

**Investigation into the circumstances surrounding the  
death of a man at HMP & YOI Swinfen Hall  
in June 2009**

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

**February 2010**

This is the report of the investigation into the circumstances surrounding the death of a man. He was found hanging in his cell at HMYOI Swinfen Hall in June 2009 and was pronounced dead by paramedics shortly afterwards. He was 20 years old.

I would like to offer my personal condolences to the man's family, friends and everyone affected by his death.

One of the Ombudsman's investigators undertook the investigation. In addition, the local Primary Care Trust (PCT) asked a clinical reviewer to undertake a review of the man's clinical care, and I am grateful for her contribution to the investigation. I would also like to thank the Governor of Swinfen Hall and his staff for their participation in the investigation.

The man was remanded into custody to HMP Altcourse in May 2008 and sentenced to 30 months imprisonment in September. He spent time at six prisons, including Altcourse due to his behaviour, before moving to Swinfen Hall in April 2009.

In June, the man was moved to the segregation unit after being abusive to a member of staff. He did not express any concerns about this to healthcare staff who visited him on the unit. Another prisoner in the unit at the same time as the man said that he had spoken to him over the weekend. He appeared to be alright and did not mention feeling suicidal or low. The evening before his death, he told him that he needed to think of a plan to get himself out of the segregation unit.

On a morning in June, the man was seen at 8.47am when he was unlocked from his cell and went for a shower. Staff said that he appeared in a good mood and they had no cause for concern. After having a shower, he was seen by a nurse at 10.00am during her routine review of prisoners in the unit.

At approximately 11.05am while the Governor was visiting prisoners on the unit, the man was discovered hanging from the window bars in his cell. Staff immediately intervened and cut the ligature. Both discipline and medical staff, as well as paramedics, attempted to resuscitate him for over 30 minutes, but sadly, at 11.37am he was pronounced dead.

The report makes ten recommendations. They relate mainly to information handling and sharing within the prison and adherence to ACCT procedures. Others relate to how calls are made to the emergency services, the emergency coding system and clarity of medical documentation. Two of the recommendations are relevant to other prisons that the man had been at and these will be shared with those Governors. I was disappointed to learn of the defacement of official documents from an earlier prison and, although I have made no formal recommendation, the Governor will no doubt wish to ensure that this practice is not widespread.

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

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

**February 2010**

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## SUMMARY

The man arrived at HMYOI Swinfen Hall in April 2009. He had initially entered custody in May 2008 at HMYOI Altcourse as a remand prisoner and, over the next 12 months, he moved between various prisons before going to Swinfen Hall. The reason for him moving on such a regular basis was his continued disruptive behaviour.

His behaviour while in custody is well documented. He was regularly placed on report (this is when a prisoner offends against prison rules) and spent frequent periods in segregation units. While located in the segregation unit at HMYOI Stoke Heath in March 2009, three weeks prior to his transfer to Swinfen Hall, he was discovered by a nurse in his cell with a noose around his neck. The noose was not attached to anything and, at the request of the nurse, he took it off and handed it to her. He was subsequently placed on Assessment, Care, Custody and Teamwork (ACCT) monitoring. As part of this process, an assessment was conducted during which he said he had only put the noose on as he knew that the nurse was coming and hoped that it would lead to a move out of the segregation unit. He went on to say that, he had no thoughts of harming himself or taking his life. Despite his insistence that he had no suicidal thoughts, the ACCT document remained open for approximately three weeks and was closed three days before his transfer to Swinfen Hall.

When the man arrived at Swinfen Hall a nurse asked him if he had previously harmed himself, and he told her that he had once “jokingly made a noose”. The closed ACCT document that had been sent with him was not made available to either the nursing or the induction staff who later dealt with him.

The man appeared to settle in well at Swinfen Hall but his continued disruptive behaviour resulted in him being placed on report very soon after his arrival. Staff who dealt with him regularly described him as a “cheeky chap” who would always try and push the boundaries. He was frustrated by not having a job when he arrived at Swinfen Hall and would spend most of his time in his cell on the wing. When he finally found employment, it was on the industrial cleaning course where he excelled as a student. His behaviour on the course was in complete contrast to that which he continued to display on the wing. His tutor described him as having huge artistic talent and was an example to other prisoners on the course.

Unfortunately, the man got into trouble again in June and was once again moved to the segregation unit. It is documented that he was not happy about this and staff on the unit regularly talked to him about his behaviour. He was keen to return to his wing and, on a weekend in June, he asked for his adjourned adjudication to be heard. He was informed by both unit staff and the duty governor that if he behaved and began adhering to the rules his adjudication would be heard over the weekend. Although he initially followed this advice, he again became confrontational, resulting in the adjudication not taking place.

On an evening in June, the man spoke with a fellow prisoner who was in the cell next door. The prisoner said that the man spoke about not wanting to be in the

segregation unit and that he need a “master plan” to get moved. It is not clear what the man meant by this statement.

On a Monday in June the man was unlocked from his cell as usual by staff, provided with hot water, and later given access to the shower. Despite his behaviour over the weekend, he appeared happy and talked politely to staff. He was due to go to the adjudication hearing later that morning.

At around 11.00am, the Governor went to the segregation unit to collect paperwork and agreed to see all the prisoners on the unit. He reached cell 5, which was occupied by the man, at approximately 11.05am. As the officer opened the cell door, he immediately saw him suspended by a ligature at the back of the cell and called his colleague for assistance. The ligature was cut and on doing so his body fell forward and his head is reported to have struck the toilet. Staff placed him on the floor and immediately started cardio pulmonary resuscitation (CPR).

One of the officers called for medical assistance and nursing staff quickly took over the resuscitation attempts. Emergency paramedics arrived at the prison a short while later and treatment continued for a further 15 to 20 minutes but sadly, at 11.37am they pronounced the man dead.

I conclude that there are no clear indications as to why the man chose to take his own life. He was a young man who made no secret of the plans he was making for his future and had the support of a loving partner and family. I have made seven recommendations as a result of this investigation and the clinical review.

## THE INVESTIGATION PROCESS

1. The investigator telephoned the Governor in June to ask for the man's prison records and to arrange to visit the prison.
2. Notices were issued in June informing both staff and prisoners of the investigation. They invited anyone who had information about the man's death to contact the investigator. No responses were received.
3. The investigator initially visited the prison in July where he met members of the senior management team and representatives from both the Independent Monitoring Board (IMB) and Prison Officers' Association (POA). He also viewed the cell in the segregation unit where the man was located and his cell on the residential wing. The investigator spoke with a prisoner who knew the man while he was in the segregation unit and who asked to speak with the investigator again when he returned to interview staff. While at Swinfen Hall the investigator was given all the documents relating to the man including his medical records.
4. The local Primary Care Trust (PCT) was asked to commission a review of the clinical care that the man had received whilst in custody. A clinical reviewer undertook this review and her report is attached as an annex.
5. The investigator contacted the local police who had attended the prison following the man's death to inform them of the investigation and to arrange for any relevant information to be shared. The police were satisfied that there were no unusual circumstances but statements from staff would be sought. The investigator contacted the police again in September to ask for copies of photographs taken after his death in order to clarify points raised by his family. I am grateful to Staffordshire Constabulary for sharing information.
6. A solicitor, who had been appointed to represent the man's family, contacted one of the Ombudsman's Family Liaison Officers (FLOs) in July. The FLO followed up the telephone call with a letter explaining the purpose of the investigation and offering the opportunity for the family to meet her and the investigator to discuss any concerns.
7. The investigator visited Swinfen Hall again in August where, over the course of two days, he interviewed 14 members of staff and one prisoner who had either known the man or been directly involved with assisting on the day of his death. Copies of the transcripts of these interviews are attached as annexes to the report.
8. The investigator and FLO visited the man's family at their home in Liverpool in September. Sixteen members of the man's family, including his mother and his partner attended the meeting. The family's solicitor was also present. All members of the family raised concerns or asked for clarification about his time in custody. His mother also provided a list of 57 points on which the family sought clarification. The investigator explained that he would attempt to address them during the course of his investigation but it might not be possible

to answer those that fall outside the remit of the Ombudsman's office. The family also provided a brief background about the man for which I am grateful and I have used extracts in my report.

9. The investigator also contacted HM Coroner to inform him of the nature and scope of the investigation. At the investigator's request, the Coroner sent a copy of the post mortem report, followed by a toxicology report. The toxicology report indicated that there were no illicit drugs in the man's system. The findings of the post mortem suggested that his death was the result of "a reflex vasovagal action referable to neck pressure causing his heart to cease beating." The pathologist goes on to say in his report that "this is the most common mode of demise in hanging deaths".

## HMYOI SWINFEN HALL

10. HMYOI Swinfen Hall has been a long-term closed young offenders' institution (YOI) since 1988. Prior to this, it had served as both a youth custody centre and before that as a borstal. In addition to holding young offenders aged 18 to 21, the prison also operates as an integrated young adult prison for those who are aged 21 to 25. Within the prison estate, Swinfen Hall is considered to be a high performing prison.
11. The prison has the operational capacity to hold 624 prisoners (240 young adults and 384 young offenders). It is made up of nine residential units housing different types of prisoners, such as reception/induction, offending behaviour programmes and life sentence/imprisonment for public protection (IPP) prisoners. (IPP prisoners have no automatic right to release at the end of their sentence.) The prison population is made up of prisoners from wide geographical areas who are allocated to Swinfen Hall for varying reasons.
12. HM Chief Inspector of Prisons carried out a full inspection of Swinfen Hall in September 2005. During the inspection she said that Swinfen Hall's previous description as a centre of excellence was being tested by an expansion plan that would double the prison's population. She was concerned that it was going ahead without the provision of purposeful activity for the increased numbers.
13. A follow up inspection in April 2008 was carried out and in her report she said:

"... On our last visit, while commending much of what we found, we were concerned that insufficient purposeful activity had been put in place to meet its growth. On our return, for this short unannounced follow-up inspection, we were pleased to find Swinfen Hall remained a safe, respectful place, focused on resettlement, and that much progress had been made in provision of purposeful activity ..."
14. She also said in her report of suicide prevention and segregation:

"... Suicide prevention arrangements were good, but more needed to be done to deal effectively with bullies. Nevertheless, drugs were not a significant problem and vulnerable prisoners were safely managed on normal location. Segregation staff worked well with some difficult prisoners, although paperwork was poor and use of special cells and strip clothing needed tightening up ..."

15. The Independent Monitoring Board (IMB) at Swinfen Hall published their most recent annual report on the prison in April 2008. The Prisons Act 1952 requires every prison to be monitored by an independent board appointed by the Secretary of State from members of the community in which the prison is situated. The IMB concluded:

“... Whilst finding it necessary to raise several points for attention, the board is of the opinion that Swinfen Hall continues to maintain a very good standard, providing a safe, respectful and structured environment in which all prisoners in its care are encouraged to address their offending behavioural needs. The prison has continued to deliver strongly against its KPT (Key Performance Target) measures and has been recognised with the High Performing Status award making it the best performing prison in the West Midlands and in its comparative group. In addition, it has gained the coveted Investors In People award ...”

16. The Ombudsman was given responsibility for investigating all deaths in prison custody in 2004. Since then, this is the first self-inflicted death at Swinfen Hall and there has been only one previous death from natural causes.

## KEY FINDINGS

### HMP/YOI Altcourse

17. The man appeared at court in May 2008. He was remanded into custody and taken to HMYOI Altcourse the same day. It was not his first period in custody and he had been at Altcourse during a previous sentence in 2007. He was 19 years old when he entered custody on this occasion.
18. Shortly before being remanded into custody, he had been involved in a road traffic accident and, as a result, had undergone an operation on his leg. He discharged himself from hospital against the advice of doctors the day after the operation. When he arrived at Altcourse, he was seen by a nurse who completed a health screening. He told the nurse about his recent operation but said that he had no concerns about his physical health. He said that he was supposed to have stayed in hospital for two months but said that he had no outstanding appointments. The nurse recorded that he had no history of harming himself either in custody or in the community. He told the nurse that he had used recreational drugs for the last four years, and had smoked 'weed' within the last month.
19. The following day, the man was assessed by one of the prison doctors who recorded that, despite admitting to using recreational drugs, there were no drug or alcohol issues. The doctor also referred to the operation on his leg and recorded that he had stitches in his right thigh.
20. The man reported sick in May, complaining of pain in his right knee. He was assessed by a nurse who recorded that he was now using crutches and had been advised not to bear weight. He was also told that he would be seen by the doctor the following day. A doctor, who saw him the next day, referred him for physiotherapy and also arranged for his stitches to be removed.
21. During his first week at Altcourse, the man was given a number of warnings due to poor behaviour. In May, he was given a manager's warning and was advised that any further warnings might result in him being downgraded on the Incentives and Earned Privileges (IEP) scheme. (All prisons operate the IEP scheme, which has three levels, enhanced, standard and basic. Each of the levels offers the prisoner various privileges such as time out of cell, number of social visits and amount of money available to spend, with enhanced offering the most and basic the least. All prisoners are initially placed on the standard regime but undertaking offending behaviour courses and adhering to the regime, they can progress to enhanced. However, those who continuously fail to comply with the regime or break prison rules can be downgraded to basic.)
22. In June, the man was found in possession of a mobile telephone, a banned item in all prisons, and he obstructed staff from entering his cell by wedging his crutches against the door. As a result, he was placed on report for both offences. (When a prisoner is placed on report, they will be seen by a governor and adjudication will take place. The prisoner will be given the opportunity to explain his version of events in response to any charges and can ask for legal

advice. Once all the evidence has been heard, the governor will decide whether the prisoner is guilty or not. If found guilty, the governor can give a number of punishments such as loss of privileges, cellular confinement or a suspended award depending on the seriousness of the charge. If it is a serious offence, the adjudication can also be referred to an independent adjudicator. They are serving judges who have the power to add time to a prisoner's sentence.)

23. The man's disruptive pattern of behaviour continued at Altcourse, which resulted in him being placed on report for fighting and other offences on numerous occasions.
24. In June, a nurse examined the man as he had pain in his right leg after being involved in a fight. The nurse told him that he should wait to see the doctor, but he chose to return to his wing. The following day, he was advised to go to the healthcare centre to see the doctor. He did attend but it is recorded that he again left without being seen as he felt the doctor was not quick enough. During that afternoon, he went to the healthcare wing and demanded to be sent to outside hospital. Staff recorded that he had a hostile attitude and explained that he would not be sent to hospital. He became aggressive and was told to return to his wing.
25. In June, the man attended an adjudication hearing regarding the fight the previous day and was told that his IEP status would be reduced. It is recorded in his wing history file that he was not happy with this and became abusive towards staff. The following day, he asked to see the doctor and told wing staff that he had not been assessed following the fight. However, nursing staff had noted in his medical record that this was not the case and that he had refused to be assessed. He was added to the doctor's list for that day.
26. When a doctor saw the man later that day, he recorded his previous medical history relating to the car accident and the operation. The doctor arranged for x-rays of the man's leg and sent a referral letter to the orthopaedic department at the hospital in June. He went to the healthcare centre regularly over the next two weeks to monitor the injury to his leg. In July, during an appointment with the prison doctor, the doctor recorded that the man felt his leg was getting better, that he was able to walk unaided and had stopped using his crutches. The doctor recorded that notes relating to the man's operation at the hospital had to be obtained.
27. Despite the man apparently saying that he no longer needed crutches, in July a nurse recorded in his medical record that he had asked for a pair and that this needed to be reviewed. The next day, he reported sick. He told another nurse that his crutches had been taken away and he needed them to get around. The nurse told him the matter would be referred to the doctor and gave him a sick certificate excusing him from work for half a day until the issue had been resolved.
28. A nurse asked the man's residential unit about his mobility on the wing. Staff noted in the medical record that, although he walked with a limp, he moved

around unaided and appeared to have no trouble taking part in activities on the wing. The outcome of the enquiries by nursing staff is not clear. Over the next few weeks, he was seen again by both a doctor and physiotherapist and was advised to continue with exercises to strengthen his leg. It is also recorded that he did not attend for scheduled appointments with both the doctor and physiotherapist during this time.

29. The man's general behaviour continued to be disruptive and as a result, a transfer was arranged. The reason given was to provide respite for staff and to disrupt possible gang connections. He transferred to HMYOI Forest Bank in August 2008.

### **HMYOI Forest Bank**

30. When he arrived at Forest Bank, the man was seen by a member of the healthcare team. He said that he had no physical or emotional problems and declined to see the doctor. He was on the 'basic' IEP level and was placed on the voluntary testing landing. (All prisoners on this landing are required to remain drug free and to provide regular urine samples when asked to do so. A compact is signed to this effect.) He moved to another wing after only a week, as he was unable to provide a negative sample.
31. The man remained at Forest Bank for only a short time. In September, he went to court and was sentenced to 30 months imprisonment. Following his court hearing, he was taken to HMYOI Lancaster Farms where he had served previous sentences. He was given a full induction at Lancaster Farms but only remained there for six days before transferring to HMYOI Hindley in September.
32. During the investigation, the investigator noticed that the photograph of the man on the front of his wing history file had been defaced.

### **HMYOI Hindley**

33. As with previous prisons, on his arrival at Hindley the man was seen by a member of the healthcare team who completed a health screen. It is recorded that he complained of a headache and was advised to go to the treatment room in the afternoon to obtain some medication. The nurse noted that he was calm and relaxed during the consultation and that he said he felt "alright". After this and the remainder of the reception process, he was allocated to A wing. His IEP status appears to have been changed to 'standard' as the move to Hindley was seen as a fresh start for him.
34. However, the man did not start well at Hindley. It was recorded in his wing history file that the day after his arrival, he became abusive towards staff on a number of occasions, which resulted in him losing three days association. An entry in his wing history file in September reads:

“... Not a good start for the man on A wing receiving a minor report. Looking back through his compacts, he has a lot of minor reports for

being argumentative. He needs to learn to do as he is told first time or risk being put on Basic ...”

35. After completing his induction, the man was located onto D wing in September. It was recorded that he appeared to be trying to “keep his head down” on D wing but he continued to receive minor reports that resulted in him losing periods of association.
36. In October, he was believed to have been passed drugs during a social visit. As a result, the visit was terminated. He was removed from the visits area in handcuffs and taken to the Care and Separation Unit (CSU). (The CSU is another term used for a segregation unit. All prisoners located on a segregation unit or CSU are required to be seen by a nurse and a safety algorithm completed. The purpose of the safety algorithm is to ensure that the prisoner has no injuries if they have been subject to restraint and that their mental or physical well-being is not likely to be affected by being in the unit.) A nurse assessed him on his arrival in the unit and recorded that there were no injuries or concerns.
37. The man remained in the CSU and two days later attended an adjudication hearing for possession of a controlled substance. Due to the serious nature of the charge, the case was referred to an independent adjudicator. His behaviour while on the unit was recorded as good and he was said to be polite and respectful. However, he told the Governor, during a routine visit to prisoners on the unit, that he was unhappy at being located there. Following the adjudication hearing, staff decided that he should remain on the unit, as they believed the item that he had received during the visit was still in his possession. When the case was eventually heard by the independent adjudicator, he was found guilty and 42 days were added to his sentence.
38. During an evening in October, the man and a fellow prisoner were allegedly racially abusive towards another prisoner on the unit and they were placed on report. However, at the adjudication the following day the charge was dismissed. He returned to D wing later that week.
39. There were no further serious incidents involving the man while he was at Hindley although he received three minor reports later in October and early November. His poor behaviour finally resulted in him being transferred again in November to HMYOI Brinsford.

## **HMYOI Brinsford**

40. The man's prison documents indicate that on his arrival at Brinsford, he was located into the Intervention and Support Unit (ISU), which is another term for a segregation unit. He was assessed by a nurse who recorded that he complained of mental, physical health and self-harm issues but he did not wish to see a doctor. The following was also recorded in his wing history file:

“... Received from Hindley. Previous wing history files have a pattern of poor behaviour resulting in minor reports. Has already complained about his transfer and cleanliness of cells ...”

41. The day after his arrival, the man told staff that he was not happy at being transferred to Brinsford and he submitted an application for transfer. He said that he would be unable to receive visits at Brinsford due to the distance his family and friends would need to travel. During that day, he was given an emergency telephone call from the wing office to inform his family of his move.
42. During December, the man's frustration at not receiving visits and lack of communication with his family continued. Staff allowed him to make a telephone call from the wing office as he did not have any pin phone credit but this appeared to do little to alleviate his frustration. (While in custody, prisoners use telephones that require them to enter a pin number to access calls. They are able to buy 'pin credit' each weekly if they have sufficient funds available.) During the remainder of December and early January, staff recorded on several occasions that he was abusive and had a poor attitude. Consequently he was moved between various wings. In January 2009, he transferred to HMYOI Stoke Heath.

## **HMYOI Stoke Heath**

43. The man had served previous sentences at Stoke Heath and was familiar with the regime. On his arrival, he raised no concerns with reception staff about his transfer and a nurse assessed him. During the health screen, he told the nurse about the injury to his leg and said that it meant he was allergic to wearing jeans. When asked, he denied any thoughts of harming himself.
44. A member of wing staff held a resettlement interview with the man the day after his arrival. During the interview, he said that he intended to return to live with his girlfriend after release and that he had no other concerns.
45. During an appointment in January, a doctor recorded that the man was not receiving any treatment or physiotherapy for the injury to his leg. A referral was made for him to attend remedial gym classes and he was recorded as being 'Labour Type Three'. (Prisoners are allocated work based on their labour type, which ranges from one to three. One indicates that an individual can do all types of work and three indicates that intense physical work should not be allocated. The labour type is allocated by medical staff, usually after a prisoner's initial health screening and relates to their physical health

capabilities. A prisoner's labour type can be changed as necessary during their sentence.)

46. A few days after his consultation with the doctor, the man raised with wing staff the issue of not being able to wear jeans. He told them that the doctor had excused him from wearing them. The wing staff contacted healthcare who said that this was not the case, however an entry in his wing history file on the same day records that he was excused wearing jeans. The investigator asked about this and was told that, although wearing jeans was not detrimental to his health, he had complained that they rubbed on his leg causing him discomfort. For this reason, he was allowed to wear tracksuit trousers, which were looser and irritated his leg less.
47. During the man's first two weeks at Stoke Heath he was given an induction, which he completed in January. During his induction period, his behaviour raised little concern although he is recorded as having been verbally abusive to staff on one occasion. After his induction, he was moved to F wing.
48. In January, the day after his arrival on the wing, the man was searched as staff believed that he had a mobile telephone. No telephone was found during the search but materials used to charge a telephone, including batteries, were found and he was placed on report. At his adjudication the following day, he asked for legal advice. The case was postponed for seven days and was later referred to the independent adjudicator.
49. A nurse treated the man in healthcare in February. He said that he had a mole on the top of his left arm, which would not stop bleeding, and an appointment was made for him to see the doctor. When he saw him the following day, the doctor explained that he could treat the mole by cauterising it as a minor operation. (Cauterising burns the tissue to stop bleeding.)
50. The man continued to receive negative entries in his wing history file. In March, he was found in possession of a substance that later tested positive for cannabis and an adjudication hearing was held the next day. The adjudication was postponed for seven days to allow him time to seek legal advice. During March, he was involved in a fight with two other prisoners and was moved to the segregation unit. A nurse assessed him following the fight and recorded that he had no injuries and required no treatment.
51. The following day, the man reported having an asthma attack and was assessed by a nurse who checked his medical history and confirmed that there was no history of asthma. The nurse recorded that he looked well and had no breathing difficulties. He told the nurse that he thought that he had a panic attack due to being hot in his cell. The nurse also saw him later the same day after he had knocked the mole on his arm and a dressing was applied.
52. An adjudication hearing took place in March about the fight that the man had been involved in and he was found guilty. The penalty was 14 days loss of earnings and canteen, 14 days loss of association and television and seven days removal from the wing. His removal from the wing meant that he would

remain in the segregation unit, as the two days that he had spent there pending his adjudication counted towards the sentence.

53. Following the adjudication hearing, the man appealed against the decision. The appeal form was forwarded to the Briefing and Casework Unit, which is part of the National Offender Management Service (NOMs) who deal with such appeals. They responded in May, upholding his appeal and indicating that the charge should be “quashed” and any punishments be remitted on the grounds that he had not had the opportunity to question the evidence or present a full defence.
54. Despite being in segregation, the man’s behaviour did not improve. Staff recorded that he had a negative attitude, was confrontational towards them and was suspected of smoking cannabis. While in the segregation unit, a member of the healthcare team visited him daily, (a requirement for all segregated prisoners) and he was visited by the doctor every three days. He did not express any concerns about his physical or mental health during these visits. In addition to nursing staff, staff from F wing also visited him frequently and it is recorded that during one of these visits he became argumentative and said that he did not know why he was still there.
55. Over the next few days, staff recorded that the man spat at them as they walked past his cell and passed tobacco to other prisoners out of his cell window. In March, the Governor spoke to the man, who was due to return to the wing that day. He asked the Governor about his next move and was told that a decision was to be made later that day.
56. It was believed that the man still had a mobile telephone hidden on him and so a metal detector was to be passed over him later that day to rule this out. However, an entry in his wing history file later that day indicates that the detector was not used and the Governor authorised staff to retain him in the segregation unit for Good Order and Discipline (GOAD). (GOAD is a term used when locating a prisoner in segregation without adjudication. For example, if it is thought that their behaviour might lead to a disruption in the good order of the prison. A governor is required to record the reasons for the prisoner’s removal.) The reasons set out in his record were that he was being kept in the segregation unit for the good order and discipline of the prison, pending a security investigation into recent unrest on F wing. The documents also indicated that he would remain segregated.
57. In March, a hearing was held by an independent adjudicator for the previously recorded offence of having a mobile telephone charger and batteries in his cell. The man was found guilty and 35 days were added to his sentence. He appealed against this penalty, which was reviewed by a senior district judge. The outcome of the adjudication was upheld and he was notified in April.
58. Two days later the man was placed on the ‘basic’ IEP regime after he refused to hand over his training shoes to staff following exercise. Staff explained the importance of him conforming to the rules. Despite this, it is recorded that he continued to misuse his cell call bell and had to be removed from the exercise

yard after he was caught passing items to other prisoners. On his return to the unit, the metal detector gave a repeat indication towards his lower back and staff believed that he might still have a telephone.

59. The following day when the man's cell was unlocked for exercise, he smashed his flask in temper as he was still in bed. Throughout the morning, he shouted abuse at staff as they walked past his cell and continued to misuse his cell call bell. During the evening, an officer reported his behaviour to the orderly officer, as he was constantly abusive and trying to get other prisoners on the unit to make complaints against the staff. He continued to misuse the bell the next day and, when spoken to by a member of staff, said "I will get a ship out soon and will take you out of the game." The officer recorded that he asked him what he meant by this and he replied, "You will see".
60. During an afternoon in March, the man asked to use the Samaritans telephone. (The Samaritans telephone is a cordless telephone that is pre programmed with the number of the local Samaritans and can be used by prisoners at any time if they are feeling miserable.) He was allowed to use the telephone outside of his cell where staff could observe him. He used the telephone for around 25 minutes and, when he finished, staff said that they heard a clicking noise. When they checked the handset, they found that he had removed the security seal and attempted to remove the batteries. He returned to his cell and staff told him that he would not be allowed access to the telephone in future.
61. At around 7.00pm that evening, a nurse went to see the man in the segregation unit. She recorded that he had a "noose" around his neck and told her that he thought his mental health was deteriorating. He added that he did not know why he was in the segregation unit or on "basic". The documents supplied to the investigator would suggest that it was unlikely that he did not know the reasons.
62. The nurse asked the man to remove the noose. He did so but said he would not hand it to staff until they provided him with tobacco and the Samaritans telephone. It is not clear whether these requests were met but he handed it over. An Assessment, Care, Custody and Teamwork (ACCT) document was opened and he was placed on hourly observations. (ACCT is a process to monitor any prisoner who is considered to be at risk of self-harm or suicide and ensures that they are observed frequently and supported by staff. An assessment carried out soon after the document is opened aims to identify the individual's immediate needs and concerns and a care plan is drawn up to support them.) During the remainder of that evening, he continued to be abusive and threatening towards the night staff, and misused his cell call bell to demand tobacco.
63. In March, another nurse interviewed the man in the segregation unit about the events of the previous evening to assess whether he needed any mental health treatment. The nurse asked him if he had wanted to die. He replied that he had waited until he knew that the nurse was on the unit before placing the noose around his neck. During the conversation, he also said he would kill a member of staff, before killing himself. The nurse recorded that he appeared

very angry about being in the segregation unit and that he said he did not want to be there. The ACCT form requires a trigger or possible warning sign to be recorded on the front cover. On his document, the trigger/warning sign was recorded as “doesn’t want to be in segregation”.

64. The investigator wrote to both nurses in July asking if they would be able to provide statements about their individual contacts with the man during his time at Stoke Heath. One nurse telephoned the investigator and said that he did not feel that he would be able to offer any more information than that already recorded in the ACCT document or in the medical notes. No response was received from the other nurse.
65. After the interview with the nurse, the man returned to his cell and was told that he would be moving to another cell on the unit. Later that morning, he had another adjudication hearing for being abusive to staff which again was postponed for seven days to allow him time to seek legal advice. When it was finally heard he was found guilty and received further loss of privileges for another seven days.
66. An ACCT assessment was carried out in March by an assessor. She asked the man about any recent acts of self-harm and recorded that he was agitated when discussing how he felt. He said that he had previously made a noose two nights before, but said that this had been silly, as he did not want to die then or now. He went on to say that he felt he had a good life away from prison. When asked about any current suicidal thoughts he said that he had none and no longer wanted to be monitored under the ACCT procedures. He was asked about his reasons for living and how he coped. He described a good and positive relationship with his family and partner. He said that he had been receiving regular visits before he moved to the segregation unit.
67. Following the assessment interview, the man attended an ACCT case review that was also attended by two nurses. The case review records:

“... Mental health triage completed, no evidence of mental illness, appears very angry about his current situation. The man clearly stated he did not want to die. Stated that he would kill staff before himself. Unhappy at being in segregation, said he has not got his tobacco. Went on to say if he had his personal items and tobacco he would be fine. Also said that he would like to speak to his family, as he has not had a telephone call. £3 credit due to be added to account tomorrow ...”
68. Over the next two weeks, the man’s behaviour received mixed reports. Staff who visited him from F wing recorded that, although he remained very challenging, they felt that he was displaying a better attitude than on previous days. However, other comments in his wing history file from segregation unit staff record that he continued to be abusive towards both staff and other prisoners and he had to be removed from the exercise yard on two separate occasions after he was caught passing items to other prisoners.

69. In March, a nurse attended the segregation unit following a 'code red' call. (All prisons use a coding system to notify medical staff of a medical emergency. The codes used indicate the nature of the emergency i.e. red – bleeding, and blue – breathing difficulties, which means they are able to respond with the correct equipment.) When she arrived, she found that the man had knocked the top of his mole, which was bleeding profusely. A dressing was applied and no further treatment was required.
70. The man's wing history file indicates that he had a particular difference of opinion with an officer working night duties in the segregation unit. The officer recorded in March that he was continuing to make threats to kill him and had told other prisoners that he was going to squirt urine at him through his door. The same evening the officer went to check on him as a part of the ACCT monitoring and found that he had his observation panel covered. (The observation panel is used to observe prisoners at night and to check on their well-being without having to open the door. All prisoners are advised about the need to not place anything over the panel to prevent staff from observing them.) The officer went to the exercise yard to look through the cell window and could see him standing behind his cell door, the man told him to "fuck off" when he saw him but the officer was happy with this, as he knew he was all right.
71. The following day, the man is recorded as being disruptive throughout the morning, kicking his cell door and threatening staff. During the morning, staff asked a nurse to come to the segregation unit as he had been seen with blood on his forehead.
72. A nurse assessed the man and recorded that the blood was from the mole on his left upper arm and there was no injury to his head. He told the nurse that he was waiting to have the mole removed by the doctor once his behaviour has settled down and he no longer had to be unlocked by three officers. (It is not clear when or why it had been considered necessary for him to be unlocked by a minimum of three officers. It can be assumed that staff felt that his unpredictable and at times threatening behaviour gave enough cause for concern to warrant this. However, I have not found any documentary evidence relating to this decision during the course of the investigation.) The nurse noted that no other concerns were raised and he had no thoughts of suicide or self-harm.
73. A case review of the man's ACCT was held in March in which it was recorded that:
- “...the man communicated well with good eye contact. States he has no self-harm thoughts, but states he hears voices or screams. There are no negative entries until today when he put blood over his forehead claiming that he had a cut. After cleaning it off and being examined by healthcare staff there was no cut at all, apart from picking a spot on his left arm. Due to these voices and boredom factor it is decided to keep this ACCT document open ...”

74. A further ACCT review was scheduled. Over the next two days, the man faced two additional adjudications for damaging property. One was postponed for the reporting officer and the other for the man to seek legal advice. Staff from F wing visited him and recorded that he felt that he was being “stitched up”.
75. In March, it was recorded that the man was having a “better day”. However, he still had to be brought in early from exercise after he was seen to be taking something from a cell window. He was visited again that day by staff from F wing and reiterated that he felt that he was being “stitched up” and being treated unfairly.
76. The following day, the man was removed from the exercise yard again after he was passed an item from a cell window. When staff from F wing visited him later that day he apologised for picking the item up and said that he hoped he would still have the opportunity for a shower and telephone call. (It would not be normal practice for these aspects of the regime to be withdrawn before any adjudication hearing.) In March, a meeting was held to discuss his behaviour. It was decided that as there was a visible improvement in his behaviour there was no longer any requirement for him to be unlocked by three staff.
77. The man’s behaviour continued to improve with only one negative entry in his wing file for passing items on the exercise yard. However, a review of his IEP level, decided that he should remain on ‘basic’ for the time being. Although unhappy about this decision, it is recorded that he dealt with the news in a “mature manner”. He had also been polite to staff and other prisoners and was conforming to the regime.
78. However, it seems that the improvement was short lived and the following day the man was once again confrontational towards staff. When staff from F wing visited him, he said that he felt that all staff were “stitching him up” and the next day he was said to have argued with his peers during exercise.
79. During a review of his segregation that day, the man was “argumentative” and “unreasonable”. He walked out of the review and the governor chairing the meeting recorded:
- “...the man has a very short fuse if things are not going the way he wants them to. I think that he has displayed a negative side to his character on the review today. Staff to continue to encourage and support him to maintain recent improvements in behaviour ...”
80. A record of the ACCT review, carried out in conjunction with the segregation review, was written by the Senior Officer (SO) and includes the following extract:
- “... This review was started as part of his Rule 49 review as well. Part way through the man stormed off and left the meeting. I spoke with him again afterwards and he said that he was not hearing voices before and had no intention of self-harming. He said that his main issue is being in segregation and I explained reasons for this and the

support available. He repeatedly said that he did not feel suicidal and recent entries and staff interaction support this ...”

81. Following the man’s discussion with the SO, the decision was taken to close the ACCT document. A post closure interview was scheduled to take place on 7 April. (When an ACCT document is closed, a date should be set for a member of staff to conduct a post closure interview with the prisoner. The timing of the interview can vary depending on the needs of the individual and there can be more than one follow up interview. The purpose of the interview is to discuss how the person has been feeling since the end of the additional monitoring and support how they are managing with problems and whether they feel that they could cope with similar problems in the future.)
82. No further significant issues arose at Stoke Heath over the next few days and the man was transferred to HMYOI Swinfen Hall in April 2009. The Prisoner Escort Record (PER) form completed by staff at Stoke Heath prior to his transfer indicated on the front that an ACCT document had recently been closed. This is a requirement under the guidance published by the National Offender Management Service.

### **HMYOI Swinfen Hall**

83. On arrival at Swinfen Hall, the man was not immediately seen by a member of the healthcare team. After the rest of the initial reception process was completed, he was located onto B wing that serves as the induction wing. The following day, a nurse assessed him on the wing as part of the reception process. The nurse has been working at Swinfen Hall since December 2008 and previously worked at other prisons. The medical record indicates that she had previously known him while working at Brinsford when she assessed him before his transfer to Stoke Heath. However, when asked about this by the investigator, the nurse could not specifically recall him and explained that she would have seen a large number of prisoners since then.
84. During her assessment of the man, the nurse recorded the information about his earlier leg operation and asked him about any previous drug use. He said that he occasionally used cocaine and, before he went into prison, would use cannabis daily. The nurse also asked whether he had ever been subject to ACCT in the past and he replied that he had previously “jokingly made a noose”.
85. The investigator asked the nurse whether she would have had access to the closed ACCT document during the health screening process. She replied that she would ask a prisoner about this during the screening process but it would not be usual to have the document in front of her. She went on to say that she would be aware if a prisoner was on an open ACCT but there was no way of knowing if a document had been closed other than asking the prisoner. When asked about the man’s appearance during the health-screening interview she said that she could not recall the initial interview but agreed that if there had been anything significant she would have recorded it and was likely to remember him. The nurse did record in his medical record that:

“... mentally – states well and appears level, nil thoughts of self-harm or suicide ...”

86. Later that morning following his health screening with the nurse, a Senior Officer (SO) held a reception interview with the man. The SO has worked at Swinfen Hall for ten years and been an SO for the last five. During this time, he has worked as an SO in Safer Custody and on a residential unit, and is currently the night manager. At the time of his interview with the man, the SO had been temporarily promoted to Principal Officer (PO).
87. The investigator asked the SO about an entry he made in the man’s wing history file referring to him being unsettled in previous prisons and also asked how he had obtained this information. The SO recalled that the man had mentioned his problems at Stoke Heath during the interview. The SO also said that he had gained some information from his previous wing history files. He added that he was quite calm, chatty and amiable and showed no signs that he was unhappy about being transferred to Swinfen Hall.
88. The investigator told the SO about the circumstances of the man’s previous ACCT document and asked whether he had been aware of this at the time. The SO said that he could not recall being aware but, when he asked him whether he had any history of self-harm or anything that he was concerned about, he had replied “no”.
89. Given the SO’s previous experience of Safer Custody at Swinfen Hall, the investigator asked whether he would expect an ACCT document that had been closed as recently as the man’s to be available to staff conducting any initial or induction interviews. The SO said that he would have expected the document to be held with the rest of his records but could not recall seeing it. The SO said that his impression of the man was that he was “quite a confident lad” who had put himself across well and there were no concerns that he was vulnerable.
90. The man initially appeared to settle in well on B wing and continued the induction process. In April, staff found him fighting with another prisoner in the shower area during evening association. Both the man and the other prisoner stopped when asked to do so. They were escorted back to their cells and placed on report. The nurse was asked to see both prisoners following the fight she recorded in the man’s medical record that he had red marks on his neck but no treatment was necessary. During the adjudication that followed, the charge was dismissed and no further action was taken.
91. The following day, a member of the prison chaplaincy team visited the man on the wing as part of the induction process. The member of staff recorded that:

“... Good relationship with family, happy to be here, says he is remorseful over his offence, no self-harm or bereavement issues, expecting family visits and wants to attend chapel. No major concerns ...”

92. In April, during the evening duty, a strong mobile telephone signal was detected by staff and indicated to the cell occupied by the man. (Prisons use a device that will pick up the signal from a mobile telephone. The signal is often stronger when the telephone is initially turned on or in use. Although it cannot pinpoint a location, the strength of the signal can narrow the area down to a particular group of cells.) An officer who was on duty that evening, recorded in the man's wing history file that when he attempted to look into his cell after the signal was detected, he found the observation panel covered by toilet paper.
93. The officer has worked at Swinfen Hall for four years and throughout this time has been assigned to B wing, the induction unit. The investigator asked the officer about his first impressions of the man. He said that he was a "likeable chap" who got on well with staff on the wing. He also asked how previous or current ACCT information is obtained as part of the induction and whether induction staff would have been made aware of the ACCT. The officer explained that a prisoner would be seen initially in reception where any current or previous ACCT information would be collated and passed to the induction unit staff. It would also be drawn to the attention of staff, particularly the prisoner's personal officer. (There is no evidence that this process was followed in relation to the man's previous ACCT information.)
94. In relation to an evening in April, the officer said that when he saw the man's observation glass covered his initial thought was that he was doing something that he should not be. He banged on the door and told him to remove the obstruction. When challenged, the man said that he had been using the toilet. The officer documented his concerns, informing the wing SO that it might be advisable to search the man's cell the following morning.
95. The officer and the wing SO went to search the man's cell before the prisoners were unlocked the next day. They told him that he was believed to have a mobile telephone and so he would be escorted to the segregation unit and his cell searched. The man was not angry, as can sometimes be the reaction from prisoners and the officer said he seemed to accept it as a consequence of what he had been doing. The officer said that during the cell search that followed a number of items were found, including batteries and other things known to be used by prisoners for charging mobile telephones. The man was placed on report.
96. When the man arrived in the segregation unit, a nurse completed the safety algorithm, assessed him and wrote in his medical record:
- "... Patient has been moved to the segregation unit, believed to have a mobile telephone in his possession. The PO asked to clarify where prisoner has plates following road traffic accident seven months ago. Saw the man and verbal consent given to relay any information found in his medical record to the PO and segregation staff. Entry found in patient's summary dated 2/4/09 about the possibility of patient going for x rays to locate possible metal work in his leg but was transferred before this took place ..."

97. Later that afternoon, a member of the healthcare team contacted the hospital to ask for notes about the man's operation. The hospital agreed to send the discharge letter that he would have been given if he had not left against advice. The nurse and a Governor went to the segregation unit at 3.10pm to speak with the man again. The nurse recorded that he insisted he did not have a telephone and that the detector had indicated due to the metalwork in his leg. The nurse advised him of the information supplied earlier by the hospital. The Governor also told him that the detector had signalled there was a telephone and not because of metalwork in his leg.
98. The Governor has worked at Swinfen Hall since September 2006 and is currently the Head of Offender Management. He explained to the investigator that his first contact with the man was on the day of his arrival at Swinfen Hall. He remembered him because he did not meet the criteria for placement at the prison, as he was not serving a long enough sentence. He was one of three prisoners who arrived there from Stoke Heath. The Governor was in reception that day to make sure everything was all right when they arrived but did not speak to him directly at this time.
99. The Governor recalled the man telling him that the detector had gone off due to the pins in his leg, and that nursing staff were contacting the hospital for further information. The governor said that when he was confronted with the information from the hospital, he confessed to having a telephone but said that he had broken it up and flushed it down the toilet. The man had asked whether disposal of the telephone would mean that he would not face adjudication and the Governor advised him that one would still take place. It was held the following day and adjourned to be heard by the independent adjudicator.
100. The man returned to B wing following the adjudication and continued his induction programme. The officer who was his personal officer while he was located on B wing and was interviewed by the investigator. The officer has worked on B wing for the last four years. She told the investigator that she would have a conversation with the man whenever she was on duty. He was always asking to move to C wing, as he knew people there from Liverpool. She said that he came across as a confident and jovial young man who would have a laugh with you. In all her dealings with him, she had never considered him vulnerable.
101. In April, after completing his induction, the man moved to C wing. The following day, his adjudication was heard in the segregation unit by the independent adjudicator. He was found guilty of being in possession of an unauthorised article and had 28 days added to his sentence. (He subsequently appealed against the decision but was unsuccessful, and was informed that 28 days was the correct punishment.)
102. The man was not employed immediately when he arrived onto C wing which appeared to be quite frustrating for him. Another officer was allocated as his personal officer and introduced himself to him. The officer has been an officer at Swinfen Hall for the last three years and worked solely on C wing. When interviewed by the investigator, the officer was asked about what the man had

done to try to gain employment. He said that he had settled in well to C wing and, when he introduced himself, he had already applied to do a Learn Direct and a gym course. He offered to follow both applications up for him. The officer said that it was not possible to give a timescale for how long a prisoner might wait to be employed as it depended on spaces being available which was a big problem. The officer had a period of leave at the start of May and, during his absence, another officer was the man's personal officer.

103. This officer has worked as an officer at Swinfen Hall for six years. The investigator asked her about an entry that she made in the man's wing history file in May, in which she described him as "a drain on resources". The officer said that he was a prisoner who would "always be shouting at you through his door no matter what you were doing". She said that this was not done in a "nasty or aggressive way but it was draining", as you would have to go and see what he wanted. She said that she felt that this was just part of his character and that he appeared to be unable to let you walk past his cell without shouting a question.
104. The investigator asked the officer whether she had ever considered the man to be vulnerable. She replied that she regarded him to be "the opposite". She described him as a likeable and very strong willed person. She said that there were times when he could become a little aggressive if things were not going his way, but she said that he was manageable and staff could reason with him.
105. When the personal officer returned from leave in May, the man was still without a job, and he told him that he would try to find out what was happening. Being without any activity continued to be the main frustration for the man and he complained to staff about always being on "bang up". Staff told him that they were unable to keep him out of his cell, but that he was due to begin an industrial cleaning course.
106. Over the next week, the man was given warnings about his behaviour. During a review of his IEP status in May, the SO recorded in his wing history file:
- "... Not the best reporting period. Several negative comments but now in work so improvement should follow. To remain on 'standard' regime ..."
107. Despite being on the course, the man continued to receive negative comments about his behaviour on the wing over the next few weeks. The personal officer recorded that he would constantly enquire about his prospects for release on Home Detention Curfew (HDC). (HDC allows prisoners serving between three months and under four years early release from prison to serve a maximum of 90 days in the community wearing an electronic tag, which must not be removed, and while subject to a curfew.) The officer told the investigator that he had completed the application for him to be considered for HDC. The man gave him letters and other documents to support his chance of being granted early release, which the officer took to the Offender Management Unit (OMU) who dealt with HDC requests. The officer said that the man had spoken about setting up a landscape gardening business when he was released and had

applied for a grant from the Prince's Trust. He had put together a portfolio of his plans for the business, which the officer had read and considered to be "impressive".

108. The officer recorded that during one of their conversations, the man had said that if he failed to be granted HDC he would "have nothing to lose". The investigator asked the officer what he thought he meant by this. The officer said that whenever the man said anything negative he would always have a grin on his face. He said that he was due to be released in October regardless of whether he was released early and he took his comments to mean that he did not really care, as he would soon be released anyway.
109. A review of the man's cell sharing risk assessment took place in June. He had been considered a 'medium' risk when he arrived at Swinfen Hall but following a review of his risk, this was raised to 'high' due to his behaviour. (All prisoners are subject to a cell sharing risk assessment on reception into custody. They are asked a number of questions relating to previous periods of custody, any violent or racially motivated behaviour or concerns that they may have with sharing a cell. The form provides staff with guidance on the suitability of an individual to share a cell with other prisoners. A rating is given ranging from high to low.)
110. Unfortunately, the man was informed in June that his application for HDC had been refused. He submitted a complaint the same day in which he asked to speak with the Governor about the decision. The Governor, a residential governor, replied:
- "... The main reason for being refused your HDC is that your home probation officer did not support the application and your current offence was committed while you were under probation supervision. You have also been assessed as having a high risk of reconviction. The decision was made after reading your letters so your views have been taken into account, the decision will not be changed. If you need to apply for a transfer, please complete an application form ..."
111. The man was involved in a fight with another prisoner on the same day. At adjudication in June, he was found guilty and the penalty was seven days loss of association and earnings. Due to his continued poor pattern of behaviour, on 22 June he was reduced to 'basic' on the IEP scheme.
112. The man's behaviour on the wing was in complete contrast to that on the industrial cleaning course, which he had been attending since 25 May. His tutor in the class wrote a number of positive comments in his wing history file:
- "...the man earned 10 positive entries over the first two weeks of the course earning a positive comment. He earned a further 10 positive entries to earn a positive comment, completing his Cleaning Operatives Proficiency Certificate (COPC) Level 1, will be called back for NVQ Level 2 later in the year ..."

113. The tutor told the investigator that the man's behaviour during the course was "impeccable". She said that he had spoken to her about his plans for the future and, in particular, the gardening business that he planned to start on his release. To encourage prisoners on her course to work hard she gave a 'Man of the day' award to the person who worked the hardest. The man won this award on more than one occasion and also earned a 'Man of the course' award. After the students had completed the five-week course the tutor arranged for them to clean the new education department on 22 June. They were able to put the skills that they had learnt into practice. She was so impressed with him that she wrote the following in his wing history file:

"...The man was fantastic this morning cleaning C room in new education putting the rest of the group to shame showing how to put skills learned on his COPC Level 1 into practice. I was really proud of him. He also does not enter into immature behaviour usually started by other prisoners who were throwing paper at each other this morning and he did not retaliate. Well done ..."

114. The man appealed against the decision to place him on basic. He considered that the positive comments that he had earned had not been taken into account when the decision was made. In June, before his appeal was heard, he was verbally abusive to a female officer and placed on report. As a result, the appeal was rejected and he was informed that he would remain on basic with a review in July. During the remainder of that day, he continued to display negative behaviour.

115. In June, the man's hearing for abuse to the female officer was postponed for seven days to allow him to consult his solicitor. Due to his perceived disruptive behaviour on the wing, it was decided he should remain in the segregation unit until the adjudication resumed.

116. A nurse completed a safety algorithm which indicated that there was no clinical reason to advise against segregation. The man was not happy with being kept in the unit and was demanding throughout the day, pressing his cell call bell and asking for items to be collected from the wing. During the evening, he asked an officer if he could speak with a Listener. The officer has worked at Swinfen Hall for around five years and has worked in the segregation unit for the last two and a half years. He told the man that as he was a high risk in terms of sharing a cell it was not possible for him to have a Listener, but he could provide the Samaritans telephone.

117. The officer gave the man the Samaritan's telephone but after a short while, the man told him that he could not get a signal. When the officer checked the telephone, he found that the man had tampered with the settings and been trying to dial another number. The officer recorded that the man told him that he had just wanted to "mess about" and that he had "no thoughts of self-harm".

118. The investigator asked the officer if he had any concerns about the man when he had asked for the telephone. The officer said that his demeanour was

positive; he was laughing and said that he just wanted to mess around with the telephone.

119. During the later part of the evening, the man continued to be disruptive by constantly pressing his cell call bell and demanding items to be passed to him. The SO, who had interviewed him when he first arrived at Swinfen Hall, was on duty as the night manager. He went to the segregation unit to speak with him after receiving a call from the officer on duty about his behaviour.
120. The SO told the investigator that he recalled the particular night as he had dealt with two cell fires in other areas of the prison. He said that he had received a call from the officer in the segregation unit who informed him that the man was pressing his bell constantly and making demands. When he asked him why he was down there, he explained about his adjudication earlier that day. He told the SO that he wanted some "burn" (tobacco). The SO reminded him that he could not be given anything and that while he was on segregation, he was only entitled to three cigarettes a day. The man explained that, because he had only come onto the unit that day, he had not had his allowance. He said his tobacco was still in his cell on the wing and asked the SO to fetch it. The SO Sherwin reiterated that he could not pass him anything.
121. The conversation about the tobacco went on for sometime and the man asked again for the Samaritans telephone. During the discussion, he said that he did not really want the telephone and asked again about his tobacco. After explaining again that he was not allowed to pass anything the SO told him that if he promised to stop being disruptive, he would collect his tobacco the following morning. The following morning he went to the man's cell and collected his tobacco as promised. He took it to the segregation unit at around 7.30am before going off duty. He knocked on his door to tell him that he had left it in the office and he replied "cheers boss". (The SO was on duty again the following night but had no further contact with him.)
122. During a morning in June, the man reported no problems to the nurse during her daily visit to the prisoners in the segregation unit. An officer from 'C' wing also visited and brought him cigarette lighter and a packet of cigarette papers. The man told him that he was alright and was going to try to behave in future.
123. Later that day, the man had a shower and went onto the exercise yard. He had decided that he no longer wished to speak to his solicitor and was keen for his adjudication to take place. The investigator spoke to the officer, a segregation unit officer, during the investigation. The officer has worked at Swinfen Hall for five years and has been a segregation officer for approximately four years. He said that he felt that the man was "just a prisoner that played up, one of many prisoners that play up to try and get the system to work for him". He said that this is common and that the man was trying to get out of the unit, as he did not want to be there.
124. The man told the officer that he no longer wanted legal representation. He wanted his adjudication to go ahead so that he could take the punishment and get back to the wing. The officer told the investigator that unfortunately, by the

time the man said this, adjudications had finished for that day. The officer was aware that the man had written to the adjudicating governor asking for his charge to be heard. He was present when the Governor told him:

"I cannot do it today as adjudications are finished. On the proviso that you behave yourself, follow the rules and regulations in the segregation unit then we will put your adjudication on for Sunday."

125. The officer said that the man followed these instructions for a couple of hours. He then began to misuse his cell bell again asking staff about his adjudication and saying, "right, can I have my adjudication now, I have kept my head down for a couple of hours". Staff reminded him what he had been told by the Governor. He continued to be "demanding" and was advised of what was expected of him and the rewards on offer if he conformed to the regime.
126. The man was told that if he stopped shouting and "being abusive" towards staff then the adjudication would take place as the governor had instructed. The investigator asked the officer what he meant by "being abusive" and how he would describe the man's behaviour. He described him as:
- "... aggressive, juvenile in his attitude. He would ask a question and if he did not get the answer that he wanted he would try to become intimidating, pulling himself upright and squaring his shoulders, his voice and manner would change and he would become quite aggressive in his tone bordering on shouting at times."
127. One Sunday in June, the nurse saw prisoners in the segregation unit and recorded that the man had no concerns. He also told a member of the chaplaincy team that he was alright and had no concerns. During the day, he continued to ask about his adjudication. He was told by an officer that he should stop pressing his cell bell and asking when the governor would be arriving or it would not take place. The officer recorded that he became threatening towards staff again.
128. The man continued to be abusive. He was unlocked from his cell to use the telephone during the afternoon and spoke with his mother and grandfather. The investigator listened to a recording of the call. His grandfather was disappointed that he had once again been segregated. He informed him that he needed to start behaving or he would not get out as expected in October. Prisoners in the segregation unit are allocated a set time to use the telephone so that they can all have the opportunity to use it. When he had been on the telephone for his allocated time the officer asked him to end his call. He initially refused but then complied with the request. He then complained to another officer that he felt that staff were "stitching him up" and was told that he had been given the same as all other prisoners on the unit.
129. The Governor went to the segregation unit later that afternoon and asked the staff whether they felt that the man had complied with the instructions he had been given the previous day. Staff told the governor about his continued abusive behaviour. They decided that his adjudication would not be heard but

he would be given the opportunity to have it on the Monday if he started to comply with what had been asked of him. The officer and Governor told the man the decision. The officer said that he seemed to accept the reasons and fully understood that the hearing could take place the following day.

130. However, towards the end of the afternoon, the man again pressed his cell bell and asked for his adjudication to be held that day. When he was told that it could not, he became abusive. He is reported to have said that he had a telephone and making serious threats against the Governor and the officer. The officer placed him on report. He is reported to have been quiet for the remainder of the afternoon and evening.
131. While in the segregation unit, the man spoke to other prisoners, including a prisoner who was in the cell next door to him. The investigator spoke with him during the investigation. He first met the man when he was located in the segregation unit in June. The prisoner said that the man appeared fine and would always join in any banter that was going on. He explained that both he and the man would shout to other prisoners on the unit. When asked how he felt the man got on with staff on the unit, he told the investigator that he felt at times the man's relationship with them was "mixed" and he could be a "bit of a pain". However, he also said that it seemed that staff would get into arguments with him, which served to antagonise him. The prisoner said that the man would press his cell call bell quite often and continuously ask for tobacco.
132. The investigator asked the prisoner about the Sunday and whether he could recall anything significant about the man. The prisoner said that during the afternoon the man had threatened an officer for which he had been placed on report. Following this, the man had told him that he only had a few months left and would be happy to serve it in the segregation unit. The prisoner said that he and the man discussed various things that evening. He recalled him saying that he needed a "master plan" to get himself moved out of the segregation unit, but did not say what he intended to do.

### **Events in June**

133. On the morning of a day in June, three officers arrived for duty in the segregation unit at 7.30am. The first officer told the investigator that he made a cup of tea and then checked events from the previous evening. The officer said that due to the man's attitude towards him the previous day, it was decided that the other two officers would deal with him as much as possible. Once they had discussed what needed to be done that day the first officer and his colleagues began the morning routine.
134. Prisoners in the segregation unit are provided with a breakfast pack the previous evening that contains cereal, a carton of milk and possibly a bread roll and sachet of jam. When staff begin the morning routine they go to each cell, offer hot water, and provide each prisoner with their allocated three cigarettes. Prisoners are also asked whether they would like a shower and exercise during the morning. Prisoners on report will also be given their adjudication paperwork

at this time. Once this is complete, the staff begin unlocking in turn those prisoners requiring a shower and/or exercise.

135. The second officer went into the man's cell to give him some hot water. The officer has worked at Swinfen Hall for six years and been a segregation unit officer for nine months. In his police statement, he said that he noticed a length of torn bed sheet tied to his bed and asked him what it was for. He told him that he was using it for "exercise" purposes. The officer told him that he could not have it and removed it from the cell, discarding it in a pile of rubbish in the corridor. In his statement the officer said that he "did not think much to this and it did not cause me concern".
136. When interviewed by the investigator some time after making the police statement, the officer did not mention these facts despite being asked to clarify his interaction with the man that morning. The investigator wrote to the officer and asked him to provide a statement giving details of this particular interaction with the man. In the subsequent statement provided, the officer said that he had noticed the torn bed sheet tied to the man's bed but after removing it had not been concerned as he said, "prisoners use bedding all the time".
137. The first officer told the investigator that the man had asked to have a shower and, as the other staff told him that he had been behaving, he escorted him to the shower room. It is recorded in the unit diary that this was around 8.47am. The officer had a conversation with him on the short walk to the shower room and thought he appeared quite happy.
138. The second officer went to see the man after he had returned from the shower to give him his adjudication paperwork. In his statement to the police following his death, the officer said that he had issued him with the documents relating to the threats he had made towards the first officer the previous day, and had read the charge aloud to him. He said that he made no reply to the charge.
139. The second officer also said in his police statement that he took the man some tobacco between 9.00am and 9.30am. He appeared to be fine and normal and was not upset or angry. The officer said that he just kept asking when he would get his exercise and about his adjudication.
140. At 9.00am, the nurse went to the segregation unit to see all the prisoners. The nurse recorded that the man told her that he felt "anxious and depressed". The investigator asked the nurse whether she had been concerned by what he had said. Despite what he said she did not feel there was any difference in the way that he spoke to her that morning to any other time. The nurse said that he always came across as "quite assertive" and "upbeat". He had never appeared to her as someone who was withdrawn and he did not seem to be withdrawn that day. She told him that he would have the opportunity to speak to the doctor who would be visiting later that morning.
141. The Governor, who was going to be the adjudicating governor that day, arrived in the segregation unit at around 10.20am and discussed with the unit staff the number of adjudications. The adjudications began at 10.30am. A number of

prisoners in the segregation unit were due to have adjudications and others needed to be collected from the residential wings. The third officer was responsible for collecting and returning prisoners to the wings. The first officer was the adjudication liaison officer, which required him to ensure the governor had the correct documents during the adjudication.

142. The Governor of Swinfen Hall went to the segregation unit that morning in order to collect some documents. He told the investigator that he was completing paperwork in his office on the Monday morning and needed some information about an ongoing adjudication. He was aware that adjudications would still be taking place so staff would be busy and therefore decided to collect it himself.
143. When the Governor arrived at the unit, no staff were visible and he assumed that they were all involved in adjudications. He went to the unit office and signed the diary to say that he had been there when, the second officer came in. The officer told the Governor that there was a break in the adjudications as they were waiting for some prisoners to be returned to the wings and others to be brought down. The officer asked the Governor if he would like to do the "rounds" which involves speaking briefly to all the prisoners located on the unit. The Governor agreed to do so while he was there and amended the entry that he had just made in the diary to read, "All seen", although he had not yet visited each prisoner.
144. The Governor said that the officer explained why each prisoner was held on the unit and their progress. He recalled the officer telling him about the man's behaviour which had also been mentioned during the morning briefing meeting. After the officer briefed him about each prisoner, they went out into the corridor to visit the prisoners, starting at cell number one. As the nurse was interviewing the prisoner in that cell, they moved immediately to number two and the first officer joined them.
145. As they were leaving cell number four at approximately 11.05am, the prisoner asked the second officer a question and he stepped back to answer him. The Governor and other officer continued to cell five, which was occupied by the man. As the first officer began to open the door, he turned to the Governor and said, "watch yourself with this one gov" which the Governor understood to mean a warning about the man's behaviour. The officer opened the observation panel. The Governor saw that it was covered with paper and thought to himself that he would need to challenge the man about this.
146. The officer said that, as he opened the man's door, he saw him hanging at the back of the cell from the window grill. He shouted to the second officer but could not recall exactly what he said. The officer went into the cell and took hold of the man by what he thought was his t-shirt and tracksuit bottoms to lift him up while he cut the ligature with his anti-ligature knife. (All staff who have direct contact with prisoners are issued with an anti-ligature knife. The knife has a tamper proof blade and is designed for cutting ligatures quickly and safely.)

147. Although the officer thought that he had a secure hold of the man, as he cut the ligature it quickly became apparent that he only held his t-shirt and he slumped forward striking his head on the toilet. The second officer had gone into the cell behind the first officer and between them they lifted the man and laid him on the floor of the cell. The second officer had already called a 'code blue' via his radio to request medical assistance. (There are two codes in use at Swinfen Hall. Blue and Red, code blue indicates a prisoner who has either stopped breathing or has breathing difficulties. Red is used when a prisoner is bleeding.)
148. The man was not breathing and the first officer could not find a pulse. The officers began to administer cardio pulmonary resuscitation (CPR). The Governor, who was still at the door, told the investigator that, as he was not needed to help with the CPR, he left the cell to see whether assistance was arriving. He saw the nurse, who had been on the unit, running towards him and she went into the cell.
149. Another Governor who had been conducting the adjudications arrived at the cell and asked whether an ambulance had been called. The first Governor then went to the office and telephoned the control room to tell them that an ambulance was required. The control room staff telephoned back to find out whether the person was conscious or unconscious. (The relevance of this question is to assist the emergency services in sending appropriate assistance.)
150. On hearing the 'code blue', the nurse immediately made her way to cell five and saw the Governor standing outside. When she went into the cell, both officers were administering CPR. After assessing the situation, she ran back to the treatment room in the unit to collect an oxygen cylinder and other emergency equipment. By this time, other staff who had heard the radio calls began to arrive on the unit.
151. A Senior Officer (SO) was working in the programmes department situated close to the segregation unit when he heard the 'code blue' and immediately made his way there. He was directed to the man's cell and saw both officers and the nurse administering CPR. The second Governor asked the SO to take over the chest compressions from the second officer, as he was becoming tired. This officer and the SO then continued to take it in turns to give chest compressions until the third officer, who had returned to the unit on hearing the 'code blue', was asked to take over from the second officer.
152. The Healthcare Manager also went to the unit and took with her a portable defibrillator. (Defibrillators deliver a brief electric shock to the heart, which enables the heart's natural pacemaker to regain control and establish a normal heart rhythm. The defibrillator is an electronic device with electrocardiogram leads and paddles. During defibrillation, the paddles are placed on the patient's chest, staff stand back, and the electric shock is delivered.) She said that when she arrived the nurse was giving the man oxygen and she took over. She placed an airway into his mouth and gave some breaths before placing the defibrillator pads onto his chest. She said that she checked for signs of life

throughout. The defibrillator did not shock him and she explained that this indicated there was no shockable rhythm, so CPR was continued. This was carried out in two-minute cycles and the defibrillator continued to indicate that there was no heart rhythm. She said that she had been administering treatment for around ten minutes before paramedics arrived.

153. The 'first response' paramedics arrived in the segregation unit at 11.13am, ten minutes after the 'code blue' call had been made. An ambulance and further paramedic staff followed at 11.25am. The Healthcare Manager said that the paramedic staff took over the first aid. They continued to attempt resuscitation for a further 15-20 minutes. At 11.37am, paramedic staff stopped resuscitation attempts and pronounced the man dead.

### **Following the man's death**

154. Swinfen Hall contacted HMP Liverpool following the man's death, at 12.25pm and made a request for someone from Liverpool to be sent to inform his next of kin. It is usual practice for the prison where the death has occurred to break the news but when the next of kin live some distance away it is not unusual for other prisons to be asked to assist. Governors at Liverpool were happy to assist and contacted Swinfen Hall at 3.55pm to say that the family had been informed. A Governor at Swinfen Hall telephoned the man's mother at 4.40pm and expressed his condolences. He also informed the family that he had appointed a liaison officer to assist the family.
155. Other prisoners who were considered to be at risk of self-harm at Swinfen Hall at the time of the man's death were all reviewed as part of the ACCT procedures. Also, staff and prisoners working and located in the segregation were offered support from the staff care team and chaplaincy.

## ISSUES

### ACCT post closure interview

156. The ACCT procedures require a post closure Interview to be conducted with a prisoner within seven days of the document being closed. This remains a requirement even when a prisoner is transferred within the seven day period, as happened to the man. HMYOI Stoke Heath as required indicated on the Prisoner Escort Record (PER) that an ACCT had been closed in the last seven days. However, when he arrived at Swinfen Hall this information was not acted on or passed to the relevant department. (The PER is a form that accompanies staff escorting prisoners on journeys to and from the prison. It provides a chronological record of the events on the journey eg meals served, times journey started etc. It also serves as a communication tool about risks a prisoner poses on escort or transfer.)
157. During the investigation, the investigator asked about the procedures in place at Swinfen Hall to ensure that post closure interviews take place. He was given a copy of the prison's Safer Custody Policy that sets out the requirements under PSO2700:

"... When receiving a prisoner in the post-closure phase of ACCT (i.e. the ACCT Plan has been closed, but the final post-closure review has not been signed off) the receiving Unit Manager must nominate a Case Manager (or undertake the role themselves) to oversee the continuing closure process.

"The closure must be recorded in the F2052A (history sheet)."

"The closed ACCT Plan remains on the wing until completion of the post closure interview(s). Once it is confirmed there are to be no further post closure interviews the closed ACCT Plan must be stored safely in the F2050 core record ..."

158. In spite of this policy, it is clear that no systems were in place at Swinfen Hall to ensure that these instructions are carried out and the man did not have a post closure interview.

**The Governor should ensure that a system is in place at Swinfen Hall to identify prisoners who require post closure ACCT interviews and a record of the completed interview should be made in the individual's wing history files. This should include prisoners transferring into the prison.**

159. As part of the clinical review, the clinical reviewer commented that while at Stoke Heath, the man was reviewed daily by a member of the healthcare team while in segregation. However, a consultant forensic psychiatrist assisting with the review has said that when he was placed on the ACCT a referral to the prisons mental health in reach team (MHIT) would have been appropriate. As a result she makes the following recommendation. This recommendation is relevant to HMYOI Stoke Heath and will be shared with the Governor.

**Consideration should be given to systems in place for referral to the prisons in reach mental health team.**

160. The clinical review panel comment that the man's reception screening records indicate that he had raised no issues with regards to his mental health or self-harm. However, he had requested to speak to a Mental Health Nurse while at HMYOI Altcourse in 2007, as he felt low and depressed. Following this a referral was made but he failed to attend two subsequent appointments. The clinical review panel indicate in the clinical reviewer's report that it is good clinical practice to outreach on the prison wing or to ascertain the reasons behind the non attendance. It is the opinion of the panel that the man's non attendance at appointments contributed to the eventual outcome in any significant way. The clinical reviewer makes the following recommendation. This recommendation is relevant to HMYOI Altcourse and will be shared with the Governor.

**Consideration should be given to systems in place for the reporting and follow up of prisoners that fail to attend appointments.**

**Sharing information between departments**

161. On reception and during the induction process both nursing and discipline staff spoke to the man but none of them had access to the closed ACCT document that should have been stored with his wing history file, as per the guidance previously mentioned. The information gained about his previous ACCT history was only obtained by questioning him and was not recorded anywhere that would inform other staff who would deal with him later.
162. The man's previous ACCT had been opened because he placed a ligature around his neck while in the segregation unit at Stoke Heath. Although he indicated that he did not intend to take his own life at that time, this information should nevertheless have been recorded when he arrived at Swinfen Hall.
163. During the investigation, the investigator asked staff working in the segregation unit whether they would have dealt with the man differently if they had known that he had tied a ligature around his neck only a few weeks earlier. The staff were not aware of the incident. They pointed out that knowing this would not have necessarily have led to another ACCT being opened, but it would have indicated that he might need to be watched more closely for changes in his behaviour.
164. If this information had been recorded in the man's wing history file when he arrived at Swinfen Hall, it would have enabled staff to make themselves aware of his previous history. The importance of sharing information between the different departments should not be underestimated.

**The Governor should remind staff of the importance of recording information in a prisoner's wing history file.**

**The Governor should ensure that when prisoners are transferred into Swinfen Hall their previous wing history files are kept with those subsequently opened so that information can be shared.**

**The Governor should instruct residential wing staff to pass on all relevant information from the wing history file to segregation unit staff when a prisoner moves to the unit.**

### **Ligature points**

165. During the initial visit to Swinfen Hall, the investigator was shown the cell that the man occupied in the segregation unit. He was concerned that the ligature point used by the man was an obvious one that could potentially result in further self-harm attempts. He brought these concerns to the attention of the Governor who assured him that immediate action would be taken to address this problem. I am aware that changes to the fabric of the segregation unit is a matter of funding which has been sought by him. The Governor has provided assurances that all prisoners will be suitably assessed before being located in the cells highlighted by the investigator. I make no further recommendation in relation to this.

### **Requesting emergency assistance**

166. Although there is no suggestion that the prison failed to call an ambulance, there does appear to have been some confusion amongst staff about the process for doing so.
167. When the man was found, officers immediately began to administer CPR and healthcare staff brought equipment quickly. When the Governor asked the control room to call an ambulance for a 'code blue', this should have been sufficient for one to be immediately called. However, the control room staff telephoned back to enquire whether the patient was conscious or unconscious. I feel that this is information that is required by the emergency service switchboard and should have been available to the control room staff at the outset to ensure that there was no chance of a delay.
168. The clinical reviewer has also highlighted this confusion in her report. I make the following recommendations, the first of which takes account of the views expressed by her.

**The Governor should produce guidance for control room staff to clearly explain the process to be followed when an ambulance is requested and specify who is responsible for ensuring that this is done.**

**The Governor should also issue a Notice to Staff reminding them of the medical emergency coding system and providing a clear definition for each of the codes.**

## **Emergency first aid**

169. The staff that discovered the man and the nurse that initially attended were quick to begin performing CPR and giving mouth to mouth, and administering oxygen as soon as it was available. The clinical review panel highlight a need for staff to have access to pocket masks in order to assist them in emergency situations. The clinical reviewer makes the following recommendation.

**It is recommended that healthcare staff are provided with pocket masks for use in this type of situation.**

## **Medical records**

170. During the review of the man's medical records, the clinical reviewer found that a large number of abbreviations were used. While easily understood by those writing them, they proved less so for any other person attempting to gain information. As a result of these findings, she makes the following recommendation.

**The Head of Healthcare should ensure that the use of abbreviations on medical records is avoided unless a locally agreed list of abbreviations is in place.**

## **Defacement of documents**

171. The investigator noticed that the photograph of the man on the front of his wing history file had been defaced. It is not known who did this but regardless of who was responsible, this is an official document and this act was inappropriate and very unprofessional.

## CONCLUSION

172. The man had been in prison on and off for a number of years and was aware of the rules and regulations. He spent time in several prisons during his most recent sentence, being transferred from the majority because of his reluctance to abide by the rules and regimes.
173. It has been clear throughout the investigation that, despite the man's battles with authority, he also had a very likeable side and was referred to by staff as a "cheeky chap" who enjoyed a laugh. The character that he portrayed while on his wing or in the segregation unit was in complete contrast to the young man who took an active part in his cleaning course. His tutor described him as having qualities that she admired, that he always wanted to be the best and had huge artistic talent. He had expectations of starting his own business and was apparently looking forward to his release when he died.
174. The investigation has uncovered no clear reason why a young man who had the support of his family and partner and expectations for his future would choose to take his own life. Indeed, the man's explanation that he had "been silly as he did not want to die then or now" when he was found with a noose around his neck on an earlier occasion suggests that he may well not have intended his actions in June to result in his death.
175. The investigation concludes that in relation to the way in which the man was dealt with while in custody was appropriate. The clinical review also indicates that the clinical practice at Swinfen Hall and medical staff interaction with him was appropriate.

## RECOMMENDATIONS

1. The Governor should ensure that a system is in place at Swinfen Hall to identify prisoners who require post closure interviews and a record of completed interviews should be made in individual's wing history files. This should include prisoners transferring into the prison.

**The Prison accepted this recommendation and gave the following response:**

*When an ACCT Plan is closed and a Post Closure Interviews date is set, the Case Manager will:*

- *E-mail's the establishments SPC advising of the ACCT closure and the date of the Post Closure Interview.*
- *Record this date in their S/O Handover diary as well as on the Prisoners' Prison NOMIS Wing File.*

*In addition The SPC will:*

- *Place the date of the Interview onto his/her Outlook Calendar and forward this via the "Invite Attendees" Email service to the Prisoners Wing Managers.*
- *This will place the Interview onto the Wing Manager's outlook calendars.*

*Once a Post Closure Interview has been conducted the Case manager will:*

- *Record details of the interview on the Prisoners' Prison NOMIS Wing File.*

*If further Interviews are required, set a new date as per the above procedure*

2. Consideration should be given to systems in place for referral to the prisons in reach mental health team. (This is relevant to HMYOI Stoke Heath)

**A response to this recommendation is still awaited from HMYOI Stoke Heath.**

3. Consideration should be given to systems in place for the reporting and follow up of prisoners that fail to attend appointments. (This is relevant to HMYOI Altcourse)

**The prison accepted this recommendation and gave the following response:**

*The healthcare manager will implement a system to ensure those offenders who fail to keep mental health appointments are routinely followed up*

4. The Governor should remind staff as to the importance of recording information in a prisoner's wing history file.

**The prison accepted this recommendation and gave the following response:**

- *Prison NOMIS has now been introduced at Swinfen Hall. This is an IT system that staff use to record prisoner information in their individual computer Wing history files. All staff have access to these files.*
  - *Hard copy Wing history files are currently retained (where applicable) on the Prisoner's wing.*
  - *Information to Staff (ITS) reminder to be issued.*
5. The Governor should ensure that when prisoners are transferred into Swinfen Hall their previous wing history files are kept with those subsequently opened so that information contained within them can be shared.

**The prison accepted this recommendation and gave the following response:**

- *Prison NOMIS has now been introduced at Swinfen Hall. This is an IT system that staff use to record prisoner information in their individual computer Wing history files. All staff have access to these files.*
  - *Hard copy Wing history files are currently retained (where applicable) on the Prisoner's wing.*
6. The Governor should instruct residential wing staff to pass on all relevant information from the wing history file to segregation unit staff when a prisoner moves to the unit.

**The prison accepted this recommendation and gave the following response:**

- *Prison NOMIS has now been introduced at Swinfen Hall. This is an IT system that staff use to record prisoner information in their individual computer Wing history files. All staff have access to these files.*
- *Hard copy Wing history files are currently retained (where applicable) on the Prisoner's wing.*

7. The Governor should produce guidance for control room staff to clearly explain the process to be followed when an ambulance is requested and specify who is responsible for ensuring that this is done.

**The prison accepted this recommendation and gave the following response:**

- *A Control Room protocol for code red and blue has been produced and the Local Security System (LSS) has been updated with the following;*
- *LSI 5.31 Code red and code blue definitions*
- *LSI 5.35 Oscar 1 response to code red/blue*
- *LSI 5.34 Control room - response to urgent message code red/blue.*

*The LSS is available to all staff on the Intranet*

8. The Governor should also issue a Notice to Staff reminding them of the medical emergency coding system and providing a clear definition for each of the codes.

**The prison accepted this recommendation and gave the following response:**

*Information to Staff (ITS) to be issued regarding the emergency coding system definitions as per the LSS in Recommendation 7.*

9. It is recommended that healthcare staff are provided with pocket masks for use in this type of situation.

**The prison accepted this recommendation and gave the following response:**

*Currently working with the Resuscitation officer of the PCT to overhaul emergency equipment. This includes issuing each nurse with a pouch to connect to their belt containing a pocket mask and gloves. Each nurse here at Swinfen does have a face shield that was issued this year.*

10. The Head of Healthcare should ensure that the use of abbreviations on medical records is avoided unless a locally agreed list of abbreviations is in place.

**The prison accepted this recommendation and gave the following response:**

*The record keeping review team recommend that abbreviations are not used. It is acceptable to write longhand with abbreviation in brackets afterwards if the entry contains the expression repeatedly but the abbreviation only counts for that entry.*