Investigation into the death of a man whilst in the custody of HMP High Down in June 2008

Report by the Prisons and Probation Ombudsman for England and Wales

September 2009

This is the report of the investigation into the death of a man, a remand prisoner who was found hanging in his cell at HMP High Down in June 2008. He had been at High Down for 11 months and was awaiting trial for murder. I offer my sympathies to his family, friends and all those affected by his passing.

The investigation was conducted by my investigators. A clinical review was undertaken by the local PCT and overseen by the Quality & Clinical Governance Manager, from the PCT. The PCT commissioned a psychiatric report to assist their review, written by the Consultant Forensic Psychiatrist. Although delayed, I am grateful to both the Quality & Clinical Governance Manager and the Consultant Forensic Psychiatrist for their reports. I am also grateful to the Governor of High Down and his staff, in particular the Governor who made all the practical arrangements for the investigators.

The man was a foreign national whose first language was Spanish. He enrolled in an English language class soon after arriving at High Down to try to improve his English. He was admitted to the healthcare inpatient unit for observation on his arrival, due to his potential vulnerability arising from the alleged offence. Apart from an isolated incident of self-harm just over a month after his arrival, no more concerns were raised. Despite a number of reported incidents of problems with other prisoners, his behaviour was considered by staff to be good. He made no mention to staff that he was being bullied or threatened despite being asked.

During a routine roll check in the evening the man was discovered hanging in his cell. He was resuscitated by staff and paramedics and taken by emergency ambulance to the hospital where he later died.

I conclude that he was a young man who kept his feelings hidden from those around him. It is clear from the investigation that separation from his family caused him distress that was not evident to others and his actions could not have been predicted by those responsible for his care. I commend staff for the speed of their intervention. I also make nine recommendations, primarily covering provision for foreign national prisoners, anti-bullying and three relating to healthcare procedures.

Of the twelve recommendations made the Prison Service accepted in full ten of these and partially accepted one. A further recommendation was not accepted, but this remains unchanged in the final report due to evidence available during the investigation.

The version of my report, published on my website, has been amended to remove the names of the woman/man who died and those of staff and prisoners involved in my investigation.

Jane Webb
Deputy Prisons and Probation Ombudsman **September 2009**

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SUMMARY

The man arrived at HMP High Down in July 2007, having been extradited from Spain to face charges of murder. He had never been in custody in England but had been imprisoned in other countries.

On his reception at High Down, a health screen was completed by a nurse who recorded that the man had no health concerns and so no referrals to other agencies were made. He was placed in the healthcare centre for his first 48 hours in custody due to the nature of the charges he faced. During this time no concerns were raised.

The man spoke little English and so enrolled in an education class. His tutors said that he was a good student who made significant progress. He would talk to other Spanish speaking prisoners during the lessons and would often help translate for them as his English improved.

There was an isolated incident of self-harm in September 2007 when the man cut his arms. When asked he told staff that he felt isolated by his language difficulties. He was placed on Assessment, Care in Custody and Teamwork (ACCT) monitoring which remained open for a week and was then closed following a case review. There were no other incidents of self-harm and he raised no other concerns about his vulnerability.

The man was found in possession of a mobile telephone in September 2007 and a home made weapon in October 2007, following which he was moved to houseblock 2. He remained there for only a few days and asked to move to houseblock 1 where there were other Spanish speaking prisoners. He was subsequently moved and appeared to settle in well.

However, during the first few weeks on houseblock 1 he reported to an officer with minor injuries to his face which he claimed were the result of a fall. The officer considered the injuries to be consistent with an assault. The officer took him to be seen by a nurse and his injuries were checked. Despite this incident, he continued to go to education regularly and received favourable reports. There is little documented information about him during the first part of 2008.

In June, he was approached in his cell by six other prisoners and a fight ensued. Staff intervened and, along with one other prisoner, he was taken to the segregation unit. A nurse assessed him and recorded that he had some superficial cuts to his mouth. A senior officer from houseblock 1 asked him what had caused the fight to which he responded that he had “just been angry”.

The man returned to the houseblock the following day. On his return, the senior officer asked if he was content to be there despite the other prisoners remaining. He said that he was alright and gave no indication that there would be any further problems. Staff continued to investigate the cause of the incident and information from another prisoner suggested that the man had been targeted by a gang of bullies. Staff did not speak to the man about the information and he did not report that he was being bullied. The other prisoners remained on the houseblock.

The man went to education as usual during the morning he was found hanging, but kept to himself. His tutor, who had heard about the incident, asked if he was alright and he said that he was. The tutor said he appeared reluctant to discuss what had happened. He did not get involved in the lesson as much as he usually would, but he did not appear as though anything was bothering him.

In the afternoon, the man was taken to the segregation unit for the adjudication hearing about the incident two days earlier. The Governor, who held the adjudication, said that the man pleaded guilty. When asked what had happened, he said that he had punched the other prisoner, but provided no other explanation. The Governor decided to postpone the adjudication so that the officer at the fight could appear. The Governor said that during the adjudication she observed nothing to suggest the man was at risk or vulnerable.

On his return to the houseblock, the man is said to have argued again with the group of prisoners who entered his cell in June. However, this was not witnessed by staff.

All prisoners were locked in their cells at 4.30pm as there was no evening association. At around 8.20pm the officer who was conducting a routine roll check on the house block said when she initially checked him she thought that he was sitting by the window. On a second, closer inspection a few moments later, it became apparent that he was hanging. The officer immediately called her colleague for assistance and went straight into the cell, cut the ligature and placed him on the floor. Both officers, who had medical backgrounds, attempted to resuscitate him until the arrival of healthcare staff. An ambulance arrived quickly and was followed by other paramedics. They continued resuscitation and he was taken to hospital by emergency ambulance.

Although the paramedics got a physical response from him, he never regained consciousness. Tests carried out on his arrival at hospital confirmed that there was no brain activity and the decision was taken to withdraw medical treatment. The man was pronounced dead by medical staff at 1.45am.

After the man's death, prisoners subject to ACCT monitoring were checked. His family were notified via the Columbia Embassy and his body subsequently repatriated to Columbia. Letters written in Spanish were found among his possessions in his cell. They were translated by the police and indicate that he had considered taking his own life. The report includes 12 recommendations.

THE INVESTIGATION PROCESS

1. My investigator opened the investigation in June 2008. She met the Deputy Governor, a representative from the Independent Monitoring Board (IMB) and the prison liaison officer.

2. Notices were published informing both staff and prisoners of the investigation and inviting anyone with relevant information to contact the investigator. No prisoners or staff contacted the investigator in response to the notices.

3. The local PCT were commissioned to undertake a clinical review to assess the man's medical care at High Down. This included a psychiatric review. I am grateful to the psychiatrist, and the consultant forensic psychiatrist, for their reports.

4. My investigator contacted the Metropolitan Police in June and spoke to Detective Inspector (DI) who was dealing with the murder enquiry for which the man had been charged. My investigator agreed with the DI that any relevant information would be shared with police during the course of the investigation.

5. One of my Family Liaison Officers (FLOs) made contact with the legal advisor in July. He is a legal advisor at the Columbian Consulate who was representing the man's family. My FLO explained the aim of the investigation which would be independent of those conducted by the police and Coroner. The legal advisor said that he had spoken with the man's family and they were keen to know as much as possible about what happened. Due to the family's first language being Spanish, the FLO explained to the legal advisor that she would arrange for a copy of the information leaflet for families to be translated. It was also agreed that a copy of the report would be translated.

6. Following the issue of the draft report the man's family were given the opportunity to respond to the report. No response was received.

7. During September and October 2008, my investigators went to High Down on a number of occasions in order to interview staff and prisoners. Transcripts of the interviews are annexed to the report.

The man

8. Little is known of the man's life prior to his arrival at High Down. However, from correspondence translated after his death, it is clear that his family meant a great deal to him and keeping in contact with his partner and child was important.

9. At High Down, he was described as a quiet person who generally kept to himself. He had a small group of close friends who were mostly other prisoners who spoke Spanish. He enrolled in the English for speakers of other languages (ESOL) classes run by the prison education department. His tutors described him as a very likeable individual who was a keen student. At no time during the classes did he give any cause for concern. Although his English was limited he was said to be able to make himself understood and equally understood what was being asked of him.

HMP HIGH DOWN

10. Opened in 1982, HMP High Down was originally a local prison but in 2003 also took on the role of a category B training prison. There are six houseblocks each of which has three levels. The prison serves the Crown Courts of Croydon and Guildford as well as the surrounding Magistrates Courts.

11. There is a wide range of activities available to prisoners as part of the regime, which includes education, catering, workshops. There are also various courses that enable prisoners to address their offending behaviour.

12. Healthcare at High Down is commissioned by the local PCT and provided by Surrey Community Health Services. Sussex Forensic Medical Services provides the GP cover. There is a healthcare wing with an inpatient capacity of 23 beds in single cell accommodation. In addition to this, a day care facility and a wide range of primary care services are available.

13. Every prison in England and Wales has an Independent Monitoring Board (IMB). The members are volunteers appointed by the Secretary of State for Justice to independently monitor the day to day life in their local prison and whether proper standards of care and decency are maintained. The IMB published their most recent report in 2007. They wrote that they believe High Down is well run, with "the vast majority of staff committed to providing a secure, fair and decent regime for prisoners". They also commented on the Assessment, Care in Custody and Teamwork (ACCT) process, which was well established at the prison, but described the quality of some observations of prisoners on open ACCT documents as "variable." (ACCT monitoring is put in place for all prisoners who self-harm or where there is concern that they may do so. It provides additional support and a higher level of observation and interaction.)

14. HM Chief Inspector of Prisons conducted a full inspection of High Down in May 2006. She said in her report of this inspection:

> "High Down, along with all local prisons, is under tremendous pressure as a result of the growth in the prison population. Despite this, the establishment had made considerable strides in a number of areas.
>
> "There was a good suicide prevention policy in place. Monitoring entries in ACCT's were generally good, although case reviews were poorly attended and the timing of some night entries was too predictable."

15. In relation to bullying and foreign national prisoners, HM Chief Inspector of Prisons said the following:

> "Prisoners complained of intimidation by staff both in our survey and in focus groups. Allegations submitted confidentially referring to intimidation and bullying by officers were not properly dealt with. Prisoner-on-prisoner bullying did go on, and was under-reported. The

quality of investigations into alleged incidents of bullying was very poor. Residential house blocks were not always effectively patrolled by staff, leading to some perpetrators of assaults going undetected. There was no intervention work for bullies, and little support offered to vulnerable prisoners.

"While foreign nationals constituted a large proportion of the prison's population, there was no foreign nationals committee and no overall strategic direction in the work being done. The foreign nationals' coordinator had insufficient time to develop the work, and there was little evidence of provision filtering down to the prisoners in most need. There was no independent immigration advice, and there was an over-reliance on the parole clerk."

16. The Ombudsman took on responsibility for investigating all deaths in prison custody in 2004. Since then there have been five apparently self inflicted deaths at High Down. No issues raised in this report are relevant to any of the previous deaths.

KEY FINDINGS

Initial reception at High Down

17. The man was charged with murder and remanded into custody in July 2007, following his extradition from Spain. A Columbian national, he had spent periods in custody abroad but this was his first time in prison in England. He was taken to High Down where, on reception, a member of the healthcare staff assessed him and a health screen was completed. He said that he had seen a doctor within the last few months, but this had been for "nothing important". The nurse wrote on the health screen that,

    "... He appears stable. Rather quiet in presentation, though does not have any intention of harming himself ..."

18. The reception health screen instructs that a prisoner charged with murder or manslaughter should be referred for a mental health assessment. No referral to drug services or mental health was made for the man and it was not considered necessary for him to be seen by the doctor. The initial health screen provided little information which could have been due to his language difficulties. Nevertheless, as he had been remanded on a charge of murder he was located in the healthcare centre for observation. (It is normal procedure at High Down for all prisoners that have been charged with such offences to be located in the healthcare centre for the first 24 - 48 hours in custody. This is partly for observational purposes as the prisoner could be vulnerable.)

19. As a Columbian national, his first language was Spanish. The Cell Sharing Risk Assessment (CSRA) completed on his reception recorded that he spoke little English but could communicate to a basic standard. No other issues were recorded and he was considered to be "low risk" and suitable to share with any other prisoner. (The CSRA is completed for all prisoners on their reception to make sure that unsuitable prisoners do not share cells. An example of this could be an openly racist prisoner and one from a visible ethnic minority. The assessment involves the prisoner answering questions about their behaviour and any previous custodial sentences.)

20. The man remained in the healthcare centre until July. He attended the Well Man clinic where a further assessment of his medical history was undertaken. The form was not signed and it remains unclear who completed it. During the assessment, he said that he was a smoker and had no wish to take part in a smoking cessation programme. He said that he would like to receive a vaccination against Hepatitis B and a referral was made for him to attend the clinic. No other medical concerns were identified. During the afternoon of 30 July, having completed his induction he was moved to houseblock 4. There is no documentation to confirm whether he had been given a full induction or provided with information that would assist him in settling into life at High Down.

21. Before leaving the healthcare centre, a discharge plan was completed by a nurse. She recorded that he needed to "ventilate his feelings" and that he was on an open ACCT. However, the ACCT document was not handed to the wing

and no further mention of it was made. The investigator interviewed the head of healthcare at High Down. My investigator asked her if she could explain why the ACCT was not available. She said that judging from the entries in the medical record, she considered it unlikely that he would have been on an open ACCT. She said that it was more likely that the nurse who completed the discharge plan had completed the wrong section on the discharge document. However, she said that she would need to look into the matter further to be sure that an ACCT document had not been opened. (The head of healthcare contacted my investigator on 6 November to confirm that she had spoken with the nurse who did the, discharge plan who could not recall whether the man had been subject to ACCT monitoring when she discharged him. The document had not been traced and it was likely that it was a clerical error on the discharge plan.)

22. In mid-August, the man began to go to an education class for ESOL. The tutor in this class said that the man could speak a little English and was a quick learner. She said that, although the man's English was limited, he could communicate and understood what other people were saying and what was happening.

23. Another tutor in the ESOL class, told my investigator that when the man had first come to the class he had almost no English. Despite this she said he was a good communicator and could make himself understood with gestures. His English improved a lot and he was able to make himself understood at a basic level. My investigator asked her whether she thought that the man would have been able to communicate easily with prison staff. She said that she did not think that he would have found this easy. She found him to be a "proud person" who would probably have been reluctant to be open about his problems, but he seemed to get on well with staff. The tutor said that she did not think that the man's language skills were good enough to talk about his personal feelings. She said that he spoke several times to a volunteer who helps in the classes and speaks Spanish.

24. The volunteer said that she could not recall how she had first met the man. She had been made aware that there was a Columbian prisoner who spoke little English and she thought that he would benefit from a visit. My investigator asked about her conversations with him and she said that they would discuss his case and his family. She said that the man's partner was expecting a baby and they talked about his worries. My investigator asked whether the man ever discussed problems he was having in the prison. She said that he would sometimes be "very low" and she would ask him if he felt suicidal. However, the man was a devout Catholic and told her that he would never commit suicide under any circumstances. She said that she had never considered opening an ACCT document as she did not think that he was at risk of self-harming during the time that she was seeing him.

Incident of self-harm in September 2007

25. In September, the man moved from a shared cell to a single cell. There was no particular reason for the move other than to give him the benefit of more privacy. Later that day, he pressed his cell call bell and, when an officer went to the cell, he noticed that he had several fresh cuts to his arms. He was taken to a nurse to have the cuts treated. He told the officer that he wished to move back to the shared cell, as he felt isolated alone in the single cell. The officer opened an ACCT document and arrangements were made for him to return to a shared cell.

26. A requirement of the ACCT process is that a trained assessor carries out an assessment within 24 hours of it being opened. The man's assessment was completed by an officer in September. The officer recorded that translation was difficult, but the man said that he had become depressed due to his inability to communicate effectively. The man said that his self-harm had been a slow build up and that he needed to release some pressure. However, he did not want or expect to die.

27. When the officer asked him about any previous history of self-harm, he showed a scar on his right arm that he said had been a result of a serious suicide attempt eight years before. (It had not been mentioned or recorded during the health screen completed on the man's reception at High Down.) The officer asked if he had any suicidal thoughts or intentions and he replied that he had not. When discussing how he was coping, the man spoke about his children and said he telephoned his family at least three times a week. The officer recorded that, while this was a great comfort he became very emotional when discussing his children. The officer believed that being away from his family was at the core of the man's problems. On concluding his assessment, the officer recorded that, due to the language barrier, it was difficult to be sure that the man fully understood the ACCT procedures. (There is no evidence to suggest that using a translation service was considered.)

28. After the ACCT assessment, staff arranged for the man to speak with another Spanish-speaking prisoner, who was also a Listener. (Listeners are prisoners who volunteer to be trained by the Samaritans to provide confidential support to other prisoners at times of crisis.) In addition, hourly observations were carried out when the man was in his cell and staff recorded all their interactions with him in the document during the core day. The ACCT remained open until 7 September when it was closed following a case review. The man went to the review with two other prisoners who helped to translate. It was recorded during the review that the man felt less isolated, was now settled and agreed to the ACCT document being closed. A post closure review was carried out by a SO in September, when he recorded that the man was "happy on A spur, houseblock 4 and he would like to remain on there". The SO told him about the support that was available to him if he required it.

Discovery of mobile phone and bladed article

29. During a routine cell search in September, the man was found to possess a mobile telephone. The wing history record indicates an entry by the officer who had opened an ACCT document indicates that another officer had placed the man on report. There is however no information as to whether an adjudication took place and, if so, the outcome. (When a prisoner commits an offence against prison rules such as possession of a banned article they are placed on report by the officer who discovers the offence. An adjudication (hearing) follows chaired by a governor. If found guilty, the prisoner will be awarded a punishment ranging from forfeiture of privileges to cellular confinement. The governor can also choose to suspend any award for a minor or first offence.)

30. The discovery of a banned item in any prison should be reported to the security department via a security information report (SIR). (SIRs are used by any person working in a prison to inform the security department of an incident that might need monitoring such as friction between prisoners, the discovery of illicit items or other relevant information) the man's security file indicates that no such report was received by the security department at High Down.

31. Information was however received by the security department, via an SIR that the man was in possession of a bladed weapon. As a precaution, staff searched the man and his cell and a sharpened toilet brush handle was discovered. (It has been known that prisoners melt the ends of plastic toilet brushes and fashion them into a point to make a rather crude but effective weapon.) As a result he was placed in the segregation unit under Rule 53 of the Prison Rules. (Rule 53 authorises the governor to segregate any prisoner suspected of committing an offence pending adjudication.) He was seen by a nurse who completed a Segregation Safety Screen. (The purpose of the screen is to determine whether there are any healthcare reasons why a prisoner cannot be held in segregation. It provides a "snapshot" of a prisoner's mental well-being while also taking account of their physical health.) No medical objections were identified to him being segregated. He remained in the segregation unit for a couple of hours before being moved to A spur on houseblock 2.

32. An adjudication took place in October chaired by the Deputy Governor. The man pleaded guilty and was awarded five days loss of association and loss of access to television. (Association is the time that prisoners are out of their cells and make telephone calls, take part in other wing based activities and talk to each other.) It was also decided that the man should not return to houseblock 4. The same day, a wing officer recorded in the man's wing history record (page 16) that, he had "kept a very low profile over the last couple of days".

Move to houseblock 1

33. The man asked to move to houseblock 1 where there were other Spanish speaking prisoners. He was allocated to a shared cell in houseblock 1, A spur, in October where he reportedly settled in well.

34. Ten days later, at 6.30pm in October, the man approached an officer with scratch marks on his neck and bleeding from his upper lip. The officer recorded on a form F213 that he considered the injuries to be consistent with being assaulted. (F213 is the form used to record an injury to a prisoner. Details are recorded of how the injury was sustained and what treatment staff provided.) However, the man said that he had fallen over. The officer took him to the treatment room where he was examined by a senior nurse. The nurse wrote in the man's medical record, "… Complaining of pain on nose, little bleeding, no swelling. No other injuries except minor cut to inner and upper lip ..."

35. Nothing relating to this event was recorded in the man's wing history file, but an entry in his security file says that there was an altercation between him and another prisoner at 6.30pm in October. There is also no evidence that either prisoner was placed on report. The information in the security file came from an SIR which could not be found and so was not available to the investigators. It is likely that the altercation referred to is the one that resulted in the man's injuries on 22 October.

36. My investigator asked the wing manager on houseblock 1, if she could recall an assault on the man in October. The wing manager said that she had spoken to him about the incident but he refused to discuss it. She also told my investigator that the prisoner who had assaulted the man was known to have a very bad and violent attitude towards staff and prisoners. She added that he was a strong man who was known to be a bully, and had been moved to the prison due to his violent behaviour.

37. Although the SIR was received by the security department in October, it is likely that it was sent there the previous evening. A Principal Officer explained to my investigator that SIRs submitted after 3.00pm are collected the following day at 7.30am and processed by 11.00am. Those submitted before 3.00pm are processed during the course of the day.

38. The man had limited contact with healthcare but did report sick again in December 2007. It is recorded in his medical record:

> "...For about 2 - 3 weeks pain around his right eye and also mucus and pus in his right eye. Slight swelling below right eye but no visible inflammation. To be given 400mg Ibuprofen 2 week course and eye drops to be applied 6 times daily..."

39. There are very few entries in the man's wing history file and, apart from one entry in January 2008 that shows that he had not been approved for enhanced status on the Incentive and Earned Privileges Scheme (IEP), there is a gap of almost two months. (The IEP scheme rewards prisoners for good behaviour. There are three levels, basic, standard and enhanced. Incentives include access to in-cell television, more cash to spend, wearing their own clothes, more time out of the cell and community visits. Each prison sets its own criteria to obtain each level. Basic is the lowest level and is usually used for prisoners

who consistently fail to adhere to the prison regime, standard is the most common and enhanced the highest.) There was no explanation as to why the man was considered to be unsuitable for the enhanced level and he remained on standard.

40. During the morning in March, a prisoner from another houseblock came into houseblock 1 to collect cleaning equipment. On seeing the man, he began making threats that he was going to "kill him". The prisoner then reportedly went to the gates onto the spur and shouted to other prisoners that he would pay anyone who got the man £1,000. An SIR was submitted to the security department but despite an instruction by the security manager, no entry was made in his wing history file.

41. The SIR was processed by the security department and the security manager wrote:

> "... The prisoner's employment status to be reviewed if he is in a trusted position as this suggests he should be removed. He cannot be allowed freedom of movement around the prison if he is going to behave in a threatening manner. The man may have to be moved for his own safety, a note is to be made in both wing history files and observation books. Not to be located together ..."

42. The SIR was passed to the duty governor who commented, "... the man has previously seriously assaulted the prisoner, which was his mitigation on adjudication ..." It is not clear whether the comment refers to the adjudication on the prisoner for the threats he made towards the man or for the previous assault. My investigator attempted to gain further information but was unable to do so. What is known is that there is no previous SIR information relating to the man and the prisoner and no adjudication records for the man relating to an assault on the prisoner.

43. In April, an officer made the following entry in the man's wing history file:

> "... Apart from taking his time when its time to go to his place of work he has not been a problem on houseblock 1, B spur. Enjoys going to the gym and recently given a single cell which he maintains. Limits who he associates with ..."

44. The officer told my investigator, that she knew him very well. She described him as a "loner" who associated with few other people. She said that his English was not good but he was able to communicate with staff. The officer said that the man did not like getting up in the mornings which had led to him being late for education, and he was warned about this. Other than this, the officer said that he was no problem and settled in well on the houseblock.

45. My investigator asked the officer whether she was able to recall the man having any trouble with other prisoners. She said that she could not recall any problems on houseblock 1. However, she said that he had asked to move to another houseblock as he wanted to be with friends who spoke his language. It

was confirmed by the officer that he did move to another houseblock but returned after a relatively short time and was located onto C spur, houseblock

46. The officer, who was working on B spur, said that she spoke to him after his return to houseblock 1. She told him that she would move him back to B spur as soon as a space was available. He subsequently moved to a single cell on B spur.

47. There is no mention in the wing history file of the man being moved to another houseblock or the reasons for his return to houseblock 1. My investigator asked the officer whether she was aware of a reason why he had returned to houseblock 1. The officer said that she recalled saying to the man, "You made such a fuss that you wanted to go over there, how come you are back?" He replied that he did not like it and was not getting on with people, but the officer said that he did not mention any names.

48. However, during an interview with the wing manager, she told my investigator that the man had asked to move to houseblock 5 (where there were a number of other Columbian prisoners) as he felt isolated on houseblock 1. He moved across but had problems relating to the incident with the prisoner who had made threats towards him earlier, so returned to houseblock 1 the following day.

49. The wing manager had made monthly entries in the man's wing history file and she was asked whether this was normal practice. The wing manager said that she made monthly entries for all prisoners on the spur as this was a requirement of the personal officer scheme. She said that she had been trained at another prison and was used to doing so every month. (The personal officer scheme is nationally operated but each prison has its own way of delivering the scheme. A certain number of prisoners are allocated to a named officer as a point of contact. The officer completes reports on prisoners for which they are responsible, ensures entries are made in their wing history files and offers general advice.)

50. The wing manager said that the scheme at High Down was different from what she had been used to. Rather than allocating all prisoners a personal officer, only those prisoners considered to be vulnerable were given a personal officer. The officer who had accompanied the wing manager to the interview, said that the purpose of the High Down scheme is to allow staff more time to focus on those prisoners who need closer monitoring. He said that, due to the size of the prison, if every prisoner had a personal officer then staff would spend weeks writing in their history files. The wing manager told my investigator that she did not believe the man had been highlighted as requiring a personal officer, but she would normally write an entry on all prisoners who she worked with.

51. An entry in the man's history file in May shows that he was offered a space on A spur as he had issues with unidentified prisoners. However, there is no information to suggest that he had been having any problems previously. He declined the opportunity to move to another houseblock but the entry gives no

reason for his refusal or names the officer he spoke to. My investigator attempted to identify the officer who made the entry but was unable to do so. Another entry made the following day says “received back onto houseblock 1”. Again there is no other information to indicate that the man had spent the night anywhere other than houseblock 1 and nobody could account for this or the previous entry.

52. The volunteer helper told my investigator that she last spoke with the man in May before she went on holiday. She said that he was nervous about his trial and had been sent a suit by his partner. He had said that he was going to grow his hair as he felt that this would look better in court. She said that, although he was nervous, he told her that his solicitor thought that there was enough evidence to clear him.

53. As mentioned earlier, very few entries were made in the man’s wing history file between January - June 2008. My investigator interviewed, a prisoner who was friends with the man. The prisoner explained that he had been a classroom assistant in the English class attended by the man. He explained that High Down has a system whereby prisoners who are fluent in a foreign language or English assist the teachers.

54. He said that the man was a “cool guy” and was always friendly. He said that the man had been in the class for sometime and had himself become almost like a “mini-assistant” to the teachers. He would help by explaining things to other Spanish speaking prisoners. My investigator asked the prisoner whether he thought that the man had any problems communicating with staff. He said that he felt that the man understood what was being said and equally could express what he felt. In his view, his English was very “advanced”.

55. My investigator asked whether the man ever spoke about any concerns or problems. The prisoner said that the man’s partner had given birth while he was in custody. As he was a father they had this in common. They would talk a lot about it and the man spoke of his desire to see his baby. He said that the man never became emotional but it was clear that this was something that was important to him.

56. Apart from his family, he said that the man also spoke about his impending trial. He spoke about his prospects of being acquitted, but equally the possibility of being found guilty. He told my investigator that he never said that if he was found guilty what he would do and that he always looked at things in a positive way.

Incident in June 2008

57. At 6.20pm in June while on association, six prisoners went into the man’s cell and a fight ensued. The officer who responded to a general alarm on houseblock 1 that indicated a problem. He was directed to the man’s cell where he witnessed the man punch one of the prisoners. The officer, along with other staff, restrained him who was taken to the segregation unit. The prisoner that the man punched was also sent to the unit. (The purpose of

segregation is to maintain safety, order and discipline. A segregation unit provides temporary accommodation for prisoners that have become violent or disruptive, committed offences against prison rules or require protection if they are under threat from other prisoners.)

58. The wing manager, who was on duty on houseblock 1, followed the man to the segregation unit and spoke with a Principal Officer who was in charge. She asked the Principal Officer if she could speak with the man as she had had a number of dealings with him and he probably spoke with her more than any of the other SOs. The wing manager told my investigator that she went to his cell, sat on the bed with him and discussed what had happened. He told the wing manager that the four prisoners had entered his cell and tried to use a mobile telephone. He had refused and they began pushing one another. He explained that this was when the officer had pressed the alarm. The man said that he hit the other prisoner after staff had responded to the alarm. The wing manager asked why he had done this in front of staff and whether it was so that he would be moved off the houseblock. The man responded to this question by saying that he had done it because "he was angry".

59. When the man went to the segregation unit, he was seen by a nurse who completed the routine segregation safety screen. The nurse also completed a form F213. She recorded that he had a small cut inside his upper lip which required no treatment and also had redness around his right eye for which he was provided with an ice pack. She recorded no medical objections to the man remaining in the segregation unit.

60. Once the healthcare section of the segregation safety screen has been completed, the duty governor has to authorise it by signing the form. In June, the duty governor. The segregation safety screen document does not specify a requirement for the duty governor to physically see a prisoner located in the segregation unit. However, a manager in the segregation unit, was asked by my investigator whether it was normal for a duty governor to sign the form without seeing the prisoner first. The manager in the segregation said that 90 per cent of the time the duty governor would see the prisoner first and the exception to this would be if they were not available. He said that he felt it was good practice for a duty governor to speak to a prisoner who had been brought to the unit to explain why they had been segregated. He said that it was also a way for the governor to satisfy himself that the segregation was justified and acceptable. My investigator asked him if the duty governor would always be aware that a prisoner had been segregated. He said that they would always have to be made aware and provide approval. My investigator asked Governor who had signed the form whether he had spoken to him before signing the form. The Governor said that he did not see him. My investigator asked if he was happy to sign without checking the prisoner and confirming that he was located there for the proper reasons. The Governor said "I just assume that the orderly officer would have his reasons for putting him there."

The man's return to houseblock 1

61. The man remained in the segregation unit and returned to houseblock 1 the following day. The wing manager and an officer spoke with him on his return before he went back to his cell. They asked if he felt safe on the houseblock and whether there were likely to be any further problems. The prisoners involved in June were also still on houseblock 1.

62. The wing manager said that the man was adamant that he would be fine. He kept saying that there were no problems and everything was fine. He told my investigator that she had the wing history files of prisoners involved the previous evening. She showed their photographs to the man, asking if he had any problems with them. She said that he just continued to say that everything was fine. At no time did he mention that he was being bullied.

63. Another prisoner, a Listener and anti-bullying representative on houseblock 1, told my investigator that he recalled speaking to the man when he returned from the segregation unit in June. (The role of an anti-bullying representative is to support anyone who is a victim of bullying and to report to the safer custody team if they feel that a prisoner is being bullied. Their role is not to challenge the bullies.) He said that he knew the man pretty well as he had been in the opposite cell on houseblock 1 for about four months. The prisoner said that the man's English had not been very good but he was able to communicate easily and make himself understood. He considered him to be a quiet individual, who kept to himself. He had never gained the impression that the man felt depressed or suicidal and did not consider him to be vulnerable. On the contrary he said that he felt the man was "very much able to defend himself".

64. My investigator asked the prisoner about his conversation with him when he returned to houseblock 1. He said that the man had not asked to speak with him but he spoke to him in his capacity as anti-bullying representative. The prisoner asked if he was content to return to the houseblock after the incident the previous evening. The man said that he was fine about coming back to the houseblock. However, the prisoner told my investigator that he had got the impression that the man felt isolated and he had informed him that there was support if he required it.

65. My investigator asked him if he noticed any further trouble between the man and the group of alleged bullies. He said that the group still targeted the man and he knew that he was preparing to defend himself if the situation arose again. He had seen a weapon the man had made and he felt he was capable of retaliating if the group attempted to pressurise him again.

66. The prisoner continued by saying that he feared that the man might harm individuals from the group rather than himself and he had therefore spoken to a SO, who worked in safer custody. The prisoner said that he wanted staff to keep an eye on the man as he feared that he might "lash out".

67. The SO told my investigator that, as a member of the safer custody team she was responsible for co-ordinating the Listeners and the anti-bullying

documents. This entailed collating how many were open and on which houseblocks. (An anti-bullying document is opened on an individual when it is believed that they are involved in the bullying of other prisoners.) The SO said that the prisoner came to see her on the afternoon as he was concerned about the man. His main concern was that the man could receive a long sentence if convicted, so he believed that he would have nothing to lose by retaliating. The SO completed an SIR and spoke with the houseblock PO in the presence of the wing manager. The SO asked if they were aware of the prisoner named as bullying the man. They replied that they were and it was being dealt with.

68. Following the interview with the SO, my investigator spoke again to the wing manger and asked if she could recall the conversation with the SO. The wing manager could not recall it but did speak with the SO quite often. However, she said that she had received no information from the anti-bullying representatives and, if she had, then different action would have been taken. She said that the prisoners who had gone into the man's cell in June were being watched but, due to lack of information, none had been placed on anti-bullying monitoring at that time.

69. The wing SO was off duty and returned the following day. My investigator asked the wing SO if he had known the man prior to the incident. He said that he had seen him every day as he would any other prisoner. The wing SO said that the man was very quiet, polite and fairly amiable.

70. My investigator asked the wing SO what he did when he came on duty. He explained that he was required to brief the staff and, before doing this, would read the wing observation book to find out what had happened the previous evening. He said that, as the wing SO, he had to investigate the incident to establish the motivation behind it, such as bullying or racism. He said that he made an entry in the observation book informing all the unit staff of the actions that he wanted them to carry out, which included observing the prisoners.

71. The wing SO said that the information he gathered was later thought to be inaccurate. It was initially thought that the prisoners had gone into the man's cell with the intention of using a mobile telephone, and if they had been caught they would have blamed the man. (Mobile telephones are not allowed inside prisons and cannot even be carried by those working there.) However, the wing SO was told later that the man was himself in possession of a telephone and the group had gone in with the intention of removing it. The wing SO said that this information had not been substantiated. My investigator asked if the prisoners involved had been placed on anti-bullying monitoring. He said that this had been one of his actions. The prisoners had been considered to be "potential bullies" and their movements were to be monitored. He said that it was expected that at least one entry per day would be made in the documents.

72. My investigator asked the wing SO if he considered moving or separating the prisoners. The SO said that he moved the prisoner he considered to be the ringleader and thought that sufficient. He said that this prisoner had been on anti-bullying monitoring at the time of the incident so there was enough evidence to justify moving him. My investigator asked if the SO could be

certain that the prisoner had been moved as he was the one who was hit by the man and taken to the segregation unit with him. The documents provided to the investigators suggested that this prisoner had remained on the houseblock until 14 June.

73. The wing SO told my investigator that he was sure that the prisoner moved before this date as he recalled receiving a telephone call from an SO on the houseblock that the prisoner had moved to. The SO had asked him to confirm that the prisoner required a single cell. The investigators told the wing SO that it was very difficult to ascertain whether the prisoner had moved or not as events had been poorly documented.

Events of Friday

74. The SO, who had been on duty on houseblock 1 on the evening, submitted an SIR following the incident. He wrote "... I suggest that all bar the man have out stayed their welcome at High Down and should be transferred ASAP ..." He also made a note in the wing observation book that, in his opinion, the group should be separated. My investigator asked the SO if the individuals had been separated and, if not, the reason why. The SO said that they had not been separated and, when he returned to duty in June he was surprised to find them still on the same wing. The SO said that he was told that a decision had been taken to deal with it "in-house" but he did not know who had made that decision. The SO went on to say that he was told that the man had been asked whether he was happy to be back on the spur with the prisoners he had problems with, and he had replied "yes, I have friends on the wing, I am happy where I am".

75. The man went to education on the Friday morning. The house block PO told my investigator that she asked him if he was alright as she was aware of the incident on the houseblock. He replied that he was alright, but he did not seem to wish to talk about it. She told my investigator that it did not seem to bother him, but he did not join in with the class as much as he usually would. He spent time on his own working on the computer, which he had not done before, and would have normally joined in the discussion.

76. The prisoner who was a classroom assistant was also in education that morning. He told my investigator that he too was aware of the altercation involving the man as he had not attended education the previous day. He said that the man had told him that he had a mobile telephone and the prisoners had gone to his cell with the intention of taking it from him. He said as a result the man had lost the telephone and was upset by this. The man had told him that one of the things that had kept him going was being able to contact his partner. He said that he would talk to her a lot at night and she would tell him about the baby. The prisoner said, although the man should not have had the telephone, it was clear to him that this gave him considerable comfort.

77. My investigator asked him if he was worried about the man during their conversation. He said that he was not. He could see that he was upset about losing the phone as he had communicated with his partner every evening for

sometime. He likened it to the man coming home from work and talking to his partner, telling her about his day and "offloading" to her. He said not having any way of contacting his partner and speaking about the baby was upsetting him the most. He said that the man did not seem to think that losing the phone, was the end of the world, and he said that he would have to find a way of getting another.

78. When asked whether he spoke with the man about anything else, he said that they discussed meeting at the gymnasium over the weekend. He explained that his houseblock went to the gymnasium on different days to the man so he had told him that he was going to speak to his wing manager to see if they would allow them to attend the same session. As there was no education on a Friday afternoon, he did not expect to see him again until the Monday.

Adjudication for the fight in June

79. During the afternoon of Friday in June, the man was taken to the segregation unit for his adjudication hearing at around 3.00pm.

80. The Governor who did the adjudication explained to my investigator that she had no knowledge of the incident before the adjudication as she would otherwise have been ineligible to hear the case. The first information she had about the incident was when the report was read out at the hearing. The Governor asked the man whether he understood the evidence. He replied that he did and that he had no questions. The Governor asked him to explain what had happened in his cell. He told her that he had an argument with another prisoner and then punched him in the face. He said that he had hit the other prisoner first and the other prisoner had not hit him back. The Governor recorded on the adjudication document and told the man her impression that he was not telling her everything and that someone had told him what to say.

81. There was another officer who was present in the adjudication as an escorting officer. He showed the man the word "bully" in a Spanish phrase book to ascertain if he was under pressure from anyone. It is recorded in the adjudication papers that the man confirmed "yes" when he was shown this. The adjudication was postponed to allow the officer who had reported the incident to attend and the man was taken back to his cell.

82. My investigator asked the Governor whether she was able to communicate with the man easily. The Governor said that she could but he had "quite an attitude" and been "quite flippant" and did not want to say very much. The governor said that when the man was shown the word "bully" it was not clear whether he was indicating that he understood the word or if he was being bullied. My investigator asked the Governor whether she would have done anything differently if she had felt that the man was being bullied. The Governor that he did not appear to her to be vulnerable, and appeared quite a confident man.

Events during the evening in June

83. There is little documented about the man's movements following his return to the houseblock after the adjudication. The second prisoner told my investigator that he had seen the same group of prisoners, "baiting" him during the afternoon. He overheard the man say to one of the prisoners "let's go into the showers to sort this out then". The man then went into the shower area with the prisoner, followed by the rest of the group, before then walking out again. The prisoner told my investigator that the group then shouted to the man "if you are going to threaten us then we will threaten you" but he returned to his cell. This is the last account of anyone seeing the man that afternoon. The prisoner said that this would have been around 4.00pm.

84. My investigator asked the prisoner whether staff would have seen this exchange taking place. He said that he did not think so. He said that staff are generally aware of bullying on the houseblocks and do take action against known bullies. The prisoner told my investigator that this particular group of prisoners were known for stealing and there had been some tension on the wing for a few weeks. When asked how effective he felt the anti-bullying representative was, the prisoner told my investigator that he did not think it was as effective as that of a Listener, and prisoners rarely approached him to say they were being bullied. He added that he had not spoken to him as a Listener and he had not said that he felt vulnerable or unhappy.

85. On Friday afternoons prisoners are locked up earlier and there is no evening association. They are locked in their cells after collecting their evening meal and not unlocked again until the following morning, unless there is an emergency. There is no record of any problems on the houseblock during the early evening or anything to suggest that staff had to go to the man's cell for any reason. He was seen sitting on his bed at 7.15pm by an officer while he was conducting a roll check.

86. The first officer on the scene who was on duty on houseblock 1 during the evening and was due to leave at 9.00pm. The night officer, Operational Support Grade (OSG) had arrived on the wing and begun to do the roll check. (At various times of the day a count of prisoners takes place, usually at shift handovers.) The first officer on the scene said that it was getting close to 9.00pm and she had been told that she could go off duty as soon as the roll had been reported. To help the OSG, she began counting on the third landing, and started on C spur before moving across to B spur where the man's cell was located. She explained that in order to check that each prisoner was in their cell, it was necessary to open the observation panel and look inside.

87. The first officer on the scene said that when she looked into the man's cell, she saw him sitting by the window with the lights off. She said that from the way he was sitting, it looked as though he was "hanging a line" out of the window. (Prisoners use lengths of torn bed sheet or other material to make a "line" which they then use to pass items from their windows to other prisoners.) She thought that this was unlike the man and she continued to count along the landing. When she got to the end of the landing, she thought that she should to go back to check what he was doing and so she returned to his cell. She opened the observation panel slowly to see if she could catch him doing

something. She realised that he was still in the same position. She told my investigator that the man was a "bizarre" colour and she called for assistance from her colleague who was also on the houseblock.

88. The first officer on the scene told my investigator that, after calling to the second officer, she pushed the alarm button on the landing. She decided to open the door and go in without waiting for the second officer. (Prison staff are advised to wait for assistance from a colleague before entering a cell if they are unsure.) She used her anti-ligature knife to cut the ligature, which was attached to the window bars, and lowered him to the floor. (The knife is a tool for cutting ligatures and is carried by all prison staff for use in an emergency.) By the time that she had lowered the man to the floor, the second officer on the scene arrived and they began to administer cardio pulmonary resuscitation (CPR.) She said that, as a trained nurse, she was very familiar with performing CPR. She had checked for a pulse and ascertained that there was not one and the man was not breathing.

89. The second officer on the scene told my investigators that he was on duty with the first officer on the scene on the evening of June. He had completed the earlier roll check at around 7.15pm and recalled seeing the man sitting on his bed. He said he thought it was about an hour later at 8.15pm when he heard the officer's alert and went to assist her. My investigator asked him if he or the officer used their radios to request medical assistance. He told my investigator that the SO who was the duty senior officer and he asked him to contact the control room to call an ambulance and medical assistance. My investigator asked the second officer on the scene how long it would have been from him arriving at the cell to the SO requesting medical assistance. He said that it was "within seconds."

90. The SO who was the duty senior officer told my investigator that he was about to leave the houseblock when he heard the first officer on the scene shout. He was unsure whether she was calling him and then heard her call the second officer. The SO said that there was something in her voice that made him think that there was a problem, so he went back to the houseblock. He told my investigator that he saw the first officer on the scene on the third landing and the second officer making his way up the stairs. The SO called up to first officer on the scene and asked what the problem was and she replied that a prisoner was hanging. The SO said that he could not recall if it was himself or the second officer who made the radio call to alert the control room of the situation, but it was made straight away. The call was recorded by the control room at 8.40pm. The ambulance was contacted at 8.42pm. The SO went to the office to collect an intervention kit and an emergency first aid kit before making his way to the cell. (An intervention kit is located on each wing and contains basic first aid equipment.)

91. The SO and the second officer on the scene were unable to get the airway aid to work and none of the staff had been issued with face masks. Instead, the second officer on the scene used a piece of J cloth as a face mask and continued giving breaths to the man. The SO told my investigator that he thought to himself that the man could not have been found by two better staff,

as the first officer on the scene was an ex nurse and the second officer on the scene was an ex healthcare officer. The two officers continued CPR until healthcare staff arrived.

92. The nurse, who arrived for night duty, had just taken the radio call sign Hotel 2 (which is the emergency response) when he heard the call for medical assistance. My investigator asked Hotel 2 to explain the coding system at High Down for medical emergencies. Hotel 2 said that there are three codes. Red indicates a prisoner with severe chest pain, collapsed, not breathing or hanging, essentially a life threatening condition. Amber indicates a prisoner who may have cut themselves and green is for a minor ailment such as a headache. Hotel 2 confirmed that the call that came over the radio was "red" and he quickly made his way along with other nursing staff to houseblock 1.

93. The SO who had also arrived for duty and taken over as the night orderly officer. (The night orderly officer is in charge of the entire prison during the night state.) He was with the duty governor, when they heard the alarm sound on houseblock 1. The SO told my investigator that, within 30 seconds of hearing the alarm, a code red was called over the radio and he told the Governor that he would go to the houseblock. When he got there he was directed by staff up to the man's cell. The SO told my investigator that the two officers were administering CPR when he arrived. He immediately used his radio to contact the control room and ensure that an ambulance had been called and staff were available to escort it straight to the houseblock. The SO then contacted the Governor and asked him to make his way straight to the houseblock.

94. The Governor arrived at the cell at the same time as the healthcare staff who then took over from the officers administering CPR. Hotel 2 said that they continued to try and get a response from the man but failed to establish any signs of life.

95. The ambulance arrived at the prison at 8.45pm and was taken directly to houseblock 1. Paramedics took over and continued to treat the man. The first ambulance crew were assisted by paramedics from the Helicopter Emergency Medical Services (HEMS). This is operated form the Royal London Hospital and provides a service to the Greater London area and often consists of a trauma doctor and paramedic. The HEMS team arrived by car at the prison at 9.10pm. The medical team continued to treat him and eventually obtained a pulse. He was transferred by emergency ambulance to the hospital, at 9.57pm.

96. The SO arranged for two members of staff to accompany the man in the ambulance. Due to his condition, no restraints (handcuffs) were used. He said that initially there was a disagreement with one of the HEMS doctors who said that there was not enough room for prison staff to go in the ambulance, but it was quickly agreed that one member of staff would travel in the front of the HEMS car and the other in the ambulance.

97. The man was taken into the trauma room at the hospital. The SO told my investigator that the escort staff rang and told him that he had suspected brain

damage and medical staff were carrying out further tests and more should be known within the hour.

98. Medical treatment continued but, at approximately 1.40am, medical staff took the decision to withdraw treatment as tests confirmed that the man had no brain activity. He was pronounced dead at 1.45am.

Actions following the man's death

99. The SO told my investigator that, after hearing that the man had died, he asked his staff to ensure that all prisoners on open ACCT documents were checked. He explained that this is a requirement following a death in custody.

100. A member of the IMB at High Down, was on call in June and was contacted at home when the man was discovered. She told investigator that the ambulance was outside when she arrived at the prison. The member of the IMB attended the "hot debrief" (this is an opportunity for staff involved in an incident to share their observations and for managers to ensure that they are alright). She said that she was next to the first officer on the scene who was upset. She then went to houseblock 1 where she met the OSG who she described as being "in a bit of a tizz". She told my investigator that she stayed with the OSG for a while and then the IMB chairperson arrived. She said that IMB chairperson also stayed on the houseblock for a short time and then went to the detail office where the debrief had been taking place. The member of the IMB decided to remain with OSG and accompanied her as she walk around the houseblock checking those prisoners on ACCT monitoring.

101. As the member of the IMB walked around the houseblock she spoke to a number of prisoners who indicated that, in their opinion, the man should not have been left there. One prisoner said that he had spoken to safer custody about prisoners being bullied. However, she was not able to provide the names of the prisoners who had spoken to her.

102. The second officer on scene told my investigator that when he arrived for duty on the morning of 14 June, the mood on the houseblock was quite subdued. As the SO had reported sick, and he was put in charge. During the course of the morning there were various rumours that something was going to happen during the exercise period. My investigator asked him to explain what this meant. He told her that the rumours were around the man having been bullied by the group of prisoners and other prisoners were speculating that this was why he had taken his life. The officer said that as a precaution to ensure that all prisoners were kept safe, he cancelled the exercise.

103. The Governor who was also the duty governor gave instructions for the prisoners identified as involved in the bullying to be removed from the houseblock to the segregation unit.

104. The prison liaison officer and the SO came into the prison and took over notifying the man's next of kin. This was proving difficult as he was a foreign national. The prison contacted the Foreign Office, Columbian Embassy, UK Immigration Services and the Metropolitan Police murder squad, (who had been dealing with the man's case) in the hope of gaining further details about his next of kin.

105. The Columbian Embassy contacted the prison at 2.30pm that day and said that they had already been notified of the man's death. Similarly, his solicitors had

also been told. The prison was told that the man's solicitor would not be available until the Monday when details of the next of kin would be provided and that they were based in Columbia.

106. My investigator, visited High Down to open the investigation, the Governor explained that another prisoner who was the man's friend had telephoned his wife. He asked her to contact the Columbian Embassy so that they could tell the man's partner about his death. Fortunately, the prison was able to contact the Embassy to ask them to pass the news on before it reached the man's family by this unofficial route.

107. My investigator also spoke with the SO who informed her that the appointed prison family liaison officer (FLO). The SO explained that the prison had initially contacted the Foreign Office as they were unable to contact the Columbian Embassy. The legal Advisor at the Columbian Consulate in London, contacted the man's family in Columbia on the afternoon of 14 June.

108. The legal advisor visited High Down on 16 June. He said that the man's family had asked for help to have his body flown back to Columbia and they wanted his correspondence from the family to be retrieved from his cell. The legal advisor added that a cousin of the man might travel from Columbia to sort out the arrangements.

109. The prison arranged for the man's body to be repatriated and met the costs.

110. My investigator spoke with the legal advisor on 28 November and asked how he first came into contact with the man. He was contacted initially by the man's legal team as he wanted to give the power of attorney to his partner in Columbia and so a lawyer was required. The legal advisor visited him at High Down, with his solicitor, in May 2008.

111. My investigator asked the legal advisor whether the man had mentioned any problems in the prison or concerns about his family. He replied that the man mentioned having trouble with some prisoners who tried to take property from him. He confirmed that this would have been prior to the events.

112. The legal advisor was asked by my investigator whether the man appeared distressed but he said that he appeared quite calm and very relaxed. He said that the man spoke very calmly and appeared to be a gentle person and he did not notice any depression or anger. The man was mostly concerned with his family in Columbia, especially his baby daughter, whom he had not seen and which he was sad about.

113. My investigator asked the legal advisor about a conversation that he had with a police officer in Columbia. (This was in relation to the man receiving a telephone call a few days before his death from someone in Columbia making claims about his partner's personal life.) He said that he spoke to the man's partner after his death about the rumour. She told him that it did not make sense as she kept in touch with him all the time. She spoke to him two nights before he died when he was very happy because his court case was going well.

Liaison with the Metropolitan Police

114. Following the man's death, one of his tutors, was sorting through his course work. She discovered two exercise books that contained what appeared to be letters written in Spanish. It was apparent that the books could contain significant information and, when my investigator was notified of their existence, she informed the prison that they should be passed to the police.

115. The exercise books were subsequently passed to Detective Inspector (DI), Metropolitan Police, who arranged for them to be translated. The police also found an undated letter written in Spanish amongst other correspondence in the cell and it was also translated.

116. After the documents were translated, the police shared the findings with my investigator. The letter found in the cell appeared to be a suicide note although it had not been placed in a prominent place to be found by staff. In the letter, the man wrote that he was unable to continue. He thanked his partner for the time that they spent together and that he wished he could change things to see his daughter grow up. The man ended the letter by saying "this is my good-bye".

ISSUES

Provision for foreign national prisoners

117. The most recent report by HM Chief Inspector of Prisons, is critical of the provision of services for foreign national prisoners at High Down. The man was located in the healthcare centre on his reception at High Down where he spent his first 48 hours in custody and his induction took place.

118. The induction policy at High Down says that it will take place over two days with various subjects being discussed with new prisoners by peer advisors (who have volunteered to be a point of contact for fellow prisoners). Information for foreign national prisoners is scheduled to be provided on the second day. Prisoners like him who are not located directly onto a houseblock are seen individually by a peer advisor the day after their arrival. There is no record in his wing history file of the content of his induction and is nothing signed by him to confirm that he had one.

When a prisoner is not immediately located onto a houseblock following their reception into custody, the Governor must ensure that they are provided with the same opportunities for induction and that this process is clearly recorded in their wing history files.

119. Staff at High Down use the "The Big Word" telephone translating service. The local operating procedure states "... High Down aims to support prisoners whose first language is not English and do not have sufficient knowledge of the language to participate in the regime or make use of the support services ..."

120. Some staff recorded that the man was able to communicate and make himself understood. Equally, others said that his lack of English was a frustration for him. He attended ESOL classes to try and improve his English. His tutors considered that, although he made significant progress, when he first entered custody his English was poor.

121. The Big Word translation service might have proved useful following the man's self-harm in September 2007 when the officer conducting the assessment was unsure whether he had fully understood the process. It would have been equally useful to use their services to ensure that the man fully understood the adjudication process and to clarify that he had no concerns with being located on the houseblock.

I recommend that the services of the 'Big Word' are clearly displayed on residential units for both staff and prisoners and that staff are encouraged to use them.

122. The induction documents and information provided to prisoners were not filed in the man's wing history. Therefore I am unable to say whether or not this was given to him in English or Spanish. It is essential that information for prisoners whose first language is not English is available in a wide selection of languages.

The Governor should ensure that information for prisoners is available in as many languages as possible.

123. During the investigation the investigators asked to see a copy of the Foreign National Policy but were informed that it was being re-written and was not currently available.

I recommend that the Governor ensures that an up to date Foreign National Policy is published and available to all staff.

124. The man was found in possession of a mobile telephone on more than one occasion. It is known from his conversations with others that he missed his partner and child. It seems that his reasons for having the telephone were to enable him to maintain regular contact with his family rather than for any nefarious reason.

125. Contact with their family is something that is likely to be important to all prisoners and must be more so for a foreign national prisoner whose family live abroad. Although arrangements are in place at High Down for foreign national prisoners to be able to purchase extra telephone credit, it is likely that the high price of international calls makes obtaining a mobile telephone attractive.

126. There is also the issue of time differences as some foreign national prisoners are unable to call abroad. I understand that this is a national problem across the Prison Service, but the Governor may wish to look at ways this can be addressed within the policy at High Down.

127. The Consultant Forensic Psychiatrist, who completed the clinical review, also makes the following comment in relation to foreign national prisoners:

> "...when a foreign national with limited English language abilities is remanded in custody, it is essential that the health needs should be identified with the use of interpreting services to at least provide a baseline health assessment. It is difficult to know now whether the man understood the questions asked of him on the reception screening and Well Man screen or could convey information about his background health history..."

Assessment, Care in Custody and Teamwork (ACCT) procedures

128. The man was placed on ACCT monitoring in September 2007 following an isolated act of self-harm. The procedures when opening the document were correctly followed and it was appropriately closed following a multi-agency case review. There was no indication that an ACCT needed to be opened at any other time. Even after the incident on 11 June I am satisfied that there was no evidence to suggest that he was at any greater risk of self-harm.

Security Information Reports (SIRs) and adjudications

129. During the man's time in custody, several SIRs were submitted in relation to him having weapons and possible problems with other prisoners. One SIR referred to another prisoner, threatening him on houseblock 1 and offering to pay £1000 to any prisoner who harmed him. The duty governor recorded on the SIR that the man had previously "seriously" assaulted that prisoner, but there is no SIR or adjudication information to support this.

130. It was recorded in his wing history file that the man was found in possession of a mobile telephone on 25 September for which he was placed on report. However, there are no records to indicate whether an adjudication took place and no SIR relating to this incident was recorded as having been received by the security department. I make the following recommendation:

    The Governor should remind all staff of the importance of recording and sharing information. Sharing information, no matter how minor, could add to a bigger picture and identify a person who might be at risk or a risk to others.

Incident on 11 June

131. Following the incident on houseblock 1, the man was moved to the segregation unit with one other prisoner. I believe that this was appropriate given the nature of the offence. He was seen by a member of the healthcare staff who confirmed that he was fit to be held in segregation and completed the segregation safety algorithm as required. The algorithm does not state that it is necessary for the duty governor to see a prisoner before signing the record. However, it was established during the course of the investigation from staff working regularly in the unit considered it good practice for duty governors to satisfy themselves of a prisoner's well being by seeing them before signing the document. The investigator was told that this happened on the majority of occasions.

    The Governor should make it a requirement for the duty governor to see a prisoner before signing a segregation safety screen.

132. On his return to houseblock 1 the following day, the wing manager asked him whether he was alright to return to his cell. The man confirmed that he was. However, during this investigation, it became clear that other information had been available to staff during the course of that day. It indicated that he had been targeted by a gang of bullies. This information does not seem to have been shared with all the staff on the houseblock and he was not asked about the new information.

133. The prisoner who was taken to the segregation unit with the man also returned to the houseblock. Given that this prisoner was already subject to anti-bullying procedures prior to the incident, I question whether it was appropriate for him to return to the same houseblock.

134. The five other prisoners involved in the incident were placed on stage 1 of the anti-bullying measures. At High Down, stage 1 should be used where there is not enough evidence to prove that the prisoner is bullying. The prisoner is monitored for a period of 28 days and should be interviewed beforehand.

135. It appeared during the investigation that staff were confused as to the requirements of the anti-bullying procedures. Some officers believed Stage 1 was ”covert” and that prisoners were not told they were being monitored. Others said that it was necessary to inform the prisoner as stated in the guidance.

The Governor should publish a notice to staff reminding them of the correct procedures to be followed in respect of anti-bullying documentation.

The Governor should ensure that managers are completing daily checks on all anti-bullying documents and that these are recorded.

136. The guidance also requires a minimum of one quality entry to be made daily in the document. The investigator found that this was not happening. In one document there was a gap of five weeks without an entry. When the investigator asked, she was told that the prisoner had been moved to a different houseblock and they were unaware that he was subject to anti-bullying procedures. The procedures at High Down clearly state that managers must check anti-bullying documents daily to ensure that entries are being made.

137. In addition to monitoring alleged bullies, there are also procedures for supporting the victim. They indicate that an AB4 Support for Victim form should be completed at the same time as the anti-bullying monitoring form, in consultation with the victim. Following this, regular entries should be made in the prisoner’s wing history file relating to his welfare.

138. There is no evidence that the man was consulted or that an AB4 was completed. There are no entries in his wing history file after the event to his welfare.

The Governor should ensure that victims of bullying are supported in line with the published guidance and that this forms part of the management checks.

Response to the man’s hanging

139. When the first officer on the scene realised that there was a problem with the man in June she immediately called the second officer for assistance. At the time of the incident, the first officer on the scene was a relatively new member of staff. Realising that the man required immediate help, she made a decision to enter the cell on her own. I am aware that staff entering cells on their own is often the subject of some debate. By assessing the seriousness of the situation, noting that the man was in a single cell and making the decision to go into the cell I consider that the first officer on the scene exercised good

judgement and her actions are commendable. I have been made aware that the Governor has already recognised the actions of the officer and I would be grateful if my comments could also be shared with her.

140. The second officer on the scene responded quickly and as both the officers had a medical background, they ensured that first aid was administered appropriately until the arrival of the medical staff. In particular, the quick thinking of the second officer on scene when he realised that there were no face masks deserves mention. Again, I would be grateful if my comments could be passed on to him. I make the following recommendation.

The Governor and Head of Healthcare should ensure that all emergency response boxes contain the necessary equipment including face masks and that they are checked on a regular basis.

Other clinical findings

141. The clinical reviewer, has covered a number of areas in her report which I summarise here:

> "... Within the man's notes the Well Man screening was both undated and unsigned. An in possession medication assessment was not completed, although he was subsequently prescribed medication to hold in possession. (All prisoners who require medication should be assessed as to their suitability to hold their own medication. They are then required to sign a compact that states that they agree to abide by the rules relating to this.) There is also a suggestion that a care plan was to be put in place on his discharge from the healthcare centre. The Consultant Forensic Psychiatrist was not provided with any information relating to any care plans. The guidelines for completing notes have not been followed in respect of the Well Man screening which was neither signed nor dated and in places illegible.

The Head of Healthcare should ensure that a regular audit takes place of the quality and accuracy of the notes in prisoner's medical records.

> "The reception health screen indicates that a prisoner charged with murder or manslaughter should be referred for a Mental Health Assessment, this does not appear to have happened for the man and there appears to have been no mental health interaction during his time in custody. It is important that the reception health screen is followed. Although he appears to have been a very settled prisoner he does not appear to have had the opportunity to discuss his situation, and ability to cope with the prison environment in the face of serious charges ...".

The Head of Healthcare should ensure that a clear pathway for referrals to mental health Inreach is published and, where a referral is made, the follow up needs of a patient are explicit.

CONCLUSION

142. The man seems to have been a very private person. He had a tough exterior, evident in the way he dealt with the problems he encountered with other prisoners, and chose not to share his feelings. The information that came to light after the man's death would indicate that he was a vulnerable man despite the impression he portrayed to his group of friends and staff who knew him well.

143. The letter discovered in his cell was clearly written as a suicide note and would indicate that he was ending his life. It is unclear why the man chose to take his life, but it is evident that he thought the world of his partner and daughter, and found it difficult to cope with being separated. It is possible that, facing the possibility of a life sentence, he found this separation too much to bear.

RECOMMENDATIONS

For the Governor

1. **I recommend that the Governor ensure that an up to date Foreign National Policy is published and available to all staff.**

   The Prison Service accepted this recommendation and said:

   The latest Foreign National Local Operating Policy was published in March 2009. This is a live document and is reviewed regularly.

2. **I recommend that the services of the 'Big Word' are clearly displayed on residential units for both staff and prisoners and that staff are encouraged to use them.**

   The Prison Service accepted this recommendation and said:

   The Diversity department will ensure that the posters/information regarding 'the big word' translation company are clearly displayed on all residential units. A Governors Notice will be re-issued regarding the translation services available for staff. Foreign National posters are displayed in all areas. Staff are aware that they can use the big word. Regular reminders are published in the bulletin and will be displayed at the gate on the information screen.

3. **The Governor should ensure that information for prisoners is available in as many languages as possible.**

   The Prison Service accepted this recommendation and said:

   Laptop computer and translation software has recently been purchased. All relevant paperwork is being translated into 12 languages. Target date December 2009.

4. **When a prisoner is not immediately located onto a houseblock following their reception into custody, the Governor must ensure that they are provided with the same opportunities for induction and that this process is clearly recorded in their wing history files.**

   The Prison Service partially accepted this recommendation and said:

   It is not possible for prisoners located in other areas of the prison to receive the full induction process on HB3 after arrival and initial allocation. This is due to prisoners being vulnerable/security risk/discipline issues etc and therefore not suitable to locate/mix with the main population. However, prisoners are seen on the Saturday by the induction officer and peer worker. The induction officer can record in the prisoners case notes that they have visited and inducted the prisoner. However if there are staff shortages the induction officer may not be available and the peer worker should then inform staff of his attendance for

them to record this in the case notes. This work should be revisited in the review exercise of the current profiles. Target date January 2010.

5. **The Governor should remind all staff of the importance of recording and sharing information. Sharing information, no matter how minor, could add to a bigger picture and identify a person who might be at risk or a risk to others.**

The Prison Service accepted this recommendation and said:

This will be addressed by a Governors Order being published. Also, this will be addressed through new case management procedures that are being implemented. One person will be responsible for managing and receiving all the information in relation to an individual prisoner. This is hoped to be in place by September and will be fully established by the target date of January 2010.

6. **The Governor should make it a requirement for the duty governor to see a prisoner before signing a segregation safety screen.**

The Prison Service accepted this recommendation and said:

Governors Orders will be issued, however this will not be met if a prisoner is segregated during the evening. The Governor's Orders should therefore state that the Governor will visit the prisoner at the earliest opportunity when commencing duty the following day and must satisfy themselves that the Orderly Officer has seen the prisoner and reported back to the Duty Governor in full. Target date January 2010.

7. **The Governor should publish a notice to staff reminding them of the correct procedures to be followed in respect of anti-bullying documentation.**

The Prison Service accepted this recommendation and said:

Governors Notice to be issued to all staff. Target date January 2010.

8. **The Governor should ensure that managers are completing daily checks on all anti-bullying documents and that these are recorded.**

The Prison Service did not accept this recommendation and said:

There are no national procedures to be followed in relation to Anti-Bullying measures. PSO 2750 states that depending on the impact and resources available, each establishment must devise their own local approach. Unit Senior Officers should carry out management checks of the Anti Bullying documents.

I accept that Highdown have a local protocol for managing open Anti Bullying documents. However, during the course of my investigation I did not find any

managers including Unit Senior Officers carrying out regular quality checks. The recommendation remains unchanged.

9. **The Governor should ensure that victims of bullying are supported in line with the published guidance and that this forms part of the management checks.**

The Prison Service accepted this recommendation and said:

There is a local procedure for monitoring and prevention of bullying and the anti-bullying book procedures should be followed by staff and the unit managers should be checking these procedures are being adhered to. Target date January 2010.

For Governor and Head of Healthcare

10. **The Governor and Head of Healthcare should ensure that all emergency response boxes contain the necessary equipment including facemasks and that they are checked on a regular basis.**

This recommendation was accepted and actions have been completed. In response, the Head of Healthcare said:

Each house block and reception, inpatients and outpatients have ambu bags, airways and defibrillation machines. There is a bag, which has additional resuscitation equipment in it. Nurses are trained In CPR and defibrillation and also receive regular updates. There is also a full resuscitation trolley within the inpatient unit.

11. **The Head of Healthcare should ensure that a regular audit takes place of the quality and accuracy of the notes in prisoner's medical records.**

This recommendation was accepted and actions have been completed and are ongoing. In response, the Head of Healthcare said:

Regular audits do take place on medical records. Surrey Community Health has an audit template for medical records, this is used within the prison, and the findings are reported through our governance structures.

12. **The Head of Healthcare should ensure that a clear pathway for referrals to mental health Inreach is published and, where a referral is made, the follow up needs of a patient are explicit.**

This recommendation was accepted and actions have been completed. In response, the Head of Healthcare said:

Clear referral pathway in place. There is a weekly multidisciplinary allocation meeting for new referrals. All referrals are scrutinised on a daily basis. Once a patient has been assessed, they are allocated a key worker if appropriate.

There is a care plan and regular reviews by the key worker. If there is no identified mental health need the in reach team will refer to appropriate agencies when necessary and will clearly state that the referral has been assessed and case closed.