 the man had a history of saying that he wanted to kill himself, and often said he felt suicidal every day. The head of healthcare observed that the man chose cutting himself and food refusal as his methods of self harm, and often appeared to use them to obtain what he wanted such as transfers or moves in the prison. She noted that, once he obtained something, he would "change his goal posts" and had been described as "manipulative and always wanting to be in control". The summary ends by saying that the man did not engage with healthcare but was improving physically and was fit for normal location.

285. In interview, the head of healthcare said that, in the course of preparing the summary, she noted that the man had refused treatment on 40 occasions, both at Rye Hill and at previous prisons, which had caused difficulties for nursing staff.

286. At 5.10pm, the man was transferred from healthcare to Hastings unit. The records do not give any indication why he was returned to the unit.

Another PCO, PCO L, who was one of the escorting officers, recorded in the SASH document that "The man has stated that he will be taken out to hospital today or will die". The investigators could find no information in the records to show what was done in response to the man's words.

287. PCO M came on duty at 8.45pm, and took over the SASH observations. In interview, he said that officers watched for an hour at a time, and he remained until just before 10.00pm. He was briefed by the previous officer, and recalled that the man was quiet when he came on duty and was lying on the bottom bunk watching television.

288. At approximately 10.00pm, PCO M handed over the SASH observations duty to PCO N. Soon after taking over the observations, PCO N asked for medical assistance as the man was picking at his wounds. PCO O was on duty that evening, and attended with the Registered General Nurse (RGN), nurse E. Nurse E wrote in the medical record, "asked if the man was ok or wanted any help, there was no response". The nurse added, "was unable to see the wounds". It is unclear from the clinical notes whether or not nurse E entered the cell to assess the injuries but he was aware of the man's self harm history.

289. PCO O took over the SASH observations from 11.00pm until almost midnight, and at other times during the night. He said that the man was agitated and paced about the cell. He smoked a lot and asked for a light a couple of times. There was no more conversation between them, and the man would not talk about what was bothering him. PCO O said that the man spat quite regularly at the door and floor.

23 May

290. At 1.00am, a code 2 was called by PCO M who had returned to the SASH observation duty and seen the man picking his wounds. A number of prison and healthcare staff responded to the call. PCO M and nurse E stood at the door trying to get a response, but did not unlock the door. PCO M told my investigator that he could see blood on the mattress and floor during the night, but did not remember when he first noticed it. He moved away from the door so that others could speak. He did not hear the man say very much, in particular whether he was willing to be treated.

291. Nurse E recorded in the SASH log, "Called to see code 2. Blood on bed. Unable to see arm. Refusing to speak to me. Asked if I could just look at his arm, would not respond. Just sitting watching TV. Blood on bed, does not look to be a large amount." At interview, Nurse E clarified that his observations were not based on a physical examination of the man as he did not ask the night manager to unlock the cell. He said the man looked up from the television and told him to "go away, I don't want to see you". Nurse E did not think it was necessary to go into the cell, and instead looked through the observation glass and spoke through the gap in the door (the quarter inch gap between the door and the doorframe).

292. PCO O also responded to the code 2 call, and described a puddle of what he thought was watered down blood on the floor. In interview he said that it appeared to have been thinned, did not smell and was not clotting. He was

present whilst nurse E talked to the man, but did not remember what was said and did not think that the night manager had been asked to open the cell.

293. The night manager, night manager A, that night also went to the man's cell. She had been told that the man had opened an old wound and there was blood all over the sheets. In interview, she said that they could not see what the man had done to himself as he was sitting with his back to the door, watching television and playing with his arm. She said that nurse E offered treatment, and that the man either refused to reply, grunted or swore, and this was taken to mean that he refused the offer. Because the man was being constantly observed by staff, the night manager said that she was not unduly concerned and knew that someone would be watching him all the time. She described him as awake, fine and watching television, and so not in danger.

294. A second code 2 was called an hour later at 2.00am by PCO Q, as the man had again harmed himself. Several staff responded to the call, including PCO M, PCO O, PCO Q, nurse E and night manager A. The communication log records that permission to enter the cell was requested 20 minutes later at 2.20am, and the senior manager from HMP Wolds (who was still acting as Duty Director) was informed by telephone. It is of concern that there was a 20 minute delay before staff entered the cell, especially as this was the second code 2 in an hour.

295. It is worth noting that the cell the man was in at that time measures approximately 3.76 metres x 2.14 metres, although it tapers in length at one point to 3.14 metres to accommodate sanitary pipes. On the right hand side as you enter the cell are two single beds in a bunk bed arrangement. Each bed measures approximately 2 metres x 0.87 metres. The lower bed is raised off the ground, and both beds are attached to the cell wall. As well as the beds, there is a toilet, sink, wardrobe and desk. Four staff (PCO O, PCO M, PCO Q and nurse E) went into the cell. At interview, all the staff gave slightly different accounts of what they had seen.

296. Nurse E said he saw the man standing at the sink and then moving back to the bed, a distance of about three steps. He noticed that more blood was present than before, and described it as a pool approximately three foot by one foot across, which he estimated as between 300 and 400 millilitres. He spoke to the man and knocked on the door for about eight to ten minutes, discussing with night manager A the possibility that he might have a weapon. The man made no reply and so nurse E decided that he needed to go into the cell. The night manager unlocked the door, and nurse E went in. The PCO O said he had a cursory look round the cell as they went in, and there was no time or need to search the cell, as they were focused on the man.

297. Nurse E stood nearest to the man, with the three officers behind him and another officer and the night manager outside the cell. Night manager A said at interview that she saw blood on the bedding and fresh blood on the floor, which she described as the size of a tea plate. She said the man had tied some socks around his arm like a tourniquet. Because the night manager was the key holder, she said that she tried not to become involved with managing the situation.

298. PCO M told the investigators that he remembered the man lying on his back on the floor and saw a substantial amount of blood. He said the staff lifted the man on to the bed, which he did not resist. PCO M said that the man was quiet, very pale and did not appear to be conscious. He also said that he could see a substantial amount of blood coming from his forearm, but could not recall which one. (His account differs from those of the other three staff present who said that they found the man on the bed rather than the floor.)

299. PCO Q said that the man was lying on his bed, and did not respond when they arrived. He said the man's eyes were closed but he could see that he was breathing. The officer said it was the first time he had met the man, whom he described as thin and gaunt. He said he did not notice any sign of blood in the cell.

300. At interview, nurse E said the man was lying on his stomach, with his right arm hanging over the side of the bed. They turned him on to his back so that medical checks could be carried out. He was unable to say whether the man was semi-conscious, but he did not speak when the nurse told him what he was going to do. He described the man as stiff, but that he did not resist being turned over. Nurse E pulled up the sleeve of the man's t-shirt which was blood stained. He started to carry out medical observations, including taking his blood pressure and lifting his eye lids to check his pupils. (night manager A said that nurse E also removed the socks tied round the man's arm.) The checks were satisfactory and nurse E decided that there was no need to admit the man to healthcare or outside hospital.

301. Whilst nurse E was considering what action was needed, the man punched him on the left arm, shouting to him to go away and leave him alone. PCO M described the man lying still, without responding and then suddenly lashing out, swinging one of his arms in the direction of nurse E who said he was shocked and left the cell straightaway. Night manager A described nurse E as angry about being hit. She said that the RGN had not had a chance to dress the wound.

302. The three officers restrained the man and he did not resist. As the man was not causing any further problems, the officers left the cell and PCO O locked the door. PCO O said that he did not notice any blood as he was pre-occupied with dealing with the situation.

303. Night manager A said in interview that she did not consider moving the man out of the blood stained cell because his mood was volatile and she was concerned for the safety of the staff. She confirmed the cell was not searched.

304. Nurse E looked back into the cell through the observation panel and saw that the man was sitting up in bed and grinning at him. At interview, he confirmed that no treatment was administered and there was no discussion about moving the man.

305. The senior manager from HMP Wolds told my investigator that he was telephoned at approximately 2.15am on 23 May. He was told that the man had superficially harmed himself and, although his arms had been bleeding, this had since stopped. The information he received was that the man was threatening and staff felt that it would be unsafe to go in. Staff told him that they expected the man to resist, so he clarified that there was no medical intervention needed insofar as the man had stopped bleeding. The senior manager added that, as the man was on constant observations, unless his circumstances changed during the night there was no need to enter the cell and "force the issue", and any matters would be dealt with in the morning. The senior manager said he was not contacted a second time and he assumed that nothing had changed, nor was he asked for permission to enter the cell and was unaware that a member of staff had been assaulted. (Upon receiving his interview transcript, the senior manager told my investigators that he had been mistaken and had received more than one telephone call that night, although not all related to the man.)

306. The prison buddy became aware of the man's self harm attempts and went to see him at about 8.30am. He told my investigators that he looked through the observation panel and saw blood in the cell. He described the blood as mixed with water. It was all round the floor, on the bedding and down the side of the bed.

307. The officer on SASH observations opened the door to check the man and the buddy took the opportunity to ask the man what he had done. The buddy said that he got no reply and the man kept turning over to face the wall. He said that the staff tried to enter to clean the cell, but the man refused to let them in.

308. At 9.00am, as is customary at Rye Hill on weekday mornings, all the prison's managers met to discuss the events of the previous 24 hours and make any necessary operational decisions. The meeting on 23 May was chaired by the Wolds senior manager in the absence of the usual management team. About 12 staff were present, however the senior manager could not remember their names. This is because he was temporarily covering duties at Rye Hill and did not know the names of all the staff. The senior manager briefed them on his knowledge of the events concerning the man and said that medical intervention had not been required. Although he had not seen for himself the condition of the cell or the man, he told the meeting that there was a small amount of blood on the floor which required cleaning that morning. He was assured that it would be dealt with although, because he did not know the staff names, he did not know who gave the assurance.

309. From examining documents, my investigators were able to determine the names of Oscar 1 and the DSM on duty that morning. At interview the DSM, DSM B, told my investigators that she would not have attended the morning meeting, but Oscar 1 would have. DSM B could not remember any information regarding the man being handed over to her that morning. As mentioned earlier in my report, Oscar 1 was the staff member who had been suspended and has been unavailable for interview.

310. The senior manager from the Wolds said the meeting lasted about ten minutes, after which he continued with his other duties. He spent the remainder of the morning in the segregation unit, leaving it at approximately 1.30pm. He then began to go round the other wings and, as part of the Duty Director responsibilities, began to check the SASH documents. About half way through the checks, and before arriving at Hastings unit, he received an urgent telephone call on a matter unrelated to the man. This occupied the rest of the day and meant that the remaining SASH documents, including the man's, were not checked.

311. The SASH document shows that the man did not accept any meals on 23 May and remained in his cell. The officers were required to obtain a response from him every ten minutes. PCO B took over from PCO R at 12.52pm, and continued the observations until 3.10pm. PCO R told him what was required, and also that blood had been on the floor since 3.00am that morning. (I am satisfied from other records that blood had actually been there since at least 1.00am.)

312. At interview, PCO B described the man's complexion as very pale and almost anaemic. His forearms were badly marked with recent scars. PCO B had been told about the incidents during the night and saw the blood on the cell floor. He said that the cell smelt, adding that the blood went from the door to the window and across the width of the cell. As well as the floor, he said it was "dripping off the mattress." (The man had no quilt, only a sheet because the quilt was being laundered and had not been replaced.) PCO B added that some of the blood had dried, and it was difficult to find a place to step that did not have blood. Because PCO B had had to walk on the blood stained floor to check the man, he asked for a replacement pair of shoes. He was told by a manager to have his shoes bio cleaned instead.

313. PCO B said that the man would occasionally grunt when he checked him, but did not say very much at all. The PCO said he asked a unit officer about the quilt and was told that it would be returned when it was dry. PCO B said other prisoners in the unit were concerned about the man's welfare. He voiced his own concerns about the condition of the cell to PCO S, one of the unit's staff. He said PCO S was also concerned and had apparently made two or three telephone calls to the DSM, who he believed to have been DSM A. PCO S confirmed to the investigators during an informal discussion that the cell floor was covered in congealed blood.

314. PCO B handed over to PCO T at approximately 3.20pm, and took over again at 4.30pm. The man was still lying on his bed, and was watching the television.

315. DSM A was on the late shift from 1.00pm to 9.00pm. At some stage during the afternoon, she went to Hastings unit and saw the man's cell. At interview, DSM A said that she looked inside the man's cell and saw a large amount of what she thought was dried blood on the floor. She said she had not taken any action to deal with it. She could not explain why no action had been taken other than to say no code 2 alarms were called during her shift.

316. Another unit manager, unit manger E, also came on duty at about 1.30pm and carried the radio with call sign Oscar 1. He had received a handover from a manager, whose name he could not recall, but which he said did not include anything about the man.

317. The Wolds senior manager said he was not consulted about the man again, and at about 5.30pm he prepared to leave the prison. He gave a handwritten note identifying the units he had visited to the oncoming senior manager, senior manager D. Senior manager D had returned from the manager's residential meeting, and took over as Duty Director. On the handover note, there is a cross next to Hastings unit to indicate that it had not at that time been visited by the Duty Director. The Wolds senior manager said he told senior manager D about the man's self harm during the night, and also about the blood on the cell floor which he believed had been dealt with.

318. At 5.45pm, PCO A volunteered to give PCO B a break from the constant watch. She told the investigators that she had first met the man when he arrived at Rye Hill in February 2006. PCO A had been on sick leave from 28 March to 22 May and not seen the man again until she took over the watch on 23 May.

319. At interview, PCO A gave a graphic account of her recollection of the events that evening. She said PCO B asked her if she was squeamish about blood, and when she looked into the cell she was shocked by what she saw. PCO A said she did not recognise the man at first and was shocked by the change in his condition, describing him as looking worn out. PCO A said the cell door was locked. When she looked in, the floor from the window to the door was covered in blood, with a thick pool in the middle. PCO A said the bed had a bare foam mattress which was also covered in blood. The man was lying on the bed covered by a black and white striped plastic mattress cover.

320. PCO A told the investigators that she went into the cell and the man said that he would not speak to her. She told him that she would continue to enter the cell and would touch him on the shoulder to get a response, regardless of whether he spoke to her or not.

321. She told the investigators that other prisoners began complaining to her about the man's condition. She described the atmosphere on the unit as tense. The prisoners wanted the situation to be dealt with, and were looking in the cell whenever she went in. They complained that officers were walking in the blood in the cell and then back onto the landing, which was unhygienic. They were also unhappy that the cell was alongside the meal servery area.

322. There is a Roman Catholic (RC) chaplain who works on a part time basis at Rye Hill. He had had previous discussions with the man, who had asked to be confirmed. However, when the man realised that the RC chaplain was not an ordained priest, he decided not to speak to him. Despite this, the RC chaplain said he told the man he would assist him with his deportation papers.

323. On the evening of 23 May, the RC chaplain went to speak to the man about the deportation issue. When he arrived at the cell, PCO A told him that it was in an awful state and he should be prepared for a shock. He went inside the cell and the floor from the wall to the door was covered in dried blood. He was concerned that bacteria might be present. He described one small clean patch, where he was able to stand to speak to the man. The RC chaplain added that the man had no bed linen, and was covered by a plastic mattress cover. This prevented him from seeing the condition of the man's body.

324. The RC chaplain said the man did not speak to him and so he left and asked PCO A how long the blood had been on the floor. She told him that, according to the records, it had been there since 2.00am that morning. He said that both he and PCO A were very distressed about the state the man was in, as were some of the prisoners. The RC chaplain went to the unit office and telephoned the control room to ask the Duty Director, senior manager D, to contact him. The RC chaplain said that during the next hour he spoke to senior manager D three times about the situation, and was told that he would send a manager to assess it. The RC chaplain said he asked senior manager D if he had been to see the cell for himself and senior manager D told him that he had not.

325. At interview, senior manager D confirmed he was telephoned by the RC chaplain. He described his manner as "agitated and concerned". He said he told him that he would find out the details and take the appropriate action. After one of the calls from the RC chaplain, senior manager D contacted the Oscar 1 that day, unit manager E, to ask him to go and check the man's cell. He said he expected Oscar 1 to go into the cell and try to speak to the man. Senior manager D said that he did not go himself as he thought that he could trust the managers to give him the information and, having come on duty from an external meeting, he was not wearing his prison uniform.

326. Oscar 1 (unit manager E) said he first became aware of the man harming himself when he and DSM A were called to senior manager D's office at about 6.00pm and told about the telephone calls from the RC chaplain. Oscar 1 said senior manager D asked them to look at the cell and report back to him.

327. In the meantime, the RC chaplain went to healthcare to inform the staff of the man's situation, but nobody was present when he arrived. He asked the control room to locate a nurse, and when a nurse telephoned him he repeated the information about the man. The RC chaplain was told that the man had already been offered all the help they could give and had assaulted a nurse the previous night. The medical records do not show any reference to the conversation having taken place.

328. Due to the unrelated matter that the Wolds senior manager had been dealing with earlier in the day, senior manager D said he called all the managers to his office. At the end of the meeting, he asked Oscar 1 (unit manager E) about the man's cell and was told that he had not yet been to see it. The senior manager D said Oscar 1 assured him that he would go to Hastings unit straight after the meeting. It appears that this was about 7.30pm.

329. At interview, Oscar 1 said both he and DSM A went to the cell. He said the RC chaplain and PCO A were also present and he had to begin by calming them down as they were angry at the situation. Other prisoners were about and told them that the man should be removed and the cell cleaned. (In response to the advance disclosure of my draft report, DSM A said that the man would not leave his cell during association because he felt he was being bullied. My investigators have found no evidence to show that the man was being bullied, or that the prison investigated the allegation.)

330. Oscar 1 said he opened the cell door and saw the man lying on the bed, wrapped in his quilt. He spoke to the man who did not reply or acknowledge that he was in the cell. Oscar 1 said the cell was empty and there was not a lot of property in it. He described a puddle of blood on the floor, about the size of an A4 piece of paper, and also on the quilt. When the investigators asked if he was certain about the amount of blood, he reconsidered his answer. It appears to the investigators that he was unsure whether he was referring to the man's cell, or another cell. It is also unclear whether the man had been given his quilt back at that stage. I make no criticism as Oscar 1 was not interviewed until 16 February 2007, and clearly the memory fades. He had asked prison management for a copy of his original statement, made soon after 23 May, but it had not been supplied to him. He did remember seeing a small amount of blood on the man's quilt.

331. The investigators asked Oscar 1 if he considered searching the cell and the man to find what he had used to cut himself. Oscar 1 said he had not searched the cell, but with hindsight felt that he should have. He left the unit, and went to the senior manager D's office to brief him about the blood. He said the cell required bio cleaning. Oscar 1 also reported to second senior manager D the threat from prisoners on the unit about the way the man was being treated.

332. Senior manager D said Oscar 1 telephoned him and reported a substantial amount of blood in the cell, which he did not think looked fresh. Senior manager D asked Oscar 1 if he had seen any wounds, and was told that the man was completely covered by the quilt. There is no evidence to confirm when the quilt was returned. Oscar 1 also told him that the man was awake but refusing to speak. Oscar 1 said that the cell was not a suitable place for the man to stay. He was told that another prisoner had complained about the cell, and had threatened that prisoners would refuse to return to their cells that night. Oscar 1 said that PCO A was "in cahoots" with prisoners and also thought it was outrageous that the man was in those conditions.

333. Senior manager D said he did not take seriously the threat of prisoners refusing to lock up that evening and therefore did not identify the threat as a potential incident requiring intervention. He told the investigators he had considered two options. One was to move the man to the segregation unit, but he had decided that was inappropriate. The alternative and more favourable option was to move him to healthcare. He said DSM A thought that the man would refuse to move whilst other prisoners were around. Senior manager D did not want to use force to move him and considered bio-cleaning the cell whilst he was still in it. This was rejected as the prisoners trained in

bio-cleaning, who would carry out the task, said it was unsafe to use the chemicals in the man's presence.

334. Senior manager D telephoned the prison Director to seek advice regarding the man's location. They agreed that the man should be left where he was until the other prisoners were locked away 20 minutes later, and should then be moved to healthcare. DSM A was asked to deal with the move and arrangements were made for bio-cleaning to start the following day.

335. Nurse F was telephoned by senior manager D and understood that the man was being transferred to healthcare to allow the cell to be bio-cleaned. Her understanding was that the man would only be there that evening or overnight, and was not being moved because of any healthcare needs.

336. Senior manager D spoke to the RC chaplain later, and told him what was arranged for the man. The RC chaplain returned to the unit at about 8.35pm, together with another member of the chaplaincy whom he had asked to witness the situation.

337. The RC chaplain told the investigators that they arrived just as the man left his cell. They were concerned that he had to walk from the unit to healthcare. The RC chaplain described the man as weak and vulnerable, and he believed that a wheelchair should have been provided. PCO A told him later that the man had had to walk, which the RC chaplain felt was cruel.

338. PCO A and DSM A moved the man to healthcare. The PCO described him as swaying and unsteady on his feet. She said he lacked the energy to walk and she started to help him. Because his clothing was covered in blood, she put protective gloves on and placed her arm under his. She pulled him towards her to support him. She said that DSM A told her that she should not touch the man. PCO A said that she felt his body pulling her, but it had no weight. My investigators asked DSM A if she considered providing a wheelchair and she said that she had not. She said that PCO A helped the man to walk and she opened the gates between the unit and healthcare.

339. PCO A said that, when they arrived into healthcare, the bed was not ready. She said the man was about to fall, and she supported him while the bed was cleared after which he collapsed on to it. PCO A added that the nurse asked to look at his wounds, but the man refused saying he wanted to be left alone. The man allowed PCO A to remove his jumper, but again said he wanted to be left alone. In her interview, DSM A said that a nurse was present and asked to see the man's wounds. He grumbled, and this was taken to mean that he refused treatment.

340. Nurse F was the day nurse on duty when the man was taken to healthcare and due to leave the prison after handing over to nurse E. She described the man as pale, but able to stand unsupported, and she did not think the situation was serious. She explained the consequences of treatment and thought he understood the implications.

341. Nurse E said the man was placed in the cell and then the staff went into the nursing office. He said that healthcare would not accept responsibility for the man as he was not admitted as a patient. He went on to say that nurse F told PCO A to wait until an officer was available to monitor the man. He said that the PCO became angry as she was anxious to go off duty as her shift had already ended. Nurse E said he and DSM A tried to calm the situation between PCO A and nurse F.

342. At interview, PCO A said she was angry with the nurses, and acknowledged that she felt one of them had treated her badly when she herself had been taken ill at the prison earlier in the year. She said she felt healthcare was treating the man "worse than an animal", adding that one of the nurses said he would not look after the man as he had been assaulted by him that morning.

343. DSM A told the investigators that she reported the argument between nurse F and PCO A in writing to senior manager D, at his request. However, she did not submit a similar report about the man's condition because she said it had not been asked for. DSM A explained that incident reports were prepared after a prisoner self harmed and not in other circumstances. I question why it was seen relevant to submit a report to senior manager D about an argument and not take similar action relating to the disturbing events that day. The records show that the man remained in healthcare overnight with observations carried out by prison custody officers rather than by nursing staff.

344. Nurse E was present when the man arrived into healthcare. He said the man was still wearing the same clothes as when he had examined him at 2.00am that morning. My investigators asked whether a care plan was put in place for the man. Nurse E said that, as the man was admitted at the request of the prison management, he was not considered to be a patient but a prisoner. He said that this meant that a care plan was unnecessary and the man was the prison's responsibility.

345. My investigators asked the head of healthcare about a care plan and she confirmed what nurse E had said. She explained that when prison management placed a prisoner in healthcare he was not regarded as a patient. Healthcare would take no responsibility and this in turn meant that the prison would supply an officer to look after the prisoner. The head of healthcare said healthcare would only treat a prisoner as a patient if medical staff arranged the admission. In that event, healthcare staff would look after him.

346. During my investigation a senior member of GSL, made my investigators aware of two letters of complaint that had been written to the Chief Inspector of Prisons, by PCO A. The Inspectorate is not an investigatory body, and the Chief Inspector had referred the letters to the GSL head office for them to deal with. The company commissioned an internal investigation into the issues raised by PCO A.

347. The first letter raised her concerns about the man's treatment on 23 May. The second was a personal complaint about her own treatment by the healthcare department when she had taken ill at the prison earlier in the year. Although

my terms of reference do not extend to the PCO's personal complaint, I mention it to give a fuller picture of events at the time.

24 May

348. During the morning, the RC chaplain went to see the man but found him asleep. At the same time, the Deputy Director convened an extra multi-disciplinary case review at 11.30am. This was well attended by a cross-section of staff and a counsellor. However, no medical staff were present although it is not clear whether they chose not to attend or were not notified of the meeting.

349. At the meeting, senior manager D told the Deputy Director that the man had been left in the blood-stained cell all the previous day. The minute of the previous meeting noted the seriousness of the man's condition, in particular prison doctor A's comment that he could die in prison. It was the view of the meeting that no treatment could be given unless the man became unconscious, and the Deputy Director added that he was to remain in healthcare for the foreseeable future. He said that, because the man was weak, even if he refused to allow treatment it was preferable for him to be in healthcare.

350. Reverend A reported his conversation with the man, and said he had considered using an interpreter but one was not needed as the man's understanding of English was good. He added that if the man thought a speaker was getting too close to him, he would start to say that he did not understand. Reverend A said that the man's main issues were that he did not want to be on a residential unit and did not want to be deported. The man had told him he wanted attention because he felt neglected, and had said he did not want to kill himself.

351. The meeting considered the man's deportation status, and recommended that IND be advised of his situation so that the deportation process could be speeded up. It was also decided that Reverend A should make sure that the man knew about the deportation appeal process.

352. The record of the meeting shows that consideration was given to the activities available to the man. It was suggested that access to the library and education would be beneficial. A range of caseworkers rather than one individual would keep contact with him, and it was thought that his interest in football could be a topic of conversation. Reverend A said a member of the chaplaincy team would visit each day. Given the seriousness of the situation, and the man's refusal of treatment, the prison notified the Prison Service's National Operations Unit and the GSL press office.

353. As agreed at the meeting, the Safer Custody Officer (SCO) returned to see the man at 2.50pm, and offered reading material. He told her to go away. She described him as unpredictable and wanting to control situations, saying on some days he would tell her to go away and other days would allow her to stay.

354. Reverend A returned to see the man, and asked about his grounds for appealing against his deportation order. The man said he wanted to apply for asylum because of his mother's death, but the Reverend advised that it was not a sufficient reason. Reverend A wrote that the man should not be deported because he had no family to return to in Ukraine. The man then said that he did not want his mother brought into the case, and so Reverend A deleted what he had written. He said the man then accused him of being an undercover immigration official, and so he left.

355. At 3.10pm, the SCO noted in the SASH document that the man had signed his appeal papers. An hour later, the Duty Director visited the man and recorded in the SASH document that the man had not eaten or spoken during the day. Despite the events of the previous day, this was the first occasion that a senior manager had visited the man since 9.30am on 22 May, some 30 hours previously.

356. At 5.00pm, the man ate a packed lunch and drank a cup of tea. He then accepted a second lunch, but refused another drink. At 8.40pm, PCO M recorded in the SASH document that the man was quiet and settled. Just after 10.30pm, the man asked the PCO O, who had taken over the watch, for a cup of hot water. He said at interview he told the man that he could not have the hot water as drinks were only provided at lock up, and not on request throughout the night. The PCO O noted in the SASH document that the man drank several cups of cold water and ate the second packed lunch.

25 May – 31 May

357. On 25 May a probation officer based at Rye Hill, visited the man and tried unsuccessfully to talk to him about football as suggested at the SASH review. The man asked for books to read, which the probation officer provided the following day. Also on 26 May, the probation officer told Reverend A that the man had asked to see him again. However, I understand that when the Reverend arrived, the man swore at him. It is noted in the SASH document that the man refused his canteen on 26 May, but it is unclear whether this meant he refused to make an order or refused to accept what had been ordered previously.

358. The next day (27 May), the man refused all meals and drinks during the day. The medical records state that he had demanded a toothbrush and toothpaste, and his manner to staff was very rude.

359. PCO M was again responsible for the SASH observations, and at interview said he remembered the man asking for hot water for a drink at 9.22pm. He said the request was again refused as prisoners are expected to collect flasks of hot water before they are locked up for the night, and hot water is not provided after the prison has gone into night state. He recalled that prisoners in healthcare cells were not provided with flasks, and understood that no special privileges should be given to them.

360. Over the next two days, the man appeared to settle down. He began to eat properly, and made no more attempts to harm himself. As a result, on 29 May the SASH observations were reduced to six observations per hour.

361. On 30 May, the probation officer returned to see the man, and noted that he still appeared hostile and did not want to talk. The probation officer thought that the man was suspicious of him and other staff, and was 'fickle' in what he said. He said he did not think that the man appeared to be genuinely troubled, and said he did not welcome offers of assistance.

362. The following day, a case review was held at 11.30am. It was chaired by the Duty Director, senior manager B, and was well attended by a wide cross-section of staff. The Duty Director, told the meeting the man was not invited because he would not engage in conversation and refused to speak to anyone. He said he had tried to talk to him about his own visit to Ukraine, but had been unsuccessful.

363. The Duty Director, senior manager B, reminded those present of the man's history and the actions agreed at the review the previous week. Reverend A and the probation officer reported their contact, and the meeting discussed whether the man was trying to "manipulate" his situation regarding his location.

364. The head of healthcare reported that the man had made no more attempts to harm himself since he moved to healthcare, and did not appear to have mental health problems. The psychiatric assessment had not yet taken place nor had the head of healthcare assessed him. She told the meeting that he was eating well and getting plenty of sleep, and was in no danger of collapse. She said that the man kept making new demands and continued to refuse treatment. She said that no treatment could be forced upon him.

365. The head of healthcare recommended that the best course of action was for the man to rest, eat and exercise. She told the meeting there was no need for the SASH document to remain open as the man was not at risk of self harming whilst he was in healthcare. The head of healthcare added that he could return to normal location. Contradictorily, she told the meeting that, if the man were to remain in healthcare, he should continue to be monitored under the SASH procedures.

366. The meeting considered whether a regime such as that in the segregation unit would be appropriate for the man. The reason for doing this was so that he and staff were aware of his entitlements and to "ensure that he was not treating healthcare as a hotel". There is no evidence to show that he was in fact placed on a regime akin to one in the segregation unit.

367. The Duty Director confirmed that the man would remain in healthcare for the foreseeable future, and that the level of monitoring should be reduced to three times per hour.

1 – 8 June

368. During the first week of June 2006, the prison records show that the man appeared to have settled down. He placed an order for goods from the prison shop, including a newspaper. He had a hair cut and obtained clean clothing. In addition to cleaning himself up, he also cleaned his cell. Although he

accepted most meals, there were occasions when he refused them, particularly on 2 June, when it was noted in the medical record that he felt sick if he ate and sick if he did not.

369. At a SASH review on 7 June, the meeting commented that the man had had a settled week, and noted that he had not self harmed since 23 May. The level of observations was three times per hour and it was decided that they should continue at this level and that the man should remain in healthcare.

9 – 10 June

370. The man slept well during the night of 8 June, and gave no cause for concern. However, the following morning he again began picking at his wounds and refused medical treatment. The SCO saw him during the day when she went to check his SASH book. She described him as weak, thin and very underweight, with dark rings round his eyes. He was able to move around the cell, but she said he was staggering about. Later in the morning, the man refused to complete the form for ordering goods from the canteen.

371. At 1.30pm, PCO U saw blood on the man's quilt and went into the cell. She noted in the special watch log that the man told her that he was okay, and did not reply when asked if he wanted his wounds dressing.

372. The head of healthcare said in interview that she spoke to the man for the first time on 9 June. She spent some time with him trying to draw him out and engage him in conversation. She described the man as a small, pale, bearded man who was neither verbally aggressive nor physically threatening. Her memory was that he was wearing a short sleeved top, and the only wound she could remember seeing was on the t-shirt of his arm. She said she was unaware of the death of the man's mother, despite having been at the SASH review meeting on 31 May when Reverend A brought it to their attention. The head of healthcare added that the man asked to see a priest and said he was being bullied by other prisoners. She did not believe that the man was clinically depressed. (The investigators have found no evidence that the man was being bullied or that any action was taken regarding his allegations.)

373. One hour later, PCO U made a second request for healthcare to see the man as he had increased his wound picking. The head of healthcare spoke to him again but he said that he did not want to see healthcare but wanted a smoker's pack. Neither the head of healthcare nor PCO U were authorised to issue a smoker's pack, which is the responsibility of an operational manager. The head of healthcare said the man had money in his account and would have been able to buy his own cigarettes. The request was referred to the DSM, DSM A.

374. Twenty minutes later, the head of healthcare was called to the man's cell again. She noted in the medical record that there was a pool of blood on the floor, and that she asked him to allow her to treat his arm but he would not speak to her. Because the man had lost more blood, the head of healthcare increased the level of observations to constant watch, and informed the DSM and prison doctor A of the change. (In interview, senior manager B said that he was the Duty Director who authorised the return to constant observations.)

375. Some time afterwards, because there was blood on the floor which had to be cleaned, DSM A authorised a move from cell 1 (where the man was located) to the adjacent cell, number 2. She described the pool of liquid, which was thought by staff to be blood mixed with urine, as about two feet round and the size of an A3 piece of paper. DSM A said she arranged a first response team in case force was required to move the man to the clean cell. In the event, force was not needed and the man, wrapped in a sheet and wearing boxer shorts, walked independently into cell 2 where he lay on the bed. At interview, DSM A described the man as very weak, not speaking and holding onto the wall and door to avoid stumbling. Despite his weakness, he was not assisted to move into the second cell.

376. The medical record shows that two more attempts were made to treat the man's injuries. On one occasion he told the staff to go away and he did not reply at all on the other. He was given prison tracksuit trousers at 3.55pm. At 4.53pm and 5.14pm he asked for a t-shirt and jumper, but there is no record whether they were provided.

377. The SASH document notes that, at about 5.20pm, the man was picking at his arms and blood came out "like a tap". Ten minutes later, he vomited and was noticed to be breathing heavily. The man lifted his head and spat on the floor, and did not reply when the nurse asked how he was. Five minutes later, the head of healthcare and nurse F again attempted to check the man's injuries. He said no to them and, because he raised his voice and appeared to be annoyed, they left the cell.

378. An entry in the SASH document shows that at 6.47pm the man was laying on his side and trying to vomit again. At 7.55pm, he asked for water which was given to him.

379. At about 8.00pm, DSM A was telephoned and told that the man had re-opened his wounds. On this occasion she did not request a first response team. Instead, both she and the Oscar 1, unit manager F, that night, went to the cell together. The head of healthcare was also present. DSM A said that the man was coherent and able to understand what she said to him.

380. As cell 2 now had blood in it and cell 1 had been cleaned, the man was moved back to cell 1. As before, the man was not helped to move and used the wall and door frame to support himself.

381. My investigators asked Oscar 1 whether the man was searched before returning to cell 1, or if the cell had been searched before the man went into it. He was unable to confirm what actions were taken, and said that the cell would have been empty.

382. Between 7.55pm and 8.50pm, the head of healthcare made three entries in the medical record. DSM A said the man ignored what the head of healthcare told him. DSM A left the cell and continued her duties until the end of her shift when she handed over to the night manager, night manager A.

383. The head of healthcare told the man that he needed a blood transfusion as he was damaging his organs which she said would eventually fail. She did not tell him that organ failure would lead to his death. She told my investigators he said he understood what she was saying. She asked whether he would allow his wounds to be dressed and have a blood transfusion. His voice rose and he became irritable if she asked more than two or three times so she did not pursue the matter further.

384. At about 8.50pm, the rosters manager, collected a radio and took over the observations from PCO V. She said at interview that she had carried out lower level SASH observations when she was an officer, but had not done any constant observations previously. She was told that staff would be rotated throughout the night, and she should carry out observations for the first couple of hours.

385. Before the rosters manager got to the cell, she was told that she would be required to observe the man six times per hour. When she arrived at the cell, she received a handover from the PCO V who told her that the level of observations had been increased to constant and that the man had been refusing treatment. The PCO V explained that constant observations meant standing outside the cell door, with the observation panel open, so that she could see in. At interview, the rosters manager said she remained standing, except when she sat on the chair by the door in order to write the records. She said the cell was clean and there was no evidence of any blood.

386. While the rosters manager stood at the cell door, the head of healthcare arrived and spoke to her and the man. The head of healthcare said that the man did not have enough blood inside him and so his organs would fail. At interview, the head of healthcare said she tried to discover from the man why he had been harming himself, and explained the damage that he was doing to his body. She told the man that he was an intelligent man and asked why he would not let her help him. The rosters manager said the man acknowledged what was said, and indicated that he was in pain but refused to allow any treatment.

387. The rosters manager told my investigators that the man asked the head of healthcare for a doctor because he felt sick. My investigators asked the head of healthcare about this and she said she told him that his sickness was due to blood loss. She told him that she could call the doctor, but said that what he needed was a blood transfusion. She asked if he would go to hospital for a transfusion, and he again said no, pulled the sheet over his head and ignored her. She told the investigators she did not think that he was going to die, but that the man would have refused any interventions from a doctor or paramedics.

388. The last entry the head of healthcare made in the medical record noted that the man had said he felt sick and she had told him he needed to go out for a blood transfusion. She did not record the man's request for a doctor and did not facilitate it. Shortly afterwards, nurse E arrived for duty. After handing over to him, the head of healthcare left the prison for the night.

389. The rosters manager told the investigators that approximately 40 minutes later she tried to talk to the man. He asked her for water and complained of pain. The rosters manager went on to say that she asked nurse E to get the water, as she was not allowed to stop the observations. Nurse E returned with the water and saw the man lying on the floor. Rather than calling the night manager to enter the cell, the water was placed on the cell door hatch. In order to get it, the man had to get up from the floor and walk to collect it. The rosters manager said took it took him a while to get it as he was so weak.

390. At interview, nurse E said he asked the man if he could go into the cell to carry out observations, but the man refused and said to give him half an hour. Nurse E said that, after taking the water, the man went first to the bed, and then to the floor again.

391. The rosters manager noted in the SASH document that the Duty Director, senior manager B, arrived at 9.45pm to carry out his daily Duty Director checks, and sign the man's SASH document, before leaving the prison for the night. The Duty Director looked through the door and saw the man lying on the bed on his side. Nurse E told him that the man had asked him to return in half an hour, although he did not expect to be allowed to carry out the checks. At interview, the Duty Director said that he was not aware of the head of healthcare's earlier remark to the rosters manager about the man's lack of blood and the potential for organ failure.

392. Night manager A was night manager again and went to healthcare at approximately 10.25pm as part of the normal routine for locking up the prison for the night. In interview she did not remember looking into the man's cell and did not know what his condition was. Nurse E said he asked her if it was alright for him to go into the cell and take the man's blood pressure. She agreed. At interview, she said she knew of the occasion when force was used to restrain the man on 23 May and therefore arranged for additional staff to be present when the cell was unlocked. When nurse E asked the man if he could do the medical observations, she did not hear his reply, but nurse E told her that the man had refused permission.

393. The SASH document notes that at 10.35pm the man asked for more water, which was again given at the hatch. At interview, the rosters manager said she watched him return to bed and described every step as being a huge effort. She saw him lie on the bed, change position, and pull the sheet on and off, adding that he did not talk but only moaned. The rosters manager said the man got back on the floor and removed the sheet. He then moved under the sink, where he lay for a while, before kneeling over the bottom of the bed. He had removed his t-shirt and she could see that his stomach was going in and out. When asked by my investigators if she considered this to be normal behaviour, the rosters manager said she thought that the man was just uncomfortable and restless due to pain. She said she could hear him making a noise as though it was an effort to move.

394. At 11.40pm, the rosters manager handed over the constant watch to PCO O. She told him that the man was very weak, and had refused treatment, but had asked for and been given water. She then went to other duties in the prison.

395. PCO O recorded his first observation in the SASH document at 11.51pm. He noted that the man was kneeling over the end of the bed and that he could hear him breathing. At interview he described the man as being unable to get into bed, but he knew he was alive as he could see his stomach moving in and out and could hear him breathing quietly. PCO O spoke to the man through the hatch in the door, and asked whether it was time to see the nurse. He said that the man shook his head, which he thought indicated that he did not want the nurse.

396. Night manager A returned to healthcare to tell PCO O how long he would remain on the SASH observations. She looked through the flap in the door and saw the man kneeling on the floor, with his hands and head on the bed. She could not see his face, and he did not say anything. The night manager asked PCO O what was wrong with the man. The PCO replied that the man appeared to lack the energy to get back on to the bed. The night manager also asked nurse E what was wrong with the man. Nurse E said that the man apparently did not have the energy to get back onto the bed and had, ten minutes earlier, been lying on the floor under the sink. At interview, the night manager said she replied “fair enough” to nurse E and then left to return to her office. The night manager said that she thought the man would either crawl into bed, or would sleep in the kneeling position.

397. A few minutes later, at about 11.55pm, PCO O looked into the cell. He could not see any sign of the man breathing and decided that the situation was more serious, so asked nurse E to look at him.

398. Nurse E banged on the door and called the man’s name, but could not obtain a response. PCO O asked whether he should call for code 1 emergency assistance. Nurse E agreed and ran to the treatment room to collect emergency equipment.

399. Shortly afterwards, night manager A, the rosters manager and PCO Q arrived in response to the code 1 and the night manager opened the cell. They went into the cell and nurse E took hold of the man’s shoulder to shake him. As he did so, the man fell backwards towards one of the officers who caught his shoulders and laid him on the floor. Nurse E said he felt for the man’s pulse, but it was not present so he asked PCO O to help administer cardio pulmonary resuscitation (CPR). PCO O administered chest compressions and nurse E attached the defibrillator. It instructed them to continue CPR, which they did using a face mask and oxygen. In the meantime, the night manager went to the office to call for an ambulance. After a few compressions, PCO O said some fluid came out of the man’s mouth and he thought that they had managed to revive him. PCO Q alternated with PCO O so that compressions could be delivered continuously.

400. Whilst the staff were carrying out CPR on the man, there was another radio message asking for assistance with a fire on a residential unit. The night manager left healthcare to deal with the fire. PCO O, PCO Q and nurse E continued with CPR until the arrival of paramedics.

401. The ambulance arrived at 12.20am, and the rosters manager left the healthcare centre to escort the paramedics to the man's cell. The paramedics took over administering CPR. At 12.25am, an emergency nurse practitioner arrived by car, followed five minutes later by a second ambulance which the investigators believe was responding to the fire.

402. The paramedics carried out their own tests, and confirmed the man's death a few minutes afterwards. In line with the prison contingency plans for deaths in custody, the police were called. Night manager A, who had returned, sealed the cell to ensure that nothing was touched pending police enquiries.

403. The police officers arrived and unit manager D broke the seal to re-enter the cell and formally identify the man. The cell was locked again and the rosters manager remained outside it until the undertakers removed the man's body at 4.15am.

404. The man was taken to the mortuary and a post mortem was carried out. The pathologist found a razor blade under the man's body when he was removed from the operating table.

AFTER THE MAN'S DEATH

405. Following any serious incident in prison it is normal practice to carry out an immediate "hot debrief". Hot debriefs are arranged to ensure that information is gathered as soon as possible and decisions can be made for any action which should be taken. A hot debrief did not take place after the man's death.

406. Additionally, the Prison Service suggests providing a "critical incident debrief". They allow those involved a particular incident to speak about what went well and not so well, and how they as individuals are feeling. However, the PSO dealing with the care of staff does not make a critical incident debrief a mandatory instruction, and it is therefore left to the discretion of individual Governors or Directors to offer the service. As with the hot debrief, a critical incident debrief was not carried out after the man's death.

407. The Director ensured that the prison's local care team was in place and support services made available to prisoners and staff. However, for at least one member of staff, the interview with my investigators was the first opportunity to talk about the man's death.

408. Following any death in custody, the prison is required to review all prisoners who are being monitored under suicide prevention procedures. This is a precautionary measure to ensure that those who are feeling suicidal are supported appropriately. When the Safer Custody Officer, arrived for duty on Monday 12 June, she discovered that reviews had not been carried out. She immediately ensured that all the prisoners on open SASH documents were reviewed.

409. Other than a cursory check of the prison records, little appears to have been done by the prison to trace the man's family or inform the Ukrainian Embassy.

410. The Deputy Director forwarded copies of two letters, received in the prison after the man's death, to my investigators. My investigators believed the letters, which were not written in English, contained an address and arranged to have them translated. The outcome was positive and, after involving the Coroner's office, the Ukrainian Embassy in London, and the British Embassy in Kiev, the man's father was eventually traced in December 2006 and told that his son had died. Sadly, it was six months after the man died before his family knew what had happened to him.

411. Once the Ukrainian Embassy confirmed that the man's father had been traced, my investigators telephoned him using an international translation agency. My family liaison officer then wrote to the man's father to tell him about my investigation and offer the opportunity to raise any questions concerning the care and treatment the man received whilst he was in prison.

412. The man's father asked to meet the investigators, and they travelled to Ukraine on 25 May 2007 to meet him, his daughter and son in law, plus the family lawyer. My investigators were assisted by an interpreter based in Ukraine and the man's family were given the opportunity to ask any questions. My investigators were also able to return the man's property to his father. I

hope that the meeting helped the man's family to understand the extent of my investigation and answer some of their initial questions.

413. The man's father told my investigators that the man had graduated from high school and then went into the construction industry. He studied English for four years, and could speak the language well. The man had responded to an advertisement in Ukraine offering employment in England and the opportunity to improve his language skills. When the man arrived in England the work was not what he expected, and after a short time he left for London where he found further employment with a bus company.

414. During the meeting, the man's father said his son remained in contact with his family until 2002, but did not contact them again until June 2005 when he rang to tell his father he was in prison. The man's father asked my investigators why the man had committed a crime and been in prison. My investigators were able to give him the details of his conviction and sentence, but were unable to explain why he had committed the crime. They also told him about the different prisons that the man went to and why he had moved.

415. My investigators told the man's father that his son had told immigration officials he did not want to return to Ukraine for fear of being killed. The man's father said he could not understand why his son would say this, and went on to say he had purchased a flat for his son to live in, which was unusual for someone of the man's age in Ukraine.

416. The man's father asked why it had taken so long to tell him about the man's death. My investigators explained what had happened and also gave him a letter from the managing director which he had given to my investigators to pass on. The man wanted me to know that he and his family were angry about receiving the letter at this stage, some 12 months after the man's death, and felt it was too late to offer condolences. Additionally, he said he and his family were very upset to be told of the man's death when they were celebrating Christmas.

417. The man's father asked my investigators if they could return the two letters, mentioned earlier, that he had sent to the man. The investigators had copies of the letters and have asked Rye Hill to return the originals. I am pleased to note that the originals have now been returned to the man's father.

418. Finally, the man's father asked the investigators if they were satisfied with the level of care the man received from Rye Hill. The man will receive a copy of this report which makes my views very apparent.

419. As part of the investigation, my investigators requested information about the man's immigration status from IND. One of my investigators also met with a member of staff from IND. The primary concern was whether or not the man was lawfully detained between the period he was granted parole (29 March 2006) and the date the authority to detain (IS91) was received at Rye Hill (12 May 2006).

420. On 29 May 2007, my investigators received an email from a criminal caseworker at IND with a note of explanation of the deportation process and how it applied for the man. It appears that IND failed to follow the correct process and did not consider detaining the man under immigration powers on the expiry of his sentence, pending deportation. Their reason was that, prior to May 2006, the processes were poorly defined and there were insufficient trained staff to deal with a large number of cases being considered. The note added that, regrettably, IND did not at any point consider whether to detain the man under immigration powers, despite notification from Wayland and Norwich before 21 January 2006 when he became eligible for parole. IND concluded that it appears there may not have been any immigration powers under which the man could have been detained beyond his release date. He was therefore unlawfully held at Rye Hill.

421. I am grateful to UKBA (formerly IND) for their co-operation in this case as my office does not have powers to investigate their actions. I will share my report with the Director General of UKBA and the Director of Criminal Casework Directorate who may wish to examine this matter further.

ISSUES

Prison Transfers

422. The man was transferred to seven different prisons before arriving at Rye Hill. Although his self harm history made him a difficult man to manage, there is no evidence that he transferred because any of the prisons were unable to cope. Instead, the transfers were at his request or represented normal progression through the prison system.

423. I am satisfied that the man's transfers were not because any establishment refused to accommodate him. Additionally, I am satisfied that the final transfer to Rye Hill was an arrangement agreed between Rye Hill and Norwich, instigated by a manager at Rye Hill.

Training and Development

424. Despite the man's medical history and care plan at Norwich, from his reception into Rye Hill there are no more entries in his medical record until 21 April which suggests that no medical observations were being carried out.

425. The medical records show that healthcare staff were called to see the man on 21 April after he had self harmed. The clinical review panel believes that the man's behaviour began to deteriorate from around this date and this was not recognised. His dental appointment for that day had been cancelled and the panel believes that this, combined with his fear of being deported and not getting access to computers, may have led to a change in behaviour.

Training in basic mental health awareness should be provided for all grades of staff, to enable them to recognise trigger points in relation to changes in behaviour which may lead to adverse consequences.

Searching prisoners on ACCT or F2052SH

426. It is clear that the man had access to razor blades and was allowed to keep them in his possession. It would seem from the evidence that little was done to find what the man used to cut himself, as he does not appear to have been searched after harming himself or following cell moves. For example, I have already described how, during the post mortem examination, a razor blade was found on the mortuary table.

427. Whilst razor blades are not an unauthorised item, I question the sense of allowing a prisoner who may have been using them to harm himself to have them unmonitored.

The Director should ensure that appropriate systems are in place to monitor the use of razor blades by any prisoner being monitored under the suicide prevention procedures.

The Director should ensure that appropriate searching systems are in place.

Information sharing

428. PSO 2700 contains the following mandatory instruction at paragraph 4.2.6:

> "When an at risk prisoner is in the HCC [healthcare centre] or under intermittent supervision or constant observation elsewhere in the establishment, a doctor or nurse must be consulted before any news known to be unfavourable to the prisoner is communicated to him or her."

429. Throughout my report there are numerous examples of breakdowns in communication. This has been found by my investigators in the prison files and by the clinical review panel in the clinical records. For example, on 9 May 2006 the man was issued with Annex C relating to his immigration status. That day he asked to see healthcare, but because there is no record of the time he was issued with Annex C it is not possible to establish if receiving it led to his request. Equally, it is not known whether healthcare was ever informed that Annex C had been issued.

430. Another example was on 17 May 2006 when the man was issued with deportation papers. A SASH review took place the same day and the panel heard that the man was eating and speaking to staff. But there is no indication that they were aware of the deportation form being or about to be issued. It was already apparent that the man was worried about deportation, and the clinical review panel believes receipt of the form was a potential trigger for self harm.

431. Issuing of the deportation papers does not appear to have been taken into account at the SASH review, possibly because the meeting was unaware of them. As a result, the levels of the man's SASH observations were reduced to twice hourly.

432. My investigators found no evidence to suggest that instructions in PSO 2700 had been followed.

The Director should ensure that the mandatory instructions contained in PSO 2700 are in place and followed.

433. There were at least two occasions when medical or nursing staff did not attend SASH reviews. In the man's case, there were complex health issues and his health was deteriorating. In cases like this it is essential that healthcare contribute to the SASH process. It provides an opportunity for them to share as well as to gather relevant information.

Primecare should remind all healthcare staff of their professional responsibility to engage in multi-disciplinary case conferences.

The Director should ensure that all relevant information is shared and recorded appropriately.

23 May 2006

434. Some of the man's behaviour was challenging and required careful and compassionate management. As can be seen from my report, despite his challenging behaviour, he would and did engage with staff at times. It is evident that he responded positively to those who were persistent, even when he told them to go away. There is very little evidence that he was treated compassionately on 23 May and the events of the day make particularly disturbing reading.

Medical assistance and observations

435. During the early hours of 23 May, PCO M saw the man picking at his wounds, and blood on his mattress and the floor. He used his prison radio to call a code 2.

436. I described earlier how nurse E was one of the staff who responded to the call, along with other PCOs and night manager A. Surprisingly, nurse E carried out his assessment by trying to talk to the man through the gap between the cell door and door frame which is approximately a quarter inch wide, and looking through the cell door observation glass.

437. My investigators are aware of a similar finding in relation to a death investigated at Rye Hill in 2005. I described the healthcare for that man as poor. As with the man, most of the medical consultations took place through a locked door. This practice was unacceptable then and remains unacceptable now.

438. A second code 2 was called at 2.00am and staff responded quickly. The accounts of what happened next are conflicting, but all show a 20 minute delay before staff entered the cell and tried to tend to the man.

439. After the man struck out at nurse E and was restrained, the staff left the cell. Although nurse E was doubtless shocked, and entirely entitled to protection from assault, it does concern me that the man was left without medical treatment in a blood stained cell.

Blood stained cell

440. At the manager's morning meeting that day, the Wolds senior manager told the managers present that there was blood on the man's cell floor which would require cleaning. At interview, he said he had not seen the cell for himself but was assured it would be dealt with.

441. The cell has been described to my investigators as being covered in blood, so much so that staff had to stand in the blood when checking on the man. General hygiene became a concern as the cell had begun to smell of the blood.

442. The man's cell remained uncleaned all day. He was also left with a plastic mattress cover as his only means of keeping covered. It is neither decent nor

humane that he had to live in this condition. It is also unacceptable that staff had to walk through the blood when they entered the cell, and that one member of staff was told to bio-clean his shoes. They should have been disposed of correctly and replaced.

443. The instructions in PSO3845 - Blood borne and related communicable diseases were not followed, and therefore the risk of infection to staff and prisoners was unnecessarily increased.

The Director should ensure that the instructions contained within PSO 3845 are implemented and followed.

444. The clinical review panel comments that the man was kept in a medically unsafe environment with regard to the risk of infection. They add that, given his apparent continuing blood loss, he would have been at risk of potential peripheral shutdown.

GSL should be satisfied that robust systems are in place to ensure that no prisoner is ever left in similar circumstances to those of the man on 23 May 2006.

Duty Security Manager A

445. DSM A, the duty DSM that afternoon, told the investigators that she had been to Hastings unit in the afternoon and had seen the man's cell.

446. I have already described how the DSM took no action to have the man moved out of an unfit cell, primarily because he had not self-harmed on her shift. As a manager, and in particular the duty manager for that shift, I would have expected at the very minimum for the DSM to have reported this situation to a senior colleague who could have authorised a move. Instead, she did nothing.

447. I acknowledge that, when the DSM came on duty at 1.00pm that afternoon, the man had been in a blood stained cell for at least 12 hours. This situation could have and should have been dealt with much earlier in the day, as the DSM rightly pointed out in her feedback following advance disclosure. However, the fact remains that it had not been dealt with and when she saw the cell for herself she took no action.

Senior Manager D

448. Senior manager D made a number of crucial decisions which are questionable, none more so than not seeing at first hand the situation on Hastings unit on 23 May 2006.

449. It will be a matter of concern to GSL that senior manager D was fully aware of his staff being visibly upset and angry at the man's condition and the state of his cell. He did not attend to the distressed staff, choosing instead to remain in his office (due in part to not wearing his company uniform).

450. In his advance disclosure feedback, senior manager D said that he felt that by moving the man to healthcare he had supported his staff by taking receipt of their concerns and moving the man. I am pleased that senior manager D ensured that the man was moved to healthcare. However, I am satisfied that the evidence shows that senior manager D and his managers placed emphasis on his staff being in "cahoots" with prisoners rather than being distressed. Indeed, the only matter that senior manager D asked for a report on was in relation to an altercation PCO A had had with another member of staff that evening when helping the man over to healthcare.

451. I understand senior manager D had also been told of a threat of indiscipline, which he did not regard as serious. Following advance disclosure of my draft report, senior manager D pointed out that his Prison Service Incident Command training would not have permitted him to go to the scene of an incident. This is so that the most senior person on duty at the time can take charge and oversee the incident from an area where communication can take place unhindered with advisers. I do not dispute the policy for handling an incident. However, we have already established that senior manager D did not take the threat seriously and, therefore, did not consider it to be an incident. For that reason he should not have found it necessary to implement the relevant Incident Command procedures.

452. There are a number of questions regarding decisions taken by DSM A and senior manager D that day. This report has clearly established their actions were not of a standard expected. However, it is my view that the responsibility for the man's care was not theirs alone and other managers at all levels had a responsibility towards the man. I have been unable to establish the extent of this for reasons explained earlier. I believe that GSL should re-examine the events of that day.

GSL should investigate the circumstances of 23 May 2006 and the decisions taken by managers at all levels that day.

Admission to healthcare

453. The man walked to healthcare despite being in a very weak condition. My investigators saw a wheelchair in the administration block when they visited the prison, but are aware from interviews with staff that it was not used to assist the man. PCO A was the only member of staff to assist the man as he walked to healthcare. Whilst I do not make a formal recommendation about the use of wheelchairs, the Director may wish to remind staff about the availability of aids for prisoners experiencing mobility difficulties.

454. It is clear from staff interviews that the intention was to temporarily move the man to healthcare overnight while his cell was bio-cleaned. It was not because managers or healthcare staff thought it was the appropriate place for him to be.

455. Medical staff have confirmed that the man had been admitted into healthcare by prison staff and not by healthcare. They regarded him as a 'prisoner' not as a 'patient'. As a result, no care plan was put in place.

456. The investigators questioned this rationale and found that, if a prisoner is admitted into healthcare by a member of healthcare staff, they were regarded as a patient and a care plan was drawn up. However, if a member of Rye Hill staff decides to place a prisoner into healthcare, even on strong medical grounds such as in the man's case, healthcare accepted no responsibility for him and regarded him as a prisoner, rather than patient.

457. My investigators brought the matter to the attention of the Director who had not known about it. He assured the investigators that the practice would end with immediate effect. Whilst I welcome his decision, it is worrying that he had not previously known about it. To date, the Director has not informed me of the action he has taken.

PCO A and the RC chaplain

458. It is clear from the evidence that PCO A and the RC chaplain both recognised the seriousness of the man's situation that day. Despite not receiving the level of support from their managers that the situation warranted, they did their best to protect the man.

PCO A and the RC chaplain should be commended for their efforts in demanding that prison management cared for the man appropriately.

9 June

459. Because he once again harmed himself, and as blood was present in the cell, the man had to move cells within healthcare. As before, despite being obviously weak, he was not assisted. He had to hold onto the wall and door to stop himself from falling over whilst prison and healthcare staff watched him.

460. The head of healthcare told my investigators that she spoke to the man for the first time on 9 June 2006. Given her role as head of healthcare, and given the fact the man had been in healthcare for some time and had a history of complex health issues, I find this very surprising.

461. The evidence shows that the man regularly refused medical treatment during his sentence. However, on 9 June he felt so ill that he asked to see a doctor but this was not facilitated. Later, before leaving the prison for the evening, The head of healthcare told the rosters manager that the man did not have much blood inside him and that his organs might fail. I refer to the head of healthcare's conduct later in this report.

462. A short while later, the man was seen lying on his cell floor. Both the rosters manager and nurse E described him as weak and struggling to move. Despite this, when the man asked for water he had to struggle to the door to get it. My investigators were told this was because the prison was in night state. However, in order to carry out medical observations, the cell was later unlocked. It is difficult to understand why the cell of such a weak man could not have been unlocked to give him liquids.

463. The rosters manager, although acting at the time as constant observation officer, was a manager and had all the managerial tools available to her. She saw at first hand the distress the man was in and had been told of his serious condition. She did not challenge the situation. I question her inaction.

GSL should examine the inaction of the Rosters Manager on 10 June 2006.

The final moments of the man's life

464. I accept that nurse E had asked the man if he could take his observations and the man refused. However, the level of medical care in prison should be equivalent to that available in the community. It would be hard to imagine a situation in any hospital where it was acceptable for a nurse to allow a patient to remain on the floor, knowing they did not have the energy to return to bed without assistance. The final moments of the man's life – frail, presumably exhausted, kneeling at the end of his bed with his arms extended – are painful to consider.

465. Nurse E failed to provide a reasonable standard of care for the man. I have already mentioned that Primecare have commissioned their own investigation into his actions that night. I refer again to nurse E's conduct later in this report.

466. Night manager A was in charge of the prison that night. She too was aware that the man was weak and did not have energy to get back onto his bed. She had the option to insist a doctor or an ambulance was called. She was the one person on duty that night who had direct access to the Duty Director or Director. Instead, the night manager did nothing.

GSL should examine the decisions taken by the night manager on 23 May and 10 June 2006.

467. I accept that the man might well have refused to be treated, and may possibly have become angry or lashed out. But for several staff to be aware of his condition and leave him on the floor was utterly unacceptable.

Medical treatment refusal

468. Throughout the man's period in custody there are records of him refusing medical treatment and not receiving medical care. These become more frequent whilst at Rye Hill, when for example he would not speak to staff or allow his wounds to be treated.

469. The rationale from Rye Hill was that he refused treatment and could not be treated without consent. However, the only witnessed confirmation of the man refusing treatment was on 17 June 2002 when he signed a disclaimer. The records show that the disclaimer was not updated and was in fact written during his previous time in custody, four years before he went to Rye Hill.

470. The head of healthcare and prison doctor A both said in their interviews that the man had the mental capacity to refuse treatment and they could not force it upon him. However, this was not based on any formal assessment. Indeed, it would appear on this basis that on 18 May, when the man was taken to outside hospital for treatment, it was without his consent. Whilst I appreciate healthcare staff may have had his best interests in mind, I find this inconsistent approach confusing and concerning.

471. All refusals of treatment or clinical intervention should, as a minimum, be documented in the clinical notes. If any significant event such as self harm requires treatment which is refused, a treatment refusal form should be signed by the prisoner. Refusal to sign the form should be documented in the clinical notes and witnessed by a second member of staff. This did not happen on any occasion in the man's case.

472. Rye Hill's local healthcare policy on management and prevention of self harm mentions the procedure for prisoners refusing treatment. However, there should be a specific policy for the refusal of treatment. Staff should be aware that failure to respond to medical staff is not the same as refusing treatment.

The Director in conjunction with the healthcare provider should ensure that there is a local auditable policy for the management of prisoners refusing treatment. This should be developed in accordance with the Department of Health guidelines and relevant PSO.

Clinical documentation

473. The clinical review panel has identified a number of inaccuracies and omissions in the man's clinical notes. These include unsigned, wrongly timed entries as well as missing information. This is not in keeping with National Medical Council (NMC) guidance.

Primecare should remind all staff to follow their professional body's guidelines on documentation, records and record keeping and a clinical audit tool should be developed to monitor compliance with professional standards.

Standards of care

474. On 22 April 2006, prison doctor A completed the relevant section of the man's SASH document. He noted that the man should be cared for on the residential unit as it was inappropriate for him to be in healthcare due to extreme aggression and non-cooperation. At interview, doctor A could not recall making this entry and said he did not remember the man being an aggressive person and was therefore unable to expand on the comment.

475. The clinical review panel was concerned that a healthcare professional considered a prisoner with complex healthcare needs would be inappropriately placed in healthcare due to non-cooperation and aggression. Irrespective of whether or not the doctor could remember why he made the entry, admission to healthcare should not be denied on the basis of a prisoner's behaviour.

476. An act of self harm does not necessarily warrant automatic transfer to a healthcare unit. In fact, the majority of cases can be effectively managed on residential units. However, given the man's previous self harm and medical history, the clinical reviewers and my investigators consider that a transfer to healthcare would have been appropriate so that the man could have been monitored and assessed by medical staff. It would have provided an opportunity to gather a comprehensive overview of his needs, and formulate an appropriate care plan.

477. The panel has commented that it would be appropriate for a care plan to be managed on a residential wing as well as in healthcare. Therefore, even if location in healthcare was considered unnecessary, a care plan should have been in place and regularly evaluated by medical staff.

478. The lack of care planning and poor communication resulted in the man's needs not being thoroughly assessed or met. There is no evidence of a comprehensive overview of the man's health needs throughout his time in Rye Hill.

479. In a case review meeting held on 24 May 2006 to discuss the man, the Deputy Director reminded those attending of the prison doctor A's view that the man could die in prison. The Deputy Director took the decision that the man should remain in healthcare, even if he were to refuse treatment, as he was weak. I welcome the Deputy Director's positive intervention.

Primecare should remind all healthcare professionals that they have a duty of care to prisoners who are entitled to receive safe and competent care. This includes referring to other relevant healthcare professionals as necessary.

Primecare should introduce a policy ensuring a documented care pathway approach is adopted to address physical and mental health needs regardless of the location of a prisoner.

Healthcare management

Prison Doctor A

480. Prison doctor A, recently retired from National Health Service (NHS) practice, had worked at Rye Hill for approximately two years. He said at interview that he is section 12 approved, which means he is approved to detain a patient under the Mental Health Act. He said he felt self harming was a sign of manipulative behaviour and psychological distress, rather than mental illness. He went on to say that he was absolutely sure the man understood he would die if he refused to have a blood transfusion. However, the clinical review panel comments that this significant fact is not documented in the clinical notes. The prison doctor also said he believed the man wanted to die, and was not depressed.

481. During his interview, prison doctor A said he was sceptical of the diagnosis of depression within the Prison Service. He suggested there are a lot of people inappropriately on anti-depressants and added, “You have to take it on the chin, that’s life”.

482. The laboratory request for further investigation into the man’s abnormal blood test results was not acted upon as the prison doctor thought it was an automatic follow up as the laboratory were not aware of the man’s history.

483. On 19 May 2006, prison doctor A saw the man during the morning (before 9.20am) when he attempted to assess him. The man refused to be assessed. The prison doctor noted in the medical record ‘…no need [the man] to be on healthcare, suggest return to unit’. The clinical review panel have noted that when the man’s blood pressure was recorded at 40/34 at 10.45am, following a self harm episode at 9.20am, prison doctor A was made aware but did not visit him and no treatment was ordered despite commenting in a case review later that day that the man ‘could die in custody especially if he goes into organ failure’.

484. According to prison doctor A’s entries in the medical records, he was unable to engage with the man. It is therefore unclear how he concluded that the man was not mentally ill, and felt able to comment on the man’s capacity or otherwise to refuse care. Several entries were made to request a psychiatric referral. This did not happen and the clinical review panel believes this information was vital in determining whether the man was competent or not to refuse treatment.

485. The prison doctor was responsible for the man’s physical and mental health care. He should have ensured that the psychiatric assessment requested was carried out in line with PSO 2700 and Primecare’s policy on self harm. His failure to do this and to recognise the man’s deteriorating mental and physical health resulted in significant shortcomings in the standard of care reasonably expected.

Primecare should consider an investigation into the clinical management of the man by the prison doctor and if necessary consider a referral to the General Medical Council Fitness to Practice Board.

The Head of Healthcare

486. The head of healthcare, a qualified registered mental health nurse for 20 years, had been the healthcare manager at Rye Hill for over three years. As well as her nursing qualifications, the head of healthcare has a Master’s degree in Person Centred Counselling.

487. The head of healthcare said in interview that she did not consider that self harming was always a sign of mental illness. She explained that people self harm for many different reasons, often “as a way of coping rather than actually dying”. She went on to say that, although some people do self harm to attempt suicide, in her experience much of it is a method of coping with emotional distress.

488. It is of concern to the clinical review panel that the head of healthcare, a qualified psychiatric nurse, felt that prolific self harming, treatment refusal, food refusal, a history of suicidal ideation and depression, did not suggest to her a 'mental health history'.

489. The head of healthcare also said she "did not buy in to the philosophy that self harming is attention seeking or manipulative behaviour". On the other hand, she said that it is sometimes done to gain attention and felt that you need to look at "why the person needs attention and not why they actually self harm". There is no evidence in the clinical notes that the head of healthcare or her healthcare team made any determined attempt to encourage the man to engage with them in order to ascertain the reason for his persistent self harm.

490. At interview, the head of healthcare said she was unaware of the problems the man was actually experiencing. She said he had never really engaged very much in conversation with healthcare staff. The head of healthcare said that, "Care plans should be written in partnership with the patient ideally and there was no real partnership going on with the man." She went on to say there was not a care plan for the man because he was not identified as having any health needs at the time, other than his cuts. She said the fact that he would not engage with staff was a not a problem which required a care plan. This is despite comprehensive notes in the man's medical record from Highpoint and Norwich.

491. The clinical panel's observation is that the man had a variety of problems that warranted care planning, but that there was no clear care plan designed to meet his complex needs.

492. With the head of healthcare's qualifications, she should have been well placed to ensure that continuing attempts were made to engage the man in a therapeutic relationship. There are concerns regarding her lack of involvement and leadership in assessing the needs of an apparently desperately disturbed patient, resulting in her and her team's failure to attend to the man's deteriorating condition.

493. The head of healthcare said that the urgent psychiatric referral requested in the review meetings on 19 May and 24 May came from prison not healthcare staff. She had an 'informal' discussion with the psychiatrist during which she told him that, in her opinion, the man had 'full capacity to refuse treatment'. In interview, the head of healthcare said she only met the man the day before he died. Whilst this itself is a concern, the clinical review panel believes that, without meeting the man, the head of healthcare was not in an informed position to enable her to accurately discuss his mental well being, character and capacity.

494. Despite the head of healthcare's qualifications and position in the prison, she did not undertake a mental health nursing assessment. This would have given the healthcare team a good indication of the man's mental state even in the absence of an assessment by a psychiatrist. Furthermore, PSO 2700 states that prisoners placed under constant observation should be urgently referred for a mental health assessment.

495. It is also a matter of concern that, during the case review on 19 May, the prison doctor said the man could 'die at any time'. The head of healthcare said at interview that she did not remember anyone at the meeting questioning what they were going to do. The panel believes that, as the manager of healthcare, it was the head of healthcare's responsibility to act upon this information and implement an appropriate plan of care.

496. The head of healthcare said during the case review on 31 May that she considered the man to be at no risk of self harm whilst in healthcare. He was eating well and was in no danger of collapsing, and she added that he did not want to return to the unit. She also said she felt the man did not require an open SASH document, but if he were to remain on healthcare the watch would need to remain open. I cannot understand the rationale for this. The clinical review panel also finds it surprising that, considering the man's blood loss and need for rest and food, the head of healthcare did not feel healthcare was a suitable location.

497. On 9 June 2006, a few hours before the man died, the head of healthcare spent some time trying to engage him. During her interview, she mentioned that he asked to see a doctor but she did not call one. She said she explained to the man that he needed to go out for a blood transfusion and that this is what the doctor would also say. I think that not calling a doctor was simply unacceptable and demonstrated a poor standard of care. The clinical review panel has also commented that the man's request to see a doctor was not documented in the medical notes.

498. It is the healthcare manager's responsibility to direct her team and to ensure that adequate policies and procedures are in place to provide a safe and caring environment for the patients in their care. The head of healthcare failed to provide the standard of care reasonably expected for the man both as a registered mental health nurse and as healthcare manager.

Primecare should consider an investigation into the head of healthcare's management of this case. If necessary, consideration should be given to a referral to the National Medical Council Fitness to Practice Board.

Nurse E

499. Nurse E, a registered general nurse, had worked at Rye Hill prison as a staff nurse for 18 months. The first 12 months of his employment were as an agency nurse. Subsequently, he was an employee of Primecare. He has received no specific training in caring for people who self harm or those refusing treatment.

500. At interview, nurse E said he did not have much contact with the man as he worked on night duty. He also said that every time he saw the man he would refuse treatment. The RGN confirmed that he believed the man understood his request to look at his wounds, although he felt that he might not have understood anything more detailed than that.

501. On 23 May at 1:00am, nurse E was called to Hastings unit by the prison custody officer carrying out the SASH observations. I have already explained that nurse E did not enter the man's cell. During his interview, he said that he was unable to say what the man's medical condition was at that stage because he did not enter the cell.

502. Nurse E confirmed that there were three or four members of staff present and so he did not feel unsafe to enter the cell. He said that, in retrospect, it would have been better to have entered the cell to try and persuade the man to accept treatment. However, he had been led to believe that opening doors at night should be avoided for security reasons. The clinical review panel considers that not entering the man's cell resulted in poor care delivery by the nurse.

503. Nurse E was in the healthcare unit on the evening when the man was taken there by PCO A. He confirmed that he knew the man had been in the blood stained cell all day and he agreed that this posed a risk of infection. He told the investigators about the disagreement between the healthcare staff and the PCO when she tried to hand over to healthcare staff. The panel is concerned about the PCO's allegation that nurse E said he would not treat the man because he had assaulted him earlier that day.

504. I have explained that nurse E was on duty the night that the man died and that he witnessed him lying on the floor, weak and with no energy to get back onto the bed. Nurse E said during his interview that he had no idea how ill the man really was on the night he died, although he was aware that the man had a low HB (haemoglobin) and had lost a lot of blood. This highlights the need for proper handovers and records as the head of healthcare had already told the rosters manager that the man's organs might fail.

505. The clinical review panel believes that nurse E did not, when compared to the standard of care reasonably expected, deliver even the most basic nursing care to the man. I accept that people can die suddenly. However, it is of the greatest concern that someone can die kneeling at his bedside because he did not have the energy to get back onto his bed, and particularly in a healthcare unit with a qualified nurse on duty and an officer on constant watch.

Primecare should consider undertaking an investigation into the actions of nurse E on 23 May and 9 June and if necessary consider disciplinary action and referral to the NMC Fitness to Practice Board.

Nurse A

506. Nurse A had worked at Rye Hill for three years. She has received no specific training or instruction in caring for people who self harm.

507. The nurse said that she did not remember admitting the man to Rye Hill and in fact did not remember him at all. Having looked at the transfer check-in list during her interview, the nurse confirmed that it was she who had admitted the man to Rye Hill on 23 February 2006.

508. The prisoners being transferred in that evening were seen by nurse A as part of her duties. It was her responsibility to complete the relevant medical screening documentation. Clinical records from previous prisons should be considered as part of the reception health assessment. This helps ensure a full medical history is taken into consideration when assessing, planning and delivering care.

509. The clinical review panel have found that these documents were only partially completed in the man's case. The documents said that the man had no physical, mental health or substance misuse problems, and had no self-harm or suicidal ideation. The nurse also documented that he was fit for heavy work and use of the gym, despite the man's recent 23 day food refusal. She signed to authorise all this on behalf of the doctor, which is contrary to local policy.

510. At interview, the nurse said the reception nurses are busy and short-staffed and therefore cannot look through every single page of the medical record. It was evident to the clinical review panel that, from the assessment the nurse made on the man that day, she had not read the key points on his clinical records. The panel found that the nurse failed to follow-up and act upon the nutritional assessment which had been carried out the previous month and which was documented just a few lines above her entry in the clinical notes. They felt these omissions resulted in a failure to grasp even his most basic healthcare requirements.

511. The nurse only partially completed the 'assessment for suitability for in-possession medication' form and she left the 'decision' section blank. She explained during her interview that this would have been because she required the doctor to assess the man. Her entry in the clinical notes reads 'states no physical or mental health problems'. The man was not seen again by healthcare staff until 21 April, some two months later.

512. The clinical review panel believe that essential information regarding the man's care was missed. This was despite clear care plans from Highpoint and Norwich prisons outlining the man's self harming behaviour and food refusal, plus the Norwich care plan outlining action regarding his food refusal. The actions needed were clearly outlined, but were not followed up by healthcare staff at Rye Hill.

513. The clinical review panel believe that the nurse A's omissions may have had a detrimental effect on the care offered to the man during his time in Rye Hill. There was no continuity of care for the man on his admission to Rye Hill which was in part due to the poor reception procedure.

Primecare should consider an internal investigation into the actions and omissions of nurse A, specifically relating to the reception health screen procedure on 23 February 2006.

Primecare should ensure that the local reception health screen policy is reviewed to ensure that it reflects relevant prison and health service standards and policies.

CONCLUSION

514. As the clinical review panel has acknowledged, it is clear that the man presented with complex needs which posed a challenge to Rye Hill healthcare staff. However, the lack of care planning and multi-disciplinary team approach resulted in a failure by the prison to provide the reasonable standard of care to which the man was entitled.

515. Healthcare staff used the fact that the man would not engage to explain their lack of care. Engagement with any patient cannot be formed by casual, brief discussions. Healthcare staff should have made more persistent and consistent efforts to encourage the man to explain his concerns.

516. Prison custody officers and managers are not medically qualified to respond to the complex needs of prisoners who harm themselves. As a result of the healthcare team failing to accept responsibility for the man's health and wellbeing, there were significant shortcomings in the delivery of care.

517. The law recognises that a competent adult has the right to refuse treatment, even where the exercise of that right is likely to cause death. However, due to the failure of healthcare staff to follow PSO 2700 and Primecare's local self harm policy to obtain an up to date psychiatric assessment, we are unable to determine the man's competency to refuse treatment.

518. The clinical review panel has concluded that there was a failure to monitor and assess the man on a regular basis by various members of healthcare staff at Rye Hill. They also found that there were serious omissions in the delivery of care and care planning for the man.

519. I have been very disturbed to read about the last few months of the man's life and the unprofessional way in which he was treated at Rye Hill. In particular, the disgraceful events of 23 May and 9 June make dismal reading and will undoubtedly be distressing for the man's family. I am not satisfied that the man was given the level of care, decency and medical treatment that he was entitled to receive from some staff at Rye Hill.

520. This said, there were a few staff who attempted to provide the right care for the man. The Deputy Director recognised the seriousness of the situation in May. He requested an urgent psychiatric assessment and gave instructions for the man to be kept in healthcare. The actions of PCO A and the RC chaplain show that there were members of the Rye Hill team who were prepared to fight for the man's proper care and treatment. However, overall this is as sad and shameful account as any I have penned in the near five years I have been investigating deaths in custody. That the man was almost certainly held unlawfully for seven weeks until a month before he died casts a further shadow over the whole tragedy.

A copy of this report should be sent to the Director General of the National Offender Management Service and the Secretary of State for Justice for their consideration.

RECOMMENDATIONS

I have received GSL's response to the report recommendations and have included these individually below. Where appropriate, GSL have responded to some of the clinical recommendations, however, where not appropriate, they have forwarded these to Primecare for action.

GSL have also notified me that they have terminated the contract with Primecare at Rye Hill, with effect from April 2008.

1. The Director should ensure that appropriate systems are in place to monitor the use of razor blades by any prisoner being monitored under the suicide prevention procedures.

   GSL have partially accepted the recommendation and completed the changes.

2. The Director should ensure that appropriate searching systems are in place.

   GSL have accepted the recommendation and completed the changes.

3. The Director should ensure that the mandatory instructions contained in PSO 2700 are in place and followed.

   GSL have accepted the recommendation and completed the changes.

4. The Director should ensure that all relevant information is shared and recorded appropriately.

   GSL have accepted the recommendation and completed the changes.

5. GSL should be satisfied that robust systems are in place to ensure that no prisoner is ever left in similar circumstances to those of the man on 23 May 2006.

   GSL have accepted the recommendation and completed the changes.

6. GSL should investigate the circumstances of 23 May 2006 and the decisions taken by managers at all levels that day.

   GSL have accepted the recommendation.

7. The Director should ensure that the instructions contained within PSO 3845 are implemented and followed.

   GSL have accepted the recommendation and completed the changes.

8. PCO A and the RC chaplain should be commended for their efforts in demanding that prison management cared for the man appropriately.

   GSL have partially accepted the recommendation and written to the RC chaplain only, as PCO A is no longer employed by them.

9. GSL should examine the inaction of the rosters manager on 10 June 2006

   GSL have accepted the recommendation.

10. GSL should examine the decisions taken by the night manager on 23 May and10 June 2006.

    GSL have accepted the recommendation.

11. The Director in conjunction with the healthcare provider should ensure that there is a local auditable policy for the management of prisoners refusing treatment. This should be developed in accordance with the Department of Health guidelines and relevant PSO.

    GSL have accepted the recommendation and completed the changes.

12. A copy of this report should be sent to the Director General of the National Offender Management Service and the Secretary of State for Justice for their consideration.

    GSL have accepted the recommendation.

Clinical Review Panel Recommendations

13. Training in basic mental health awareness should be provided for all grades of staff, to enable them to recognise trigger points in relation to changes in behaviour which may lead to adverse consequences.

    GSL have accepted the recommendation and completed the changes .

14. Primecare should remind all healthcare staff of their professional responsibility to engage in multi-disciplinary case conferences.

    GSL have accepted the recommendation and completed the changes.

15. Primecare should remind all staff to follow their professional body's guidelines on documentation, records and record keeping and a clinical audit tool should be developed to monitor compliance with professional standards.

    GSL have accepted the recommendation and completed the changes.

16. Primecare should remind all healthcare professionals that they have a duty of care to prisoners who are entitled to receive safe and competent care. This includes referring to other relevant healthcare professionals as necessary.

    GSL have accepted the recommendation and completed the changes.

17. Primecare should introduce a policy ensuring a documented care pathway approach is adopted to address physical and mental health needs regardless of the location of a prisoner.

    GSL have accepted the recommendation and completed the changes.

18. Primecare should consider an investigation into the clinical management of the man by prison doctor A and, if necessary consider a referral to the General Medical Council Fitness to Practice Board.

    GSL have referred the recommendation to Primecare. My office has not received a response from Primecare regarding this recommendation.

19. Primecare should consider an investigation into the head of healthcare's management of this case. If necessary, consideration should be given to a referral to the National Medical Council (NMC) Fitness to Practice Board.

    GSL have referred the recommendation to Primecare. My office has not received a response from Primecare regarding this recommendation.

20. Primecare should consider undertaking an investigation into the actions of nurse E on 23 May and 9 June and if necessary consider disciplinary action and referral to the NMC Fitness to Practice Board.

    GSL have referred the recommendation to Primecare. My office has not received a response from Primecare regarding this recommendation.

21. Primecare should consider an internal investigation into the actions and omissions of nurse A, specifically relating to the reception health screen procedure on 23 February 2006.

    GSL have referred the recommendation to Primecare. My office has not received a response from Primecare regarding this recommendation.

22. Primecare should ensure that the local reception health screen policy is reviewed to ensure that it reflects relevant prison and health service standards and policies.

    GSL have accepted the recommendation and completed the changes.

Although Primecare did not formally respond to my recommendations, following the inquest, the Medical Defence Union asked me to acknowledge within my report that Primecare had decided the doctor did not fulfil the criteria for referral to the GMC. I also understand Primecare decided to take no action in relation to its other staff mentioned in my report

OUTLINE OF THE PRIMECARE INTERNAL INQUIRY REPORT

a) On 20 December 2006, following a meeting between interested parties regarding the initial findings of my clinical review team, terms of reference were issued by Primecare to their own inquiry team. The inquiry team were asked to investigate "the healthcare provided for [the man] from 23 February until 10 June 2006 at HMP Rye Hill". The inquiry report shows that, on 9 January 2007, the terms of reference were amended "to provide for a wider inquiry than just the circumstances surrounding the death of the man, and seek to ensure that our inquiry does not in any way transgress into territory properly covered by the ongoing Prison and Probation Ombudsman and Coroners investigations".

b) The amended terms of reference are set out as follows:

1. Any failure in the healthcare systems and operational protocols at Rye Hill.

2. The standards of delivery of clinical care by the health professionals at Rye Hill.

3. The accountability of any health staff for any failure to properly care for the man at Rye Hill.

4. Any element of best practice, in either the healthcare staff or systems at Rye Hill.

c) Primecare's inquiry team was led by a previous prison governor and employed by Primecare at the time of the inquiry. The inquiry lead was assisted by three non-Primecare clinical professionals:- a prison doctor, a consultant psychiatrist and a registered mental health nurse.

d) The methodology of the inquiry shows that the team were given access to relevant documents and conducted formal interviews with the head of healthcare, three other members of staff. Interview notes and a full list of documents can be found in their report.

e) In their Executive Summary, the team explained that their enquiries focused upon:

- "Perceptions of the Healthcare Service within Rye Hill
- Clinical and Management Documentation
- Healthcare Policies and Procedures
- HMCIP and Prisons and Probation Ombudsman reports
- Healthcare Service Requirement and links with the NHS".

f) Their findings were that "whilst there are aspects of healthcare delivery and governance that would benefit from improvement the general level of healthcare provided at Rye Hill is satisfactory".

g) Also within their Summary, the inquiry team raised concerns about my draft clinical review. One of their concerns was the knowledge and experience of my clinical review panel in terms of delivering healthcare in a secure environment and issues relating to self harm. I acknowledge that, at the time of writing their inquiry report, their team were unaware of the experience of my clinical panel. For clarification my panel members were (roles and experience given as they were at the time of the review):

(1) The RGN ONC – Lead clinical reviewer, Prisons and Probation Ombudsman (PPO). The clinical reviewer worked in the National Health Service for five and half years. From 1988 to 2005 she worked in healthcare recruitment which included recruitment of healthcare professionals into the Prison Service. Since 2004, the clinical reviewer has been employed on a contract basis for the PPO to carry out clinical reviews and up to the time of the man's death had completed approximately 18 reviews.

(2) An RMN – Forensic Psychiatric Addiction Nurse Therapist. The RMN has four years experience working in a secure unit which provides care for patients sectioned under the Mental Health Act (1983) and with enduring mental health illnesses. Prior to this the RMN worked for 12 months in the community drug and alcohol team.

(3) An RGN – Staff Nurse. The RGN has ten years experience in Accident and Emergency (A&E) nursing.

(4) An RGN – Prison Healthcare Manager. The RGN has 17 years experience in A&E departments, five of these as the Senior Nurse Manager. The RGN was the healthcare manager in a high security prison for four and a half years.

(5) A Chartered Forensic Psychologist, BA (Hons) Psychology, MSc Forensic Psychology. At the time of the clinical review, the Chartered Forensic Psychologist was Head of Forensic Psychology in a secure unit providing care for patients sectioned under the Mental Health Act (1983) and with enduring mental health illnesses. Prior to this the Chartered Forensic Psychologist had worked in a prison environment as part of her specialist training and with young offenders for five years. She is currently employed by a PCT in a Secure Training Unit for 12-17 year olds.

h) The panel was overseen by my former Deputy Ombudsman, MSt. (Cantab) BSc. (Open) RN, ex-prison governor grade and Area Health Advisor for the Prison Service. Additionally, the panel received support from my investigators.

i) A further point raised by the inquiry team is in relation to four members of healthcare staff who have been criticised in my report. The inquiry report states that following a presentation of my draft clinical review on 18 December 2006 (this should read 19 December), three of the four staff were suspended from duty. I consider that it is necessary to make it clear to the reader that the

decision to suspend the staff was not that of my office. The draft clinical review recommended that Primecare conduct their own investigation and if necessary, make referrals to the appropriate professional body. Although, I have received a copy of the inquiry team's report, I have to date not received a response from Primecare regarding their actions in response to those recommendations. One of my investigators wrote to Primecare on 12 September 2008 for an update but one has not been received.

j) The Primecare inquiry team, in their report, have said they wanted to achieve a "wider view" rather than "focus on a snapshot of one particular point in time". As a result they looked at the perceptions of the healthcare service within Rye Hill. My report has focused on the man and the care and treatment he received, and therefore my investigators have not conducted a similar exercise.

k) The inquiry team then considered the healthcare services within Rye Hill and produced conclusions, six main findings, three areas of good practice and 20 recommendations. Several of the recommendations are similar to my own. However, there are findings and recommendations in the Primecare report which differ from those in my report. I do not propose to compare every finding in this report. Primecare's report has been annexed and full details can be read there. My office has not received any communication from Primecare regarding their response or actions to recommendations made in their internal inquiry report.

SUMMARY OF MEETING ON 5 JANUARY 2009 WITH THE DIRECTOR AND HEAD OF SAFER CUSTODY OF RYE HILL

l) Because of the length of time which has passed since issuing my first draft report in October 2007, my investigators offered GSL the opportunity to provide an update on actions taken following my recommendations. I also thought it important to reflect and acknowledge the changes implemented by the current Director, and her senior management team.

Healthcare

m) The Director told my investigators that GSL had terminated the contract with Primecare in April 2008. She said that this was as result of the man's death, two previous deaths at the prison, as well as a poor Chief Inspector's report. The Director added that the healthcare provision is now provided 'in-house' by medical staff directly employed by GSL.

n) My investigators were told that the prison is now forging strong links with the local Primary Care Trust (PCT). Unlike public sector prisons, the PCT is not responsible for commissioning services in contracted out prisons. It is pleasing, therefore, to note that Rye Hill have worked towards developing such links and have secured some funding support from the PCT for healthcare services.

o) The Head of Safer Custody, told my investigators that there is better healthcare involvement in the ACCT process. He said that an RMN always attends ACCT reviews. Additionally, the new Deputy Healthcare Manager leads on mental health awareness training for new prison custody officers as part of their initial training. The Deputy Healthcare Manager also leads and supports ACCT assessors at their quarterly meetings.

p) The prison have produced a Health Improvement Plan which identifies areas of development such as physical resources, mental health, patient safety, medicines management, staff development and recruitment, continuity of case management and discharge planning. The Plan uses a traffic light system to monitor and action the identified areas. The Director said that, although there were still teething problems with the new healthcare department, she was happy with the progression plans.

q) In my draft report I recommended that several of the healthcare policies be reviewed. This was also a recommendation made by Primecare in their internal investigation. Because the healthcare services are now being provided 'in-house', the Director said that previous policies would all be reviewed. This is also part of the Health Improvement Plan.

Safer custody

r) At the time of the man's death, there was one officer who dealt with co-ordinating ACCT reviews and issues relating to prisoners on ACCT. The Director has since appointed a Head of Safer Custody. His role encompasses suicide and self harm prevention as well as violence reduction and anti-bullying. He is supported by a co-ordinator and an administrator. There are also prisoners who act as safer

custody representatives on each unit. Although at the time of the man's death, prisoners had access to 'Buddies', the prison now operates a Samaritan trained 'Listener' scheme similar to that which is run in other prisons.

s) The Head of Safer Custody said that the profile of safer custody is now high in Rye Hill. He added that the prison has good links with the East Midlands area safer custody advisor who he said provides excellent support and advice.

t) Since his arrival, the Head of Safer Custody said that he had introduced a number of new monitoring systems. As an example, he showed my investigators a monitoring information board which highlights every recorded incident of self harm. This is reproduced onto a weekly document so that any patterns or issues can be easily identified and action taken. The Head of Safer Custody has also introduced a fortnightly review meeting which discusses all prisoners on open ACCTs – this is additional to the individual ACCT reviews. Unit managers are the ACCT case managers and they are required to attend the fortnightly meetings, as well as other relevant staff including healthcare, and a member of the IMB.

u) The prison now also holds 'enhanced review' meetings in which they encourage prisoners' families to be involved in the ACCT care plan (with the prisoner's consent). The meetings are held to discuss prisoners who are carrying out prolific acts of self harm, whose current ACCT care plan needs to be revised or who have been identified as having "major issues". The Head of Safer Custody said that staff are now better at identifying issues and triggers. He gave an example of a prisoner who staff had identified as not coping particularly well and they believed might benefit from having a budgie in his cell. An officer contacted the Head of Safer Custody with this suggestion which was agreed and as a result the prisoner now works in the prison aviary and appears to be more settled.

v) The Head of Safer Custody and the Director said that the Prison Service Standards Audit Unit had assessed the ACCT process and were satisfied the quality.

Additional progress

w) Since taking over as Director, the Director has increased the level of PCOs on each unit from two to three. This should allow for better interaction between staff and prisoners.

x) Training for managers at all levels is provided by G4S, and the prison is supporting Management Development Programme (MDP) training for all staff as a development opportunity. The Director told my investigators that Rye Hill is looking at developing a university degree course for their new entrant prison custody officers.

y) Senior managers at Rye Hill now wear civilian clothing. This is in response to concerns that managers were not visible on the units at Rye Hill. The Head of Safer Custody said that prisoners are now aware when there are senior managers on the unit and do approach them.