Investigation into the circumstances surrounding the death of a man at HMP Camp Hill in July 2007

Report by the Prisons and Probation Ombudsman for England and Wales

July 2008

This is the report of an investigation into the death of a man at HMP Camp Hill on 14 July 2007. At 7.00am that morning, the man was found hanging in his cell in the prison's segregation unit. His death was pronounced at 7.15am.

I offer my deepest sympathy and condolences to the man's family for their sad and untimely loss. I also offer them my apologies for the time it has taken to issue this report.

The investigation was conducted by my colleague. I also commissioned an independent clinical review into the management of the man's health while he was in custody at Camp Hill. This was undertaken by a clinical reviewer of the relevant Primary Care Trust. I am grateful to him for his contribution.

The man had not been in custody before, and he was anxious about cell sharing as he had apparently been the victim of a sexual assault in his own home. There are suggestions that his mood and behaviour may also have been influenced by long years as a user of cannabis.

The investigation found significant systemic failures in relation to ACCT procedures and the sharing of information about the man's risk between HMP Winchester and HMP Camp Hill as well as within HMP Camp Hill itself. I have made a number of recommendations that I hope will help prevent a similar tragedy occurring at Camp Hill or elsewhere in the Prison Service.

Stephen Shaw CBE
Prisons and Probation Ombudsman
July 2008

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SUMMARY

The man appeared at the Crown Court in June 2007 to face a charge of possessing illegal drugs. He was sentenced to eight months imprisonment. The man, who had not been in prison before, was initially taken to HMP Winchester. On 2 July, he was transferred to HMP Camp Hill on the Isle of Wight where he was allocated to a shared cell in the first night centre. Here, he initially seemed to get on well with his cell mate. However, he told a member of staff he had been sexually assaulted by another man in his flat prior to being imprisoned and was fearful it could happen again in prison, especially if he continued to share a cell.

Three days later, the man placed a noose around his neck without attaching it to any ligature point and said he had swallowed a number of Propranolol tablets given to him at Winchester for his anxiety. An Assessment, Care in Custody and Teamwork (ACCT) form was opened and he was taken to a hospital adjacent to the prison. Whilst there, he was assessed by a mental health nurse. He told her about the sexual assault and about his continuing fears. The nurse concluded that, if the man were to remain fearful, he might experience further impulsive reactions. The man was discharged from hospital to Camp Hill at about 9.00pm that evening. Details of the nurse's assessment were passed to a community psychiatric nurse (CPN) at Camp Hill the following morning.

When he returned to the prison, the man was initially placed in the same cell he had formerly occupied with another prisoner. However, a senior officer who saw him that evening recommended he should move into a single cell in St Patrick's wing – which holds vulnerable prisoners – as soon as possible. He was transferred into that unit at 10.00am the next morning. Shortly afterwards, he was seen in his cell by another senior officer and a CPN who together decided to close the ACCT form.

On 12 July, the man told staff he was being threatened by other prisoners. His allegations were investigated by a senior officer who found them to be without foundation. However, later that day he asked to be segregated for his own safety and he was moved to the segregation unit. Two days later, he was found hanging in his cell.

The investigation found evidence of poor transfer of medical information between prisons, as well as a series of flaws in the ACCT procedures applied at Camp Hill. There was poor communication between units about the events that led to the opening of the man's ACCT form. A mistake was made in the assessment of his capacity to cope with segregation.

Although I criticise individual members of staff, I do not believe any one of them can be held responsible for the man's tragic death. However, I make a number of recommendations that I urge the Governors of Winchester and Camp Hill prison to implement as a matter of priority.

INVESTIGATION PROCESS

1. The investigation was opened at HMP Camp Hill on 18 July 2007. On that day, my investigator met the Deputy Governor, the chair of the local branch committee of the Prison Officers' Association, the chair of the local Independent Monitoring Board and the investigation liaison officer. My investigator briefed the meeting on the nature and scope of the investigation. The following day, notices were issued to staff and to prisoners inviting anyone with information or concerns relating to the man's death to make themselves known to my investigator.

2. My investigator returned to Camp Hill on a number of occasions to conduct interviews with a total of 19 members of staff and six prisoners. A number of issues regarding the man's management at Winchester were examined through correspondence with the Governor and Head of Healthcare. My investigator also conducted informal discussions with a member of the healthcare team at Parkhurst and, separately, with the Deputy Governor about matters raised by the man's sister. My investigator also spoke to the man's legal representative, who clarified matters about which the man's sister was concerned.

3. A clinical review of the management of the man's health needs was conducted by a doctor from the local Primary Care Trust. The clinical reviewer dealt with a number of issues by correspondence with the Governor and Head of Healthcare at Winchester. He also attended some of the interviews conducted at Camp Hill.

4. On 29 August, my investigator and one of my family liaison officers, met the man's mother and sister to extend an invitation to express any concerns about matters relating to his death. The questions they raised about aspects of the man's management at both Winchester and Camp Hill prisons are addressed in this report.

THE MAN

5. The man's sister has asked that the following text be used to describe his background and personality:

> "My brother was 36 years old when he left us, the same age that our mum was when he came into the world in Epsom in 1970. He was the fifth and youngest child in the family. He leaves his two older brothers and two older sisters, one of whom is me. Dad passed away in 1999. He always kept a special look out for my brother as he was always the most highly strung and sensitive of the five of us. My brother was born with a defect with one of his eyelids and underwent several operations during his childhood to correct it. These short periods away from the family for treatment and self consciousness about his appearance during this time sometimes led him to believe that he did not quite 'fit in' with everybody else, however much we tried to persuade him otherwise.
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> "My brother was sweet natured and very intelligent. He was creative and thought deeply about everything he did, or planned to do. He was forever using his inquisitive mind and notorious fidgety fingers to take things apart and put them back together, not always successfully. He was deeply interested in science and technology in all forms. After leaving school with good passes in all of his exams he tried working in a bank but eventually settled down to an apprenticeship as an electrician at the age of 17. This suited his technological and mathematical interests for a time until his recreational interests started to impact on his life.
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> "He set about everything he did with the best intentions. He was warm and loving when given the opportunity and usually had a wide varying circle of friends. He wanted to see the best in people and would often befriend those that others in his circle had shunned, as he himself felt shunned at times. Unfortunately for my brother, his trusting nature would often be betrayed in some way or another, leading to him taking solace in other ways. He himself admitted that the first time he started using cannabis was from the age of 17 and it was from this point that his ability to deal with life's challenges was affected.
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> "He became increasingly highly strung and was also very easily influenced by those around him, from whom

he was always seeking acceptance. There were instances of petty crime in his late teens and early twenties and this eventually led to him giving up his studies completely and moving up to Yorkshire away from the family for several years. During this period he developed an interest in becoming a club DJ which satisfied his love for all things lively and technical. Unfortunately, this lifestyle is often accompanied by drug and alcohol misuse and I feel it took its toll on him both physically and mentally.

“We retraced my brother eventually and he rejoined myself and our parents. My brother did not look in the best of shape at that time but he gradually regained his health and was able to spend a few years working in various creative jobs, enjoying his pastimes such as golf, darts and snooker and serving on the committee of our local social club. Golf was something he shared as an interest with both our parents. He once secretly collected vouchers from cigarette packets and surprised mum with a pair of tickets to go to watch the Benson and Hedges Open golf championship. They enjoyed a great day out together. Secret gifts like this were typical of my brother – they may not have cost much but were always very personal and meant a great deal.

“He genuinely meant the best for everyone else whose path he crossed in life. Unfortunately, he would usually put himself last. After the death of our father, he began to associate more with some friends who had followed him from Yorkshire and, yet again, alcohol and cannabis use took their hold over him. He still continued to work in various positions in catering by this time but was finding it harder to keep up regular work routines because of his lifestyle.

“My brother’s last few years were spent living alone in a cottage with his beloved pet dog and cat. He suffered insomnia and anxiety and was deemed as unfit for work because of his cannabis dependence. He was still the same sweet, sensitive soul underneath but was also prone to rages borne out of frustration that he wanted a partner and children but seemed unable to sustain a relationship. He loved children and was always fascinated by how they remained uninhibited and natural in everything they tried to do. My children were delighted each year when he came to spend Christmas Day with us. My son loved playing the PlayStation with my brother because he ‘knew how things work’. My

daughter would sit and create art projects with him for hours because of his patience and gentle nature.

“My brother had a close circle of friends who have told me about the great knowledge and fascination he had with the technicalities of the production of cannabis plants at his home. He began this to sustain his habit and it became a great labour of love for him to cultivate and cross pollinate various varieties. Unfortunately, this is where it all starts to unravel. His pastime and his dependence led him to community supervision orders and, ultimately, the custodial sentence where his journey came to an end.”

HMP CAMP HILL

6. Camp Hill, a closed category C training establishment, is one of three prisons situated near Newport on the Isle of Wight. At the time of the investigation, Camp Hill could hold up to 595 adult male prisoners.

7. The prison comprises nine residential units ranging from Victorian style galleried units to single corridor buildings. Some of the units have specific functions. St Andrew's is the First Night Centre and St David's is the Induction Unit. St Patrick's holds vulnerable prisoners. St Stephen's holds prisoners who have reached the enhanced level of privileges. There is also a segregation unit that can hold up to 19 prisoners.

8. The prison was last inspected by HM Chief Inspector of Prisons in August 2006. The report of that inspection, published in January 2007, was critical of the quality of some of the prison's functions, including suicide prevention. In their report on Camp Hill for the period 1 August 2005 to 31 July 2006, the local Independent Monitoring Board raised no issues or concerns about suicide prevention or any other matter relevant to this investigation.

9. I have investigated one previous self-inflicted death at Camp Hill. The recommendations I made in the report of that investigation are not relevant here.

KEY EVENTS

Background

Appearance in court

10. On 14 June 2007, the man appeared at the Crown Court charged with possession of illegal drugs after police officers had found cannabis plants in his flat. Court officials confirmed that the hearing had been brought forward by a day. The man pleaded guilty and was sentenced to eight months imprisonment. Although he had 21 previous convictions, this was his first custodial sentence. He would have been due for release four months later.

Journey to Winchester

11. After his court appearance, the man was taken to HMP Winchester, the local prison that serves the Magistrates' and Crown Courts. The journey was completed in two parts. The man was initially taken to a police station and held there overnight. The next day (15 June), he was taken to Winchester.

12. The Prisoner Custody Officer (PCO), one of the people responsible for escorting the man to Winchester, completed a Suicide/ Self Harm Warning Form at 11.45am that day. The purpose of this form is to alert other agencies, especially the Prison Service, to a perceived risk of self-harm or suicide so that measures can be taken to monitor and reduce the prisoner's risk. The PCO wrote on the form:

> "Shocked at sentence. States to have taken more medication which was prescribed by GP. Taken in May but did not overdose. Slept it off. More positive after talking to his barrister. States he is <u>not</u> suicidal at all."

13. The warning form was posted to Camp Hill from Winchester on 7 August 2007, over three weeks after the man's death.

14. A note was also made on the Prisoner Escort Records (PERs) for both parts of the journey indicating that the man presented a risk of suicide.

Winchester: 15 June - 2 July

Reception procedures

15. The man told a member of the reception staff at Winchester that he had been born in Surrey in 1970. He said he was single and gave the address at which he had been living. He said his next of kin was his mother who lived in the same area.

Health screen

16. As part of the normal reception procedures, the man underwent an initial health screen. The record of that screen was passed on to Camp Hill when he was transferred there on 2 July. The record reflected only the man's height, weight, blood pressure, the fact that he was a smoker and that he had no known allergies. In fact, much more information was entered in his electronic medical record, but this was not obtained from Winchester until after his death. That electronic record contains the following details:

> "History of psychiatric disorder. Ongoing episodes of depression. Has good insight into his condition. Prescribed Propranonol 15mg OD. History of attempted suicide. Patient has attempted to overdose 3 times in the last 3 years. States has no thought of deliberate self-harm. Is aware he can talk to staff should he feel unwell. Patient's ex-partner has now moved on, making his life less stressful. Presents with good eye contact, is polite and communicative. History of alcoholism. States binge drinker at weekend otherwise drinks 10 units daily. Patient not presenting with any sign of DTs [delirium tremens]."

17. The following day, the man was prescribed 28 10mg Propranonol tablets. He was to take one tablet each day. However, it appears the prescription was not dispensed at that time and the tablets were not given to him until 25 June. The man was not subject to any formal self-harm monitoring procedures.

Cell sharing risk assessment

18. A member of the reception staff also carried out a cell sharing risk assessment. The purpose of this assessment was to measure the man's risk of harming others. The assessment informed the decision as to whether he could be placed in a cell on his own or with another prisoner. The assessor considered that the man presented a low risk of harming others and could therefore share a cell.

Medical interventions

19. The following entries were made in the man's medical record while he was at Winchester:

    17 June: "Alcohol detoxification. Alcohol score of 2 today. Coping at present."

18 June: “Seen by nurse. No changes. Due to be seen by Detox Dr tomorrow as no time today.”

19 June: “Detoxification = drug chart was in HCC and was not returned till late afternoon. Therefore missed afternoon dose of chlordiazepoxide. Reviewed by Dr given double dose this nocte by s/n as prescribed.” (Chlordiazepoxide is normally prescribed to relieve anxiety and to control agitation caused by alcohol.)

20 June: “Detoxification CDP 20mg routine alcohol detox. No problems.”

21 June: “Eczema NOS infected eczematous rash on shins.”

22 June: “Seen by nurse detox. Detox completed.”

25 June: “Seen by nurse. Seen at A wing meds room. States has been asking for Propanolol 10 mg for over a week now and nothing has been sorted. Explained that once drug round had finished would find out what has happened. Propanolol not in trolley, chart not present either.”.
(Propanolol is normally prescribed to help control the physical signs of anxiety.)

25 June: “Seen by nurse. Discussed with pharmacy, the only thing they have supplied is Fucidin. Propanolol not supplied as they have not received a prescription. To inform GP.”

25 June: “Administration NOS script for propanolol re-done not received from pharmacy.”

26 June: “Seen by nurse. Fit for transfer.”

Offender Assessment system (OASys) report

20. On 26 June, the man’s probation officer completed an OASys assessment. This is a means by which prisoners’ sentence planning needs can be ascertained. In the report that followed her assessment, the probation officer wrote an extensive commentary on the man’s social and criminal history. She said he was, by his known admission, addicted to cannabis. He had produced his own supply of the drug in order to feed his habit and because it was cheaper to grow his own than to buy it on the streets. The probation officer also recorded that the man was single and was content to remain so. Although he was an intelligent man, he was currently unable to work because of poor health. The probation officer wrote that the man was being treated for depression and had previously taken an overdose of drugs. She said he was “not currently medicated because his doctor was reluctant to prescribe with his heavy cannabis use” which was “a link to his symptoms”. The probation officer thought the man could benefit from

detoxification now that he had been imprisoned and could consequently start the process of dealing with his depression. She recorded her opinion that self-harm or suicide was a possibility, although she did not think that was a current problem. She also thought that a negative emotional state, exacerbated by misuse of cannabis or alcohol, were factors that might increase his risk.

CARATs (Counselling, Assessment, Referral, Advice and Throughcare service) assessment

21. The following day, a CARATs worker at Winchester interviewed the man. He told her he had been living alone in a rented flat. The man admitted that he normally spent between £30 and £60 a week on cannabis and between £20 and £30 a week on alcohol. He said he was registered with a doctor in his home area. He wanted support in remaining drug free. The CARATS worker therefore referred him for a one day drug awareness course and suggested he was a candidate for the Short Duration Drug Programme.

Transfer to Camp Hill

22. On 2 July 2007, the man was transferred to Camp Hill prison on the Isle of Wight. That day, the CARATS worker recorded in the man's transfer plan that she had sent his Drug Intervention Record (DIR) to the Drug Intervention Programme on the Isle of Wight for support and throughcare on release. the CARATS worker also recorded that she had discussed harm minimisation, low tolerance and overdose prevention with the man. Her concluding remarks were:

> "Care plan and DIR completed 27June 07. Unable to complete Comprehensive Substance Misuse Assessment [CSMA] as transferred on 2 July. Not completed 1 day drug awareness as transferred before next course available."

23. During the man's brief stay at Winchester, he gave no indications that he was at risk of self-harm or suicide.

Camp Hill: 2 - 14 July

24. The man left Winchester under escort at 10.35 am on 2 July and arrived at Camp Hill at 1.40pm. The Prisoner Escort Record for the journey between the two prisons carried no notation of any risk of self-harm nor of any medical or security factors other than the abuse of drugs. The journey was uneventful.

Health screen

25. Upon his arrival at Camp Hill, the man underwent a further health screen. This was conducted by a nurse who pointed out to my investigator that the details of the man's medical history available to her during the reception procedures were scant. She said some medical information was sent to Camp Hill after his arrival. The health screen nurse said the details recorded during the health screen were therefore based largely on what the man told her. She made the following comments in his electronic medical record:

> "Seen in general medical clinic. Seen Camp Hill healthcare. Fit 1B gym, 2 labour. Appears anxious in mood. Is on promethazine 50mg nocte, has a supply in possession (26 tabs). Requesting a review by MO. Appointment given. Smoker tobacco consumption. Weight 61kgs. Height 1.84 metres. Blood pressure 108/77."

(Promethazine is normally prescribed to help relieve anxiety.)

26. The health screen nurse also completed a separate health screen form on which she recorded that the man was not subject to an Assessment, Care in Custody and Teamwork (ACCT) plan (this is used to monitor and support prisoners who are considered to be at risk of self-harm or suicide), had never been the subject of ACCT procedures and did not currently feel suicidal. She also commented that he was currently on a course of medication and that he wanted to see a doctor. There is no evidence in his medical record to show whether this happened.

Cell sharing risk assessment

27. A cell sharing risk assessment was carried out the same day by an officer. He ticked the box to indicate that the man had previously been subject to a form F2052SH. (This is a document formerly used by the Prison Service to monitor any prisoner considered to be at risk of self-harm or suicide. It has now been replaced by the ACCT form.)

28. At interview, the officer who carried out the cell risk assessment said he could not recall anything about the man. He was uncertain why he had indicated on the cell sharing risk assessment form that the man had been subject to F2052SH procedures. However, he thought that as he had not been in prison before he might not have known what a F2052SH was. The officer thought he might therefore have asked the man if he had ever felt suicidal or had self-harmed. He thought the way he had completed the form was likely to have reflected that the man said he had self-harmed rather than that he had previously been subject to F2052SH procedures. At the end of the process, the officer judged that the man presented a low risk of harming others and could therefore be allocated to a shared cell.

29. The officer who carried out the cell risk assessment said the healthcare section of the cell sharing risk assessment form was always completed in the adjacent healthcare centre rather than in reception. The health screen nurse completed that task. She too concluded that the man presented a low risk of harming others. However, in answer to the question, "Following the self-harm assessment, have any concerns been raised?", she ticked neither the 'yes' nor the 'no' box. At interview, she said she could not recall whether she looked at the sections of the form completed by the officer before completing her own section. The form was countersigned by a senior officer who

agreed with the judgement that it was safe for the man to share a cell at that point.

Allocation to St Andrew's wing

30. The induction wing at Camp Hill comprises two units: St David's and St Andrew's. The latter operates as the prison's First Night Centre. In keeping with normal procedures, the man was allocated to St Andrew's. Here, he was placed in a cell with another prisoner. At interview, this prisoner told my investigator he had travelled to Camp Hill in the same vehicle as the man that day but they did not meet until after they had alighted. He said they walked together from reception to cell 19 on St Andrew's wing at about 3.00pm. The man told the prisoner he had not been in prison before. He said he was frightened of being in prison and did not like confrontations. The man said he was in prison because he had grown cannabis. According to the prisoner, he and the man shared a cell for just under a week. During that period, the man would sometimes tell jokes and at other times he was just quiet. The prisoner said the man ate all his meals and was a tidy man. The prisoner also said the man did not give him any impression that he was suffering from abuse of drugs or that he was feeling suicidal.

Conversation with Listener

31. On 4 July, the man told an officer, who worked in the First Night Centre, that he wanted to speak to a Listener - a prisoner trained by the Samaritans to offer support to prisoners in distress. At interview, the officer said the man seemed tense and impatient. He rang another wing to ask for a Listener to see the man in the First Night Centre. At about 11.00am, one of ten Listeners at Camp Hill at the time, saw the man and spent about 90 minutes with him. My investigator later interviewed the Listener in the presence of a Samaritan. The Listener said the man told him he was depressed but was in a better frame of mind by the time their discussion came to an end. However, because of the confidentiality that exists between Listeners and their clients, he was unable to offer my investigator any other details of his discussion with the man.

Discussions with a Senior Officer

32. At the time of the investigation, a Senior Officer was the manager of the induction unit. At interview, she told my investigator that the man had approached her one morning in the First Night Centre but she could not remember which day this happened. She said he had told her that, although he was getting on with his cell mate, he preferred to

be in a cell on his own. The senior officer asked him what his problem was. He told her he found it difficult to sleep in a cell with another prisoner because of things that had happened to him in the past. At that stage he did not explain what he meant. Despite this, he reassured the senior officer he felt safe sharing a cell with his cellmate. In light of this, the senior officer did not consider it necessary to take any further action.

33. The senior officer told my investigator that on another occasion - again she could not remember quite when – the man asked if he could tell her something in confidence. She therefore took him into the manager's office. The man told her he found sharing a cell difficult because he had been raped by another man in his own home before he came to prison. The senior officer could see the man was distressed. She therefore told him she would do her best to find him a single cell in a smaller unit. The man told her he would be happy to remain in the same cell as his current cellmate until an alternative cell could be found. The senior officer thought she also told the man she would refer him to a Community Psychiatric Nurse (CPN). She said the next time she saw the man was on 6 July.

ACCT form opened after acts of self-harm

34. The cellmate told my investigator that on 5 July the man woke him up at about 5.00am and said, "Can you get this off me? I've tied it too tight." At interview, the cellmate said he saw that the man had a ligature round his neck made from a torn bedsheet but had not attached the other end of the ligature to anything. The cellmate said:

> "He was standing up when he woke me. I was shocked and said, 'What are you doing?' He said, 'I've just tried to take my life by cutting off the air supply.' There was a red mark round his neck. There was nothing else wrong with him. I took the cord away. He then rang the cell bell. He put the ligature in the bin. He also said he'd taken some tablets. They were for anxiety. I believed him because I checked the box the tablets were in. There were only about 12 tablets in there in the beginning but there were none left. He was taken straight out of the cell. The staff asked me what had happened. I said I'd helped to get the ligature off his neck. That night he came back into the cell. He was apologetic. He said he'd left me a suicide note. He found it and let me see it. He just said sorry. He put the note back in his cupboard. I was shocked. I stayed awake the whole of that night so I could offer him support if he needed it. He fell asleep. He was put in another cell on his own. He wanted his own space. I feel he should not have been put in a single cell. No-one shouted out of the window at him. No-one bullied

him. He wasn't frightened of others. He did tell me once or twice he thought people were talking about him. I told him he was paranoid because of the effects of cannabis. He promised me he would not self-harm again."

35. The note to which the cellmate referred was later handed to my investigator by a member of staff. It contained a number of pictorial images and the words:

> "Sorry, I just can't take being raped. (Name withheld) who did it is guilty. Sorry [cellmate named], you're a nice bloke."

36. The man's prison record shows that, at about 6.45am that day, he had pressed his cell bell. He reported to the member of staff on duty in St Andrew's wing, that he had placed a ligature round his neck and had swallowed a number of Propanolol tablets that had been issued to alleviate his anxiety. At first glance, there seems to have been a significant delay between the time the man woke his cell mate and the time he pressed his cell bell. However, it is possible that the cellmate may have been woken up later than 5.00am. There was certainly no evidence to suggest there was a delay in the response by staff.

37. The member of staff on duty in St Andrew's wing saw no obvious signs that the man had been physically harmed and noticed that a ligature, made out of a piece of torn bedsheet, had been thrown into the rubbish bin in the cell. The member of staff retrieved it. He decided to alert the Orderly Officer.

38. At interview, the Orderly Officer explained that, when he arrived at the cell, the man gave him the same version of events as he had earlier given to the member of staff on duty in St Andrews wing. The Orderly Officer then asked the cellmate if he could confirm what the man had said. The Orderly Officer said the cellmate "denied any knowledge of anything", including removing the man's ligature. According to the Orderly Officer, the cellmate also denied seeing any red marks on the man's neck. The Orderly Officer checked the man's neck himself and saw no marks. My investigator suggested to the Orderly Officer that there was a possibility that the man may have wanted to use the bedsheet as a garrotte rather than as a ligature. The Orderly Officer expressed his view that neither option was likely to have been successful because of the flimsy nature of the ligature which, he thought, would have snapped easily under pressure.

39. The Orderly Officer explained that, when the man told him he had taken some pills, he asked him what they were. The man gave him the package in which the pills had been issued. He said he had taken 24 pills. The Orderly Officer noticed that the package the man gave him was empty. However, the Orderly Officer said the man did not appear

to be ill: he was not being sick and did not look pale. There were no visible signs of any injury or symptoms of illness.

40. The Orderly Officer said he telephoned HMP Parkhurst to take advice as to what, if any, danger the man might be in and what action should be taken. (It is not unusual for such advice to be sought from Parkhurst as it is the only one of the three prisons on the Isle of Wight that has inpatient facilities.) The person to whom the Orderly Officer spoke said he would call the hospital and would then ring back. The advice the Orderly Officer received was that the man should be taken to hospital.

41. As the end of the Orderly Officer's shift was approaching at that stage, he said he made arrangements for the man to be taken to the local hospital before handing over to other staff. The Orderly Officer also decided to open an ACCT form. (As noted, this is used to monitor and support prisoners who are considered to be at risk of self-harm or suicide.) He did so before he went off duty and before the man left the prison for the hospital. At 6.45am, the Orderly Officer recorded in the 'Concern and Keep Safe' section of the form:

> "[The man] stated he had tied a piece of torn sheet around his neck and taken his supply of 24 Propranolol pills. States he is unable to cope with this, his first, custodial sentence."

42. The Orderly Officer drew up an immediate action plan for the man in which he set the following two targets:

- The man was to remain in same location in a shared cell.
- He was to be observed twice per hour.

43. It was recorded that the man did not require telephone access (e.g. to his family, or to the Samaritans) at that stage.

Admission to hospital

44. The records show the man left for the hospital at about 7.30am. He remained in the hospital all that day. Whilst there, he was seen by Registered Mental Nurse (RMN). She wrote in the man's notes:

> "5 July. Seen on MAU ([Medical Assessment Unit] following alleged overdose of Propanolol and allegedly tying bed sheets around head. [The man] was seen in the presence of prison officers, handcuffed. He is currently serving an 8 month sentence in relation to growing cannabis. He presented as relaxed and assertive, able to give a convoluted and comprehensive history. He gave appropriate eye contact, spoke with some rapidity but not pressured and was able to stay

> focussed, no flight of ideas, but spoke at great length without pausing. He described his history in full, relating a violent incident toward his brother at age 8, his awareness that his physical appearance predisposed him to taunting and bullying at school and an adult history of persistent and perpetual drug use. He has used cannabis daily since age 17, in his youth dabbled with other drugs but has consistently used alcohol and cannabis. He presented with no overt clinical symptoms of mental illness, but was clearly able to describe his fear associated with being in prison. He feels constantly intimidated and related an incident prior to his imprisonment of an attempted male rape, which has left him disturbed by nightmares and a preoccupation that he is vulnerable to being raped in prison. He is able to state that he is motivated to remain out of prison on his release and has clearly identified factors that are both protective and motivating for the future. Today's events were directly related to his anticipation of an assault, either sexual or physical, whilst in prison and he is focussed on a substance free life on his release.
>
> "Whilst he remains fearful, his disposition to impulsive reactions remains a risk. Discussed with [the man] and the prison officers and all agree that steps can be taken to minimise risks for him tonight and a review will automatically take place in the morning within the prison. Prison in reach team to be notified by fax in the morning. [The man] will return to prison tonight when verified medically fit."

45. The man was also assessed by a doctor who recorded the following comments:

> "36 year old man with alleged OD of 20 Propranolol. Examination showed pulse 56 otherwise unremarkable. This gentleman is clearly preoccupied with his abuse prior to conviction and is having nightmares, is anxious and is suspicious of others. As he has overdosed three times and given precipitating factors, he is at increased risk of doing this again."

Notification to the man's sister

46. The Orderly Officer at Camp Hill that day told my investigator he took it upon himself to telephone the man's sister to let her know what had happened to her brother. He told her he would ring her back later that day to update her about her brother's progress at the hospital. He told

my investigator he did this during the afternoon but could not remember when.

Discharge to Camp Hill

47. The man was discharged from the hospital shortly after 9.00pm. The hospital authorities considered he did not need to be placed in a healthcare centre. When he arrived at Camp Hill, he was seen by the Orderly Officer who made the following entry in the ACCT form at 9.30pm:

> "[The man] has returned from the hospital and is in a vastly improved frame of mind. I had a long discussion with him and his demeanour and intentions are much happier. He states and promises he will not harm himself again. He asked to go back in with his original cell mate who I also spoke to earlier and is happy to help [the man]. I strongly recommend [the man] is placed in St Patrick's Hall at the earliest date and NOT in any other wing. He is very vulnerable and needs the support of St Pats for the rest of his short time to do sentence. He is to be observed every 30 minutes as a precaution during patrol state and prior to full review on 6 July."

48. The man was returned to his former cell in St Andrew's wing with his cellmate.

Move to St Patrick's wing

49. Entries made in the ACCT ongoing record show that the night of 5/6 July was uneventful. However, at 7.25am on 6 July, the man rang his cell bell to attract the attention of staff. An officer responded. He made the following entry in the man's ACCT ongoing record:

> "At 07.25 rang his cell bell handing me this. I assume he thinks he is being moved to St Patrick's Wing today. I am not sure if we have spaces there yet? I will inform the Andrew's staff of this."

50. Appended to the ACCT ongoing record presented to my investigator was a copy of the note handed to the officer who responded to the cell bell. It read as follows:

> "Please don't talk! Morning Boss. It's [the man]. I'm ready to be moved when the SO is ready. As I said to the night staff, I'm supposed to go before morning unlock. Last night I heard some shouts to me. The whole wing knows what happened!"

51. The manager of the induction unit said that as soon as she came on duty that morning she rang St Patrick's wing to arrange for the man to be allocated a single cell in that unit as soon as possible. A second officer took the call. He told my investigator the man was brought over to the unit from St Andrew's just after 9.00am. As far as he could remember, the manager of the induction unit did not tell him what had happened to the man the previous day. He said he did not know the man had placed a noose around his neck or that he had taken some tablets. Neither did he know the man had been taken to hospital. However, the second officer said he could remember the manager of the induction unit telling him the man was on an ACCT form and that the document was brought across to St Patrick's wing with him. The second officer said he did not read its contents. He placed the man in a single cell and as he did so he asked him why he needed to be on his own. The man told the second officer he had been sexually assaulted before he came into prison and was frightened it could happen again if he remained in a shared cell. The man did not say anything to the second officer about the events of the previous day. The second officer said he offered the man his support and thought he seemed happy now that he was in a single cell. He did not think the man was at risk of self-harm.

52. Shortly before 10.00am, the manager of the induction unit rang the CPN to ask him to join her in St Patrick's wing so they could see the man together to check how he was. A little later they met at his cell. They saw he was unpacking. The manager of the induction unit thought the man looked "the happiest she had seen him at Camp Hill". She introduced him to the CPN and asked if he had any concerns. The man said to her, "Thank you very much for getting me over here and I feel now that I am safe, I am secure". She said she reassured him that he could talk to anyone on St Patrick's wing because the staffing ratio there was higher than in other wings. The manager of the induction unit said she and the CPN spent quite some time with the man in his cell talking to him. Towards the end of their conversation, she asked the man if he wanted his ACCT form to remain open. She said the man told her he did not. She told my investigator that the conversation she and the CPN had with the man constituted an ACCT case review. She later made a record in the ACCT form which was in the wing office. She wrote:

> "At 0800hrs, [the man] was told he would be going to St Patrick's. He was calm and happy. At 10.05 hrs, he was transferred to St Patrick's. CPN has taken part in the consultation and it's agreed by the man that now he has a single cell, he feels safe and secure. He is happy to have the ACCT closed."

53. Whenever it is decided to close an ACCT form, the person who takes the decision should indicate in a box in the bottom right hand corner of the form the date upon which the post-closure interview will take place. The purpose of this interview is to enable staff to assess how the at-risk prisoner has coped without being monitored. The manager of the

induction unit did not enter the date of the post-closure interview. Instead, she used the box to record the date of the ACCT case review she had just held. Thus, a post-closure interview date was not planned at that point.

54. The CPN told my investigator that, after he had received the telephone call from the manager of the induction unit inviting him to see the man, he rang the crisis team at the local hospital. The person to whom he spoke read out the report prepared by the Registered Mental Nurse (RMN). The CPN asked for a copy of the report to be faxed to him straight away. He said he received it and read it before he saw the man. He was therefore aware of the fact that the RMN had expressed her concern that, whilst the man remained fearful, his disposition to impulsive actions remained a risk. The CPN interpreted the risk as that of self-harm. He said that, when he saw the man, he was satisfied he was no longer fearful because he had been moved to a single cell. The CPN also confirmed the man said he would not harm himself again. However, the CPN said he was not aware that the meeting he and the manager of the induction unit had with the man constituted an ACCT case review until it was over. Neither was the CPN aware that the man had earlier told the Orderly Officer, who opened the ACCT form, that he "could not cope with this, his first custodial sentence". The CPN said that, had he known this, he would definitely have questioned the man. He said he could remember that, after he had left the man's cell, he discussed "issues of single cell, issues of the male rape" with someone in St Patrick's wing but could not remember which member of staff he spoke to. He did not make a record of these details in the Staff Observations Book. (This book is used as a means of communicating important information about a prisoner between staff, including those on different shifts.)

Letter to friend

55. On 11 July 2007, the man wrote to a friend outside prison. In his letter, he said he was optimistic he would get his "tag" (Home Detention Curfew) release in August. The man also said he had completed his first "tag" a year earlier with no breaches and was not going to grow "weed" again because he had had enough of prison. He commented that he thought it was "not too bad at Camp Hill".

Allegations of bullying and request to be segregated

56. However, at 03.15am on 12 July, the man passed a note under his cell door to the night patrol officer. The note read as follows:

> "Gov or Miss,
>
> "Bear with me. I know it's long. Please don't speak out loud as I am in fear for my life on this wing. A completely false rumour is going round the whole wing

that I am a nonce (Paedophile!) and I have heard with my own ears that they plan to kill me!. Either that or it's the bloke next door to me, who has a similar name to me. I can't be sure who they mean. So when I heard 'noncey [the man]' this afternoon, it could have been 'noncey [man next door's name]' (cell 39). I thought they had been talking about him as I'm definitely not one! But at the beginning of association tonight, the two guys playing table tennis, both shaven headed, said, 'there's the nonce up there!' when I went to refill my hot water, and I was the only person on the landing. The whole wing has been talking and saying direct language about this for days now and the comments are getting very direct as I said above. If it is me they think is like that, then I will need to be moved to Rule 45 I think. I had a very traumatic incident at my house before I got sent down, which is why I had to be moved here to a single cell:- a so-called friend tried to rape me and then tried to kill me when I phoned the police. This man has left me unable to sleep in the same room as other men without me having unbearable nightmares, and I tried to take my own life on Andrews wing as a result. That's when, after leaving hospital, once I was checked over thoroughly for heart and brain damage, I was given this single cell on a 'safer' wing.

"I've had a gut full of stress and anxiety due to these things. Do you know what I mean? And can you please help me as I may start feeling suicidal again if I can't be sure of my not being the object of some kind of witch-hunt. Thank you for being patient.

"Signed."

57. The night patrol left the note for the man's wing manager, who saw him that morning and talked to him about its contents. The wing manager told the man he would investigate his claims. He interviewed six prisoners without making them aware that it was the man whose claims he was investigating. Each of the prisoners seen by the wing manager denied saying any derogatory or abusive remarks of any kind. However, one of them admitted shouting out of his window to tell other prisoners to shut up. During the course of the wing manager's investigation, the man told him he had talked to the prisoner in the adjacent cell, whose name was similar to his,about "sexual matters". It became evident that his conversations had been overheard. The wing manager strongly advised the man to avoid having such conversations, especially if they could be overheard by other prisoners who could be offended. Having investigated his allegations, the wing manager came to the conclusion that the man was not under any threat. He told the man of his findings. He wrote in the Staff Observations Book:

> "After interviewing a number of prisoners re [the man] feeling under threat, it was established that a conversation between him and (name withheld) through their cell windows was offensive to other prisoners as it was of a sexual nature. [The man] told that this was inappropriate behaviour. In my judgement he is not under threat and has been told to distance himself from (name withheld)."

58. Later that day (12 July), the man asked to be segregated from other prisoners. In his application form, he wrote:

> "I have had trouble with the wing I am on as it has become rumour that I could be a paedophile, but this rumour is completely false. I was placed on this wing after it became necessary for me to have a single cell due to having repeated nightmares about a male rape that took place at my house before I got sent down. The rumours were spread by a lot of the inmates on the wing for the last few days that my next door cell bloke was a 'nonce' and the comments had become very direct. Then yesterday I was pointed out as 'noncey-[man's name]' by two inmates for talking to him about his sexual habits out of my window. I was merely trying to ascertain what he was really like, but it had been taken the wrong way by inmates below us and a plan was afoot to get both of us as a 'pair of nonces'!
>
> "Therefore I now don't feel safe here. I keep myself to myself in prison so they took that as me being scared to mix with them and jumped to the conclusion it was because I am like the man in the next door cell. I don't fight or stand up to bullies well, so I'm vulnerable. The whole situation has become life threatening. I heard their plans."

Segregation safety algorithm

59. A nurse completed an initial segregation safety algorithm. This process is designed to ensure that a proper assessment is made of a prisoner's ability to cope with segregation. A number of questions must be answered by the person filling in the form. One of those questions is, "Has the person self-harmed in this period of custody/are they on an open F2052SH/ACCT or is the person currently taking any anti-psychotic medication?" The answer to this question given by the nurse was "No". In fact, the man had self-harmed on 5 July, as a result of which he was taken to the local hospital and an ACCT form had been opened for 24 hours.

Authorisation of segregation

60. The algorithm was countersigned by the Head of Residence. In so doing, the Head of Residence confirmed that he had read the initial segregation safety assessment on the front page of the form and agreed that the man's segregation was "appropriate for operational reasons".

61. At interview, the Head of Residence explained that he did not have any background knowledge of the man when he signed the algorithm. He said he therefore had no reason to question any of the responses provided by the nurse. The Head of Residence said he was certainly unaware of the fact that the man had self-harmed on 5 July and that he had been spent that day in hospital.

62. The Head of Residence authorised the man's application for segregation. He was moved from St Patrick's wing to the segregation unit at about 2.20pm that day.

Events of 13 July

63. The officer on duty in the segregation unit on 13 July, at interview, told my investigator he had infrequent contact with the man. The officer described him as quiet and polite. According to the officer, the man collected his meals and seemed quite normal. The officer said he was aware the man had applied to be segregated in his own interests and that an ACCT form had been opened and closed. The officer said he did not know the reasons for the ACCT being opened.

64. Although no date had earlier been set for a post closure ACCT review, a Senior Officer held one that afternoon. No-one else was present at the review.

65. The following table shows the Senior Officer's summary of the review:

Question	Summary
How is the prisoner feeling now?	The man states he is OK.
Have they any problems?	States he felt threatened on St Pats and is happier in seg.
Are they maintaining contact with family or friends? If so, how? If not, why not?	Has not contacted family as yet but said he may tomorrow.
Are they engaged in purposeful activity?	Declined exercise today.
Are they settled in their location?	More than on St Patrick's.
Do they feel supported by cell mate, other peers, Listeners, Samaritans phones?	Has access to Listener and Samaritans phone.
Do they feel supported by staff?	Yes.
Can they approach staff if circumstances change?	Yes. States he will.
Is a further interview required?	Not at this point.

66. As can be seen from the table, the senior officer drew the conclusion that a further interview with the man was not needed.

67. The officer on duty in the segregation unit said the man asked him for writing paper at about tea time so that he could write some letters. The officer obliged. The man wrote to his sister later that day. In his letter he expressed his concerns for his safety but said he was looking forward to seeing her and other members of his family on Saturday 14 or Sunday 15 July.

68. When the officer gave the man his writing paper, he told him he was going to be moved to another part of the segregation unit where he could have a television set in his cell. He was moved at about 6.00pm that evening.

69. Amongst the property removed from the man's cell after his death was a personal diary. The last entry in the diary made by him on the eve of his death was as follows:

> "Canteen day! Had good sleep. So tired I didn't even attempt to read. Breakfast at 8am, then cell clean. Showers Monday Wednesday and Friday only, but I'd had proper good sink wash cuz didn't think showers would be segregated but they are. I'll get one on Monday definitely … [sister] spose to be visiting me today but can't cuz no visits at Camp Hill on Thurs or Fri - I got told visits every day! Can't wait to get into proper cell with R-K this is so boring! Get visit tomorrow or Sunday – Good! F***in seg is shite. But only one month to go now! Wrote to [sister] today and handed letter to screw then chilled out in my new 'surroundings' for afternoon. Fish and chips lunch was nice and got nuff sugar for two in tea! I think I just heard that the screws plan to make me go on exercise tomorrow to get me beaten up! But I am not a nonce. Might do myself tonite!"

70. It is not possible to suggest what time the man wrote these comments. It is highly unlikely that any members of staff would have had cause to read his diary. If they had, they would have had difficulty in deciphering what he had written as his handwriting was so small.

71. The officer on duty in the segregation unit said he did not see the man after he was moved to his new cell at 6.00pm. He told my investigator he had no reason to believe the man was contemplating taking his own life. Neither did he hear any shouting or conversations between him and other prisoners.

72. That evening an officer was deployed to the segregation unit as assistant Night Orderly Officer. He came on duty at 8.00pm. The assistant Night Orderly Officer told my investigator his duties involved not only working in the segregation unit but also completing a number of tasks in other areas of the prison on the Night Orderly Officer's behalf.

He said he was probably in the segregation unit for no more than a total of about two hours. However, the assistant Night Orderly Officer said the man did not press his cell bell during the night. He also said the man did not shout through his door.

Events on 14 July

73. In a statement given to the Governor on 14 July after the man had died, an officer confirmed that at approximately 5.40am that day he carried out a roll check in the segregation unit. He said in his statement he saw nothing untoward.

74. At approximately 6.55am, the assistant Night Orderly Officer carried out a routine check of the segregated prisoners. When he looked through the observation panel in the man's cell door, the assistant Night Orderly Officer saw him hanging from the top bunk in his cell. The man was in a sitting position and was suspended by a ligature made from a piece of his bed sheet. The assistant Night Orderly Officer used his radio to summon assistance from other staff. Very soon afterwards, the assistant Night Orderly Officer was joined by an OSG who had been working in St Andrew's wing, immediately adjacent to the segregation unit. The OSG cut a section of the ligature between the man's neck and the point where it was secured to the bed, using a ligature knife.. It appeared to both the assistant Night Orderly Officer and the OSG that the man was dead. As a consequence, no attempts were made to revive him.

75. At this point, the assistant Night Orderly Officer and the OSG were led away from the cell by the Orderly Officer who had also arrived. The Orderly Officer then examined the man in an attempt to find signs of life. However, he could find no pulse or any evidence of breathing. As he did so, the remainder of the ligature came away in his hand. The Orderly Officer also thought the man was dead.

76. An ambulance crew arrived at 7.09am. They pronounced the man dead at that time but his death was formally confirmed by a doctor at 8.38am.

77. A note written by the man to his mother and sister was later found in the cell. It read as follows:

> "Sorry Mum, [sister's name] Everyone, I've got no choice. The whole prison thinks I'm a nonce. There's no other way but to finish my life myself, not at the hands of some bloody kangaroo court. I'm really terrified of what I'm hearing out of my window. My old wing is within earshot and it's silent outside. I'm going to have to do it because otherwise I will be let out for exercise in the morning even though I don't want to go. I'm going to be killed then if I'm still alive. Hopefully I

won't be. I'm not a nonce but what else can I do? Proper terrified, it's on! Goodbye. Xxx

"[name], look after [name] and [name]. Sorry mate. Why me?"

78. The man's criminal record shows that he had never been convicted of a sex offence. Neither the interviews my investigator conducted nor the documents he studied threw any light on the credibility of his beliefs that he was being taunted or that he was going to be killed.

Informing the next of kin

79. A Governor, the Family Liaison Officer (FLO) at Camp Hill, broke the news of the man's death to his mother in person at her home at about 11.00am on 14 July. The FLO was accompanied by another Governor from HMP Parkhurst.

80. The Governor of Camp Hill met the costs of the man's funeral. He sent a letter to his family in which he expressed his condolences. He also arranged for flowers to be sent to the undertakers. A memorial service was conducted at the prison on the day after the man's funeral. His sister was able to attend the service and to visit the cell in which her brother died. The man's belongings were later passed to his family.

ISSUES

81. Here I examine:

- Whether the man's health needs were adequately met at Winchester and Camp Hill prisons.
- Whether his risk of suicide was properly assessed, monitored and managed.
- Whether the response to the discovery of him hanging was prompt and effective.
- Whether staff at Camp Hill prison afforded appropriate courtesies and support to the man's family in the aftermath of his death.

82. I also provide responses to the concerns raised by the man's mother and sister.

Were the man's health needs met?

Winchester

83. When the man entered HMP Winchester on 15 June 2007, he underwent an initial health screen. This showed he had a history of psychiatric disorder and that he had attempted to overdose on prescribed medication on three occasions in the previous three years. It also revealed he had a history of alcohol abuse. The man had been convicted of a drug related offence and had not been in prison before.

84. The day after he arrived, the man was prescribed 28 10mg Propanolol tablets. These were prescribed to alleviate his anxiety. He was to take one tablet each day. However, the investigation found that he did not receive the medication until 25 June when he complained about the matter. This reflects very poorly upon HMP Winchester. Given that the medication was prescribed for anxiety, the implications in terms of safer custody speak for themselves.

85. The man was placed on a detoxification regime consisting of a chlordiazepoxide prescription. This was terminated on 22 June 2007. Three days earlier, the following entry was made in the man's clinical record:

> "Detoxification – drug chart was in healthcare centre and was not returned till late afternoon. Therefore missed afternoon dose of chlordiazepoxide. Reviewed by the doctor given double dose this nocte (night) by a Staff Nurse as prescribed."

86. Although steps were taken to administer to the man the missed dosage of chlordiazepoxide, the absence of a drug chart should not cause a prisoner to miss his medication.

The Primary Care Trust should review arrangements to ensure that prescribed medication is administered to prisoners on time, especially in the context of detoxification programmes.

87. The man was transferred to Camp Hill prison on 2 July 2007. Substantial and important medical information about him that had been stored electronically at Winchester was not included in the clinical record sent to Camp Hill that day. One of the items of information missing from the man's notes was the fact that he had a history of self-harm. Thus, the health screen conducted upon his arrival at Camp Hill was based on very limited information most of which he volunteered himself. This is a second example of poor administration that must not be repeated.

The Primary Care Trust must take urgent steps to ensure that medical information stored electronically accompanies prisoners at the point of their transfer to another establishment.

At paragraph 6.1 of the clinical review the following further recommendation is made:

"During the first part of 2008, the PCT should consider conducting a brief audit to ensure that the complete electronic medical record is being transferred with prisoners from Winchester."

88. The man was assessed as being fit for his transfer to Camp Hill almost a week before the transfer took place. Although the investigation found no evidence that this was to his detriment, I consider that the time lapse between the assessment of his fitness to transfer and the date of his move was too long. In such circumstances, the possibility of a change in the prisoner's physical health or state of mind is, in my view, too great.

The Primary Care Trust should ensure that the assessment of prisoners' fitness to transfer takes place as near as possible to the date of the transfer.

89. Whilst at Winchester, the man was referred to the CARATs team. His case was taken up by a CARATS worker on 27 June. Recognising that the man was to be transferred to Camp Hill on 2 July, the CARATS worker drew up a transfer plan and sent his Drug Intervention Record to the Drug Intervention Programme on the Isle of Wight so that the man could receive throughcare and support on release. Had the man remained at Winchester, the CARATS worker would have been able to complete a comprehensive substance misuse assessment (CSMA). However, this was not possible in the timescale available. The CARATS worker noted in the man's CARATs file that the CSMA had not been completed and that the man had not been able to complete a one-day drug awareness course because of the fact of his transfer. I am impressed by the help and support the CARATS worker offered to the man in the short time available to her and commend her for doing so.

Camp Hill

90. Upon his arrival at Camp Hill the man underwent a further health screen. The fact that his medical notes were, at that point, incomplete, has already been made. A nurse conducted a full health screen and recorded that the man was at that time on a course of medication and wanted to see a doctor. There is no evidence in his medical record to show whether he in fact saw a doctor. The nurse also contributed to the cell sharing risk assessment process. The healthcare professional with responsibility for the completion of the assessment is required to tick a 'yes' or a 'no' box in answer to the question, "Following the self-harm assessment, have any concerns been raised?" The nurse ticked neither box. At interview, she could not recall whether she had studied the information on the previous page of the form used. Although this omission caused the man no detriment, I do not think it can pass without comment:

The Governor should remind all his staff of the requirement to be meticulous in their completion of cell sharing risk assessment forms, especially in respect of the assessment of a prisoner's risk of harming himself or others.

91. The man was to spend only 12 days at Camp Hill before he died. In that time, he came to the attention of the prison's nursing and medical staff, a representative of the mental health in-reach team, and the A&E staff and specialists at the hospital as a result of an act of self-harm that occurred three days after he arrived. I comment below on the manner in which the man was managed at that critical time.

Was the man risk of suicide properly assessed, monitored and managed?

Winchester

92. Before the man arrived at Winchester on 15 June 2007, the staff who escorted him from court to the prison thought he presented a risk of self-harm. A Prisoner Custody Officer (PCO) completed a suicide warning form in order to bring his concerns about the man's risk to the attention of the reception staff at Winchester. However, the PCO concerned wrote on the form that the man said he did not feel suicidal. I believe the decision not to place him on self-harm monitoring procedures was reasonable. At no stage during his brief stay at Winchester did the man indicate any obvious signs that he was at risk of self-harm or suicide.

93. However, the investigation found that the suicide warning form was not placed in the man's prison record before he transferred to Camp Hill on 2 July. In fact, the form arrived at Camp Hill three weeks after his death. I am seriously concerned at this administrative failure.

The Governor of Winchester should review the practices and procedures in place in his establishment for the handling of suicide warning forms in order to ensure that they:

- **are properly received from private security staff in reception;**
- **are studied by reception staff;**
- **attract a prompt and appropriate management reaction;**
- **are filed promptly and securely in an appropriate place in the prisoner's record in a manner that makes for easy access if required at a later stage, for example when the prisoner is transferred to another establishment.**

Camp Hill

94. The PER for the journey between Winchester and Camp Hill on 2 July carried no notation of any risk of self harm. The man's presentation during the subsequent reception procedures at Camp Hill was such that he was judged not to be at risk of self-harm. I believe that judgement was reasonable.

95. It was not until three days later that the man gave staff cause for concern about his state of mind. In the early hours of 5 July 2007, the man placed a noose around his neck (albeit without attaching the other end to anything) and claimed he had taken an overdose of Propanolol tablets. As a result, he was immediately placed on ACCT monitoring and was taken to the local hospital for assessment. I applaud the staff concerned for their prompt and decisive action.

96. The man was discharged to Camp Hill at about 9.00pm that evening. The hospital authorities did not consider it necessary for him to be kept in a healthcare environment in the prison. With the man's agreement, he was initially returned to St Andrew's wing where he shared a cell with his original cellmate. The ACCT document remained in force. He was seen by the Orderly Officer. The Orderly Officer noted that the man was in an improved state of mind but was of the view that he should be moved to St Patrick's wing "at the earliest date" because of his vulnerability. The Orderly Officer instructed that the man was to be observed every 30 minutes, "as a precaution during patrol state and prior to full review on 6 July". I applaud the Orderly Officer's judgement.

97. The man remained in St Andrew's wing overnight. Arrangements were made the following morning for him to transfer to St Patrick's wing. He was moved at about 10.00am. As this unit was principally for vulnerable prisoners, it was in my view entirely appropriate for the man to be located there. It is also my view that, given his fear of becoming the victim of a further assault, it was appropriate for him to be placed in a single cell. (I should emphasise that the investigation found no evidence that any form of assault on him was likely to take place. It seems that his fear was based solely on the trauma caused by the sexual assault that had allegedly occurred in his flat prior to his imprisonment.)

98. However, from that point onwards, things started to go wrong. Although my investigator believed those members of staff who had most contact with the man upon his return from hospital had his best interests at heart, he discovered a series of significant flaws in the way the ACCT procedures were carried out. He also found evidence of poor communication between individual members of staff and between units. These were in relation to the events that preceded the man's transfer from St Andrew's to St Patrick's wing and with regard to events that occurred during the few days the man was in St Patrick's wing.

99. First, I provide a full examination of the quality of the ACCT procedures carried out.

100. The ACCT system requires that a number of measures are taken. These are the completion of the following:

- The completion of a Concern and Keep Safe form
- The completion of an immediate action plan
- The completion of an initial assessment of the at-risk prisoner by a trained assessor
- The completion of a care and management plan, otherwise known as a care map
- The completion of the first ACCT case review within 24 hours
- A post ACCT closure review should take place.

The Concern and Keep Safe form

101. The purpose of this form is to assist staff to elicit from the at-risk prisoner the main problems that are causing the risk of self-harm or suicide. The man's record shows that the form was completed by the Orderly Officer at 6.40am on 5 July. Significantly, the Orderly Officer noted that the man had said he could not cope "on this, his first custodial sentence."

102. I believe the Orderly Officer used the Concern and Keep Safe form correctly. However, as I shall say later, the investigation found that staff who were subsequently involved in managing the man, or in making key decisions about him, seemed not to have taken any account of his underlying anxiety as described by the Orderly Officer.

Immediate Action Plan

103. Using this form, staff are required to consider and record the most appropriate environment and regime to support the prisoner at risk prior to the first case review. The Orderly Officer devised the man's plan. The following objectives were set:

- location: to remain in same location/shared cell
- frequency of staff support: two observations per hour during patrol state

- phone access: not required at this stage.

104. I consider this plan was appropriate for the circumstances which the Orderly Officer found.

Initial Assessment Interview

105. Paragraph 15.3 of the Suicide Prevention Policy document for Camp Hill sets out the following policy for initial assessments:

> "A trained assessor will conduct an assessment with the at-risk prisoner unless there are exceptional circumstances in that the prisoner has been admitted to outside hospital and is too ill to be interviewed. In such a case, this exceptional circumstance must be recorded in the ACCT documentation."

106. This policy statement is drawn from national guidelines that are contained within the ACCT document. The guidelines stress that the exceptional circumstances are that the prisoner must have been admitted to outside hospital and is too ill to be interviewed.

107. The ACCT document sets out the structure for the conduct of the assessment interview. The interviewer should make comments in relation to the following matters:

- the individual's perception of the problems related to current distress
- issues relating and leading to the act of self-harm
- previous acts of self-harm
- current mental state
- current suicidal thoughts and intentions
- reasons for living and coping resources
- any other areas for discussion, and
- agree what is to happen now with the interview.

108. The matters discussed and recorded at the initial assessment should then set the agenda for the first ACCT case review. This should normally take place within 24 hours of opening the ACCT document.

109. The fact that no initial assessment was carried out was a significant failure. It deprived prison staff of an opportunity to draw out of the man the reasons behind his self-harm and, thereafter, accurately to measure the risk he presented of further similar behaviour. It reduced the ability of staff properly to set out a care plan against which they could monitor, manage and reduce his risk. It also deprived the man himself of the chance to become directly involved in that process from the outset.

110. The guidance I have quoted above is clear: the only circumstances in which an initial assessment interview is not advised is when the at-risk

prisoner is in hospital and is too ill to be interviewed. I do not believe the man fell into that category. I suspect the reason for the omission was that the interview was simply overlooked because he was admitted to hospital.

The Governor should make clear to all staff at Camp Hill that ACCT initial assessment interviews must be conducted within prescribed timescales unless the at-risk prisoner has been admitted to hospital and is too ill to be interviewed. The Governor should emphasise the importance of ensuring that at-risk prisoners who are admitted temporarily to hospital do not slip though the net.

The Governor may wish to consider whether this and my subsequent recommendations about ACCT procedures should be the subject of staff training.

111. The underlying problems that caused the man's risk of self-harm were assessed by the RMN when he was in hospital. The RMN came to the conclusion that the man would be at further risk if he remained fearful of an assault of the sort he claimed had occurred prior to his imprisonment.

112. The RMN's assessment compensated for the fact that the same exercise was not conducted by Camp Hill staff by means of an assessment interview. However, the details of the RMN's assessment were poorly communicated within the prison.

The Governor should review his local suicide prevention policy in order to ensure that it legislates for the prompt and effective communication of information about an at-risk prisoner between hospital authorities and prison staff as well as between relevant units in the prison.

Care and management plan (care map)

113. The care map should set out how best to deliver the care and support needed by the at-risk prisoner. The plan should have the agreement of the prisoner concerned. The Prison Service has issued the following guidelines for the creation of an effective care map:

- it should engage the person at risk
- it should identify the most urgent and pressing issues (i.e. the problems that are causing the person at risk the most pain, the resources that have most potential to support the person at risk, and the level of risk itself, including any suicidal intent or plan)
- it should set a small number of realistic and achievable goals
- it should state clearly who will complete which action
- it should be implemented
- it should be reviewed and changed over time.

114. The Suicide Prevention policy document at Camp Hill requires the first case review team to draw up a care map for the at-risk prisoner. The investigation found that no care map was drawn up for the man. This was because the ACCT had been closed at the first and only ACCT case review on 6 July, the day after he returned from the hospital, and only 24 hours after it was opened.

The Governor should make clear to all his staff that a Care and Management Plan (Care Map) must be drawn up in respect of all at-risk prisoners as a matter of course, including those who are temporarily admitted to outside hospital.

Closure of the ACCT form on 6 July

115. The ACCT document contains the following national guidelines for closing the ACCT document and for the care of prisoners after their ACCT documents have been closed:

> "A significant number of people have killed themselves after coming off the ACCT. To prevent this happening,
>
> - encourage the person at risk to build up their own support networks and coping strategies over the course of the reviews. Reduce levels of support gradually.
>
> - close the ACCT plan at a case review, when the case review team judges that the level of risk has dropped sufficiently and the individual's resources and ability to cope with remaining difficulties are adequate.
>
> - at the closing case review, check whether the problems that caused the ACCT plan to be opened have been resolved or reduced in intensity, and that the person has access to at least some resources that they find 'life promoting'."

116. I consider that these guidelines were not followed at the one and only ACCT case review that was conducted on the morning of 6 July.

117. Although it was appropriate to place the man in a single cell in St Patrick's wing, more attention should have been paid to the effects this would have upon his state of mind. His location in a cell on his own must have increased his sense of isolation. Measures should have been taken to monitor his ability to cope with that isolation over time. No thought was given to a gradual reduction in the level of support he required. Instead, the close supervision and support available was suddenly withdrawn because the ACCT form was closed.

118. The manager of the induction unit and the CPN took the man at his word when he told them he was content for the ACCT to be closed. As the

ACCT guidelines suggest, numerous prisoners go on to kill themselves after the closure of their ACCT form.

119. Although the Prison Service offers no guidance as to how quickly an ACCT form can be closed, I take the view that in the man's circumstances it was inappropriate to close it only 24 hours after he had taken an overdose of prescribed drugs and placed a noose around his neck. In that period, he had spent a day in hospital being assessed by a doctor and a mental health nurse who considered that, as long as he remained fearful (of being raped again), he was at risk of further impulsive behaviour.

120. I suggest that more consideration should have been given to the man's underlying fears rather than to his overt behaviour when the manager of the induction unit and the CPN reviewed his case on 6 July. The investigation found no evidence that any 'life promoting' measures, such as encouraging the man to mix with other prisoners and to take part in constructive activities, were put in place either in St Andrew's wing or in St Patrick's. Rather, there was a tacit acceptance that all that was needed was to put him in a single cell.

121. But I have other serious concerns about the manner in which the case review was conducted. These are as follows:

- The review was held in the man's cell. Although this offered the advantage of being out of the sight and hearing of other prisoners, it afforded little formality or authority to the proceedings. The review should have been held in an office or room that was comfortable and more spacious.

- The man had only just arrived in St Patrick's when the review was conducted. He had just unpacked his belongings and been given no time in which to adjust to his new environment. No thought was given to allowing him to settle before judging the extent to which his risk of self-harm had reduced.

- The CPN told my investigator he did not know until the meeting was drawing to a conclusion that it constituted a case review. If this was the case, the manager of the induction unit should have made clear to him from the outset the purpose of their meeting with him.

- The manager of the induction unit conducted the review in the absence of any members of staff from St Andrew's wing in which the events that led to the opening of the ACCT form had taken place the day before. She could have chosen to invite a member of staff in St Andrews wing, who was the first to respond when the man said he had self-harmed, or the Senior Officer, who had opened the ACCT form. It would also have been wise to have invited a representative of St Patrick's wing to the review, such as the officer who saw the man when he arrived in the wing.

- The CPN and the manager of the induction unit both believed that, because the man had been placed in a cell on his own, the threat of an assault had disappeared. Indeed, the man told them he felt safe and secure and would not harm himself again. However, no account was taken of the comments made in the Concern and Keep Safe form by the Orderly Officer at 6.40am on 5 July that the man could not cope with this, his first, prison sentence. This comment was, in my view, an indication of a fear that was unlikely to diminish within 24 hours. The comment was clearly recorded in the man's ACCT record for all to see.

122. The local procedural policy document for suicide prevention sets out the following clear requirements for the conduct and timing of ACCT case reviews:

- all reviews will consist of a minimum of three people, at least one of whom should be from outside the unit but who has some knowledge of the prisoner
- the initial review follows as soon as possible after assessment but in any case within 24 hours of the concern being raised
- the timing of further case reviews will be decided by each case review team, based on the individual's risk. A case review will be conducted before transfer to another establishment or residential unit.

123. The same document also sets out the following requirements for the closure of ACCT forms:

> "The ACCT document must only be closed where a multi-disciplinary team, together with the prisoner, agree that any risk has diminished sufficiently. The Care map will be updated based on the individual's needs and to assist him in developing coping strategies to help reduce the risk of further self-harm or suicide. Details in the Care map will be entered in the wing observation book."

124. The manner in which the case review was conducted was in contravention of the national guidelines contained within the ACCT form and the Governor's own suicide prevention policies.

125. It is for the Governor to decide what, if any, action he wishes to take in respect of those staff who did not follow the requirements that are clearly set out in his policy document for the conduct of ACCT case reviews and for the closure of ACCT documents.

The Governor should consider adding the following further guidance to staff about the manner in which ACCT case reviews should be conducted:

- **ACCT case reviews should not take place in a prisoner's cell other than in exceptional circumstances**
- **The timing of ACCT case reviews should take account of the specific circumstances of the at-risk prisoner under consideration**
- **The ACCT case manager should make clear the purpose of each review in advance of the meeting.**

The wing manager's investigation into the man's claims that he was being threatened by other prisoners

126. The investigation found that the enquiries made by the wing manager into the man's claims that he was being threatened by other prisoners were thorough, and that his conclusions were appropriate. However, in the note the man passed under his door at 3.00am on 12 July that gave rise to the wing manager's investigation, he said he might start to feel suicidal again if he could not be sure of not being the subject of some kind of witch hunt. This significant comment was lost to the wing manager and was not passed on to the staff in the segregation unit. Whilst I make no formal recommendation, I believe the comment should have been interpreted as an indication of the man's continuing risk of self-harm or suicide. Consideration should have been given to re-opening the ACCT form.

The authorisation and management of the man's segregation

Segregation safety algorithm

127. Before the man's segregation could be authorised, a segregation safety algorithm had to be completed. A nurse, who normally worked at Parkhurst prison, undertook this task on 12 July.

128. The following table shows the questions posed in the algorithm:

1. Is the prisoner awaiting transfer to/being assessed for a bed in an NHS secure setting?
2. Has the prisoner self-harmed in this period of custody/are they on an open ACCT form or is the prisoner currently taking any anti-psychotic medication?
3. Does the prisoner show any signs of being acutely unwell (e.g. psychotic/withdrawal from drugs/significant physical injury) at the present time?
4. Do you think that the prisoner will be unable to cope with a period of segregation?

129. The nurse replied 'no' to each of these questions. Her answer to question two was incorrect as the man had self-harmed on 5 July. The nurse told my investigator over the telephone that she asked staff in the segregation unit what they knew of the man's background before she completed the form. She said she was given no details of his self-harm on 5 July or of his admission to the hospital that day.

130. Under the heading on the safety algorithm proforma, "Notes for Healthcare" the following instructions are included for registered nurses:

Complete the screen after:

- a discussion with the prisoner
- reference to his/her clinical record and any other relevant documentation, e.g. incident report and ACCT if appropriate
- gathering information from other members of the care team/discipline staff
- reviewing the nature of the incident which led to segregation being necessary to check for indicators of mental distress.

131. The nurse was in error if all she did was to ask other staff whether the man had self-harmed or had been subject to ACCT procedures. She should have known she was required to make the full checks listed above. Whoever she asked did not say that the man had self-harmed on 5 July. This is clear evidence of a breakdown of communication between key staff with regard to the events that led to the opening of the man's ACCT document, his move to a single cell in St Patrick's wing and his subsequent application for segregation.

132. The nurse told my investigator there had been a significant shortage of healthcare staff in the three Isle of Wight prisons. This meant those on duty were less likely to have any detailed knowledge of individual prisoners.

133. I consider that the nurse could have been more diligent with regard to the completion of the man's segregation safety algorithm, irrespective of staffing difficulties at the time.

The Governor, together with the Primary Care Trust, should examine whether healthcare staffing levels are sufficient for the provision of proper healthcare for prisoners.

134. The fact that the person in the segregation unit, to whom the nurse spoke, seemed to know of the man's recent history highlights the need for there to be a structured means of communicating information about vulnerable prisoners between units as well as between individual staff in each unit. This is especially important in circumstances where an ACCT form for an at-risk prisoner has recently been closed.

The Governor of Camp Hill should review his local suicide prevention policy to ensure that the recent history of at-risk or vulnerable prisoners is properly communicated to unit staff, especially when a prisoner is moved from one unit to another. The review should place special emphasis on the communications structure to be followed in respect of those prisoners who are poor copers.

135. The CPN told my investigator that segregation reviews are held once a month, in keeping with the provisions of Prison Service Order (PSO) 1700. The purpose of the reviews is to enable staff and managers to assess how each segregated prisoner is coping with the effects of segregation and to take steps to offer prisoners support through the provision of appropriate activities. The CPN thought that the man might not have had a review board as the schedule of reviews might have fallen outside the period he was in the unit. A senior manager at Camp Hill, later told my investigator this was not the case. He said full segregation review boards were held every two weeks, normally on a Wednesday, and all newly segregated prisoners were reviewed after 72 hours. The Head of Residence confirmed that he scheduled the first segregation review for 2.20pm on 15 July. The CPN did not see the man again. I conclude that the provisions of Prison Service Order 1700, which sets out the policies for the management of segregated prisoners, were about to be put into effect. The man's first segregation review board had been scheduled for 15 July, 72 hours after his initial segregation.

136. At 6.00pm on 13 July, the man was moved to another cell in the segregation unit in which it was possible for him to have a television set. This was a positive development. The man was also given writing materials so that he could send letters to his family. He immediately wrote a letter to his sister in which he said how much he was looking forward to seeing her and their mother on the forthcoming weekend.

There was no evidence in that letter to indicate that he was about to take his own life.

Post closure review on 13 July

137. The following guidance with regard to post closure reviews is set out in the ACCT document:

> "Offer one and possibly more follow up interviews. The timing will vary, e.g. a week and a month after closure may be appropriate but it is for the case review team that decides on closure to agree this.
>
> At the post closure interview(s) discuss:
>
> - how the prisoner is feeling now
> - how they are managing with the problems that led to their episode of distress
> - whether they are now in contact with friends, family or some other support
> - whether they have now got something in their lives that they feel positive about (e.g. work, art, exercise, education, hobbies, something they enjoy that gives them a sense of purpose)
> - whether they can see alternative ways of dealing with a similar problem should it arise in the future."

138. By the time his post closure review was convened on 13 July, the man had been located in the segregation unit for his own safety. The unit manager conducted the review. He did so alone. The man told him he had felt threatened in St Patrick's wing but was more settled now that he was segregated.

139. The investigation found no evidence that the unit manager was aware of the comment the man wrote on 12 July in which he talked of the possibility of being suicidal again. Moreover, the man's presentation at the post closure review gave him no reason to believe the man was at risk of suicide at that point. He concluded that a further interview with the man was not required at that stage.

140. However, the post closure review should have been conducted by a multi-disciplinary team. I suggest that team could have included a member of staff from St Patrick's wing, the CPN or a member of the healthcare staff, and another member of the segregation unit staff.

141. The unit manager asked the man many of the questions listed above. The man's answers clearly persuaded him that he was coping. However, the post closure review took place only 24 hours after the man had been moved from St Patrick's wing into the segregation unit.

I believe it was too early to draw any firm conclusions as to whether it was necessary to review him again. Whilst I make no formal recommendation on this matter, I suggest that staff should err on the side of caution when considering the need for more than one post closure interview.

142. The events of 5 July were clearly recorded in the man's ACCT document but this information was not available to the segregation unit staff as the document was closed on 6 July. Although the unit manager knew the man had been subject to ACCT procedures, there is no evidence that when he conducted the post closure review on 13 July he had the original ACCT form with him. It seems that for the purpose of the post closure review he was required only to complete a form and pass it to the Safer Custody Manager who then filed it with the man's ACCT document.

The Governor should review his local suicide prevention policy and ensure that ACCT post closure interviews are conducted on a multi-disciplinary basis and that the closed ACCT document should be available for staff to study before and at the post closure review.

Was the response to the discovery of the man hanging on 14 July prompt and effective?

143. It was the assistant Night Orderly Officer who found the man hanging in his cell at about 6.55am on 14 July. The officer immediately summoned assistance and entered the cell. With assistance from colleagues, he removed the ligature and checked for signs of life. None was evident. The staff who entered the cell all believed the man was already dead. Although no attempts were therefore made to revive him, an ambulance was called. A paramedic crew arrived in the cell at 7.09 am and immediately pronounced the man dead. Death was confirmed by the prison doctor shortly after 8.30am.

144. I believe that in the circumstances, the decision not to attempt to revive the man was reasonable.

Were appropriate courtesies and support afforded to the man's family in the aftermath of his death?

145. The man's mother was informed of his death at approximately 10.00am on 14 July, in person at her home by a Governor, the appointed Family Liaison Officer at Camp Hill. As the man's sister is a member of staff at Parkhurst prison, the Governor was accompanied by a second Governor, a senior manager at that establishment.

146. The man's family have expressed their appreciation for the manner in which they were informed of his death, and at the way they were

supported by Camp Hill and Parkhurst staff thereafter. I deal with their remaining questions in the final section of this report.

FAMILY CONCERNS

147. Here I list the concerns expressed by the man's family together with my responses.

1. What victim support was offered to the man after the attack on him in his home (believed to be on 14 February 2007) which led to the discovery of his cannabis plants by the police attending the assault? This attack had a profound effect on hiss confidence and fragile state of mind as it was of a sexual nature by someone in his own home. He subsequently complained of panic attacks and insomnia after cell sharing with a succession of different men that brought the memories of that night to him.

No evidence was made available to my investigator with regard to the level of support offered to the man prior to his arrest, the investigation of which would be beyond my terms of reference. He shared a cell with only one prisoner whilst at Camp Hill. The investigation found there was no conflict between the man and his cellmate. However, it is clear that the man had a phobia about cell sharing which he made known to staff. The manner in which this was handled is dealt with in the main body of the report.

2. Why was the man's court sentencing date brought forward by 24 hours at short notice? {This meant that no family member was in court to see him at a very vulnerable time.]

The man's solicitor told my investigator that officials at the court did indeed bring forward by one day the man's sentencing hearing. She explained that this often happened and that she was not told of the change until the day of the hearing.

3. Was any consideration given the fact that the man's sister works as an OSG at Parkhurst during the decision to transfer him to Camp Hill so quickly into his sentence and after his initial detox? His sister was opposed to the man being transferred to HMP Camp Hill as she did not think that the regime there would suit him in his rehabilitation. She feels that her position of employment at Parkhurst may have led to some decisions being made that may have not been in the man's best interests. On the day of his first overdose attempt after three days at Camp Hill, he was kept in hospital all day for treatment and assessment. His sister was informed by telephone at 5:00pm that day that he may well be transferred to E3 healthcare wing at Parkhurst for some form of constant watch due to his state of mind at that time. This would have impacted on her ability to carry out her duties at Parkhurst and she is concerned that the man may not have been placed on E3 for that reason. This underlines the complications of partial clustering of services between prisons of close geographical proximity, i.e. Camp Hill and Parkhurst may currently be seen as separate, but their healthcare services are the same. There was always a risk of a

situation like this occurring with the man being transferred into a prison partially clustered with the one where his sister works.

The man was allocated to Camp Hill from Winchester because he was a category C prisoner and because he was apparently keen to serve his sentence on the Isle of Wight. The investigation found no evidence that the allocation decision was made hastily. Neither was there any evidence that the regime at Camp Hill was inappropriate for the man. The employment of his sister as a member of staff at Parkhurst, a higher security prison adjacent to Camp Hill, was not a factor in the allocation decision. The investigation found no evidence that the man brought this matter to the attention of staff at Winchester. My investigator spoke to the Deputy Governor of Parkhurst who confirmed that no conflict of interests arose during the brief time the man was at Camp Hill.

With regard to the possibility of admitting the man to the inpatient unit (E3) at Parkhurst, the investigation found no evidence that the man was considered for admission. The Deputy Governor of Parkhurst told my investigator she consulted the staff in the unit who confirmed they had not been asked to consider his admission. She also confirmed that, had he been admitted, she would have changed the shifts and/or responsibilities of the man's sister to ensure she would not inadvertently come into contact with him. However, the investigation found that after the man had told a member of staff at Camp Hill on 5 July that he had self-harmed, that member of staff telephoned a colleague at Parkhurst to check what system should be followed to move him to outside hospital.

4. How long was the man on an ACCT document after the first attempt at self-harm?

The man's ACCT form was opened at approximately 6.40am on 5 July and closed at approximately 10.00am the next day. This matter is dealt with in the main body of the report.

5 The man's *sister requested of the Deputy Governor via email to be able to visit her brother on Tuesday 10 July at short notice as it was her only rest day and she felt it important to see him by herself before she was due to visit their mother on 15 July. Was any consideration given to this request?*

During the course of the investigation, my investigator wrote to the Deputy Governor about this matter. He replied as follows:

> "I interpreted [the man's sister] email as an intention to visit and not as a request for this to be authorised. Given the tragic incident that went on to occur, I am obviously disturbed that [the man's] sister was possibly waiting for me to organise a visit for her on 10th July. However, in honesty, I would still interpret that

email the same way reading it again today. I have checked the Gate book entries for that date (10 July) and his sister is not listed as visiting that day. Unfortunately, I cannot locate the original bookings sheet. Had I been able to do so, I would have been able to ascertain if she had telephoned to make a booking herself."

6. When the man refused to go out on association and requested a move to the segregation unit on Thursday 12 August, was there any consideration of his ACCT being re-opened or for the chaplain or a counsellor to speak to him? The man mentioned in the last letters we received (dated Tuesday 10 August) that he had been advised by a CARATs counsellor that he would greatly benefit from counselling to deal with his anxiety to do with the assault on him in his home, but said he had been told he would receive this after his release and not before.

This is covered in the main body of the report. However, my investigator was unable to clarify whether the man was told he would only receive counselling after his release from prison.

7. When the man was actually moved down to the segregation unit was he offered the opportunity to phone friends or family to ease his mind in its state at that time? His sister strongly feels that if he had been able to speak to herself or his mother on the phone it may have calmed his panicked state of mind at that time. His sister asked the SO in the segregation unit who showed me to the scene of the man's death about access to phone calls and was informed that prisoners there only have access to the phone at weekends. Is this true?

The Deputy Governor has explained that domestic phone calls are normally only permitted to prisoners in the segregation unit at weekends. However, he said such calls are exceptionally authorised if circumstances permit. The Deputy Governor was unable to confirm whether the man was allowed to make any calls from the segregation unit. His PIN phone record shows that the last call he made was at 8.29 on 11 July when he was still in St Patrick's wing. The manner in which the man was managed in the segregation unit is dealt with in the main body of the report. However, I believe that prisoners segregated at their own request should not be disadvantaged in respect of telephone contact with their family. Indeed, given that they may have requested segregation because they are fearful, such contact is all the more important:

The Governor should review arrangements to ensure that prisoners segregated at their own request are able to use the telephone daily.

8. Was the information that the man had taken an overdose and was in possession of a ligature on his attempt nine days previously passed

on to the segregation unit staff when he was transferred from St Patrick's wing?

This is covered in the main body of the report.

9. Was that information taken into consideration when the man was moved from a single bed cell to one with double bunks on the night he took his life?

Had there been only one bed in the man's cell on the night he died, it would still have been possible to find a ligature point elsewhere. However, I understand the Governor of Camp Hill has since removed double bunks from all the segregation unit cells. Given the risks of self-harm in all segregation units, I believe this is a sensible action.

RECOMMENDATIONS

To the Governor of Winchester:

1. **The Primary Care Trust should make arrangements to ensure that prescribed medication is administered to prisoners on time, especially in the context of detoxification programmes.**

2. **The Primary Care Trust must take urgent steps to ensure that medical information stored electronically accompanies prisoners at the point of their transfer to another establishment.**

3. **The Primary Care Trust should ensure that the assessment of prisoners' fitness to transfer takes place as near as possible to the date of the transfer.**

4. **The Governor of Winchester should review the practices and procedures in place in his establishment for the handling of suicide warning forms in order to ensure that they:**

    - **are properly received from private security staff in reception;**
    - **are studied by reception staff;**
    - **attract a prompt and appropriate management reaction;**
    - **are filed securely in an appropriate place in the prisoner's record in a manner that makes for easy access if required at a later stage.**

Commendation

I am impressed by the help and support the CARATS worker offered to the man in relation to the management of his drug abuse in the short time available to her and commend her for doing so.

To the Governor of Camp Hill:

1. **The Governor should remind all his staff of the requirement to be meticulous in their completion of cell sharing risk assessment forms, especially in respect of the assessment of a prisoner's risk of harming himself or others.**

2. **The Governor should review his local suicide prevention policy to ensure that the recent history of at-risk or vulnerable prisoners are properly communicated to unit staff, especially when a prisoner is moved from one unit to another. The review should place special emphasis on the communications structure to be followed in respect of those prisoners who are poor copers.**

3. **The Governor should make clear to all his staff that a Care and Management Plan (Care Map) must be drawn up in respect of all**

at-risk prisoners as a matter of course, including those who are temporarily admitted to outside hospital.

4. **The Governor's local suicide prevention policy should include clear and detailed guidance to staff about the conduct and timing of ACCT case reviews and about the factors to be taken into consideration before decisions are made to close the document. The Governor should consider what additional staff training may be required in this subject area.**

5. **The Governor should consider adding the following further guidance to staff about the manner in which ACCT case reviews should be conducted:**

   - **ACCT case reviews should not take place in a prisoner's cell other than in exceptional circumstances**
   - **the timing of ACCT case reviews should take account of the specific circumstances of the at-risk prisoner under consideration**
   - **the ACCT case manager should make clear the purpose of each review in advance of the meeting.**

6. **The Governor, together with the Primary Care Trust, should examine whether healthcare staffing levels are sufficient for the provision of proper healthcare for prisoners.**

7. **The Governor should review his local suicide prevention policy to ensure that the recent history of at-risk or vulnerable prisoners is properly communicated to unit staff, especially when a prisoner is moved from one unit to another. The review should place special emphasis on the communications structure to be followed in respect of those prisoners who are 'poor copers'.**

8. **The Governor should review his local suicide prevention policy to ensure that ACCT post closure interviews are conducted on a multi-disciplinary basis and that the closed ACCT document should be available for staff to study before and at the post closure review.**

9. **The Governor should review arrangements to ensure that prisoners segregated at their own request are able to use the telephone daily.**

At consultation stage, the Prison Service confirmed that they accepted all recommendations.