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

Report by the Prisons and Probation Ombudsman for England and Wales

March 2009

This is the report of an investigation into the death of a man who was discovered suspended from the window bars of his cell at HMP Dorchester in the early hours of 27 July 2007. When he was found, it was clear that he had been dead for some hours and he was pronounced dead in his cell. He was 35 years old. I offer my sincere condolences to the man's family and to all those touched by the loss of his life.

The investigation was undertaken on my behalf by one of my investigators. Dorset Primary Care Trust undertook a clinical review of the care the man received.

The final version of this report was delayed pending the outcome of an investigation into complaints the man made whilst at HMP Guys Marsh. I apologise in particular to the man's family for the time it has taken for this final report to be completed. His family have been especially patient during the ten months since my draft report was issued and I share their disappointment that not all of their concerns have been addressed by Guys Marsh.

I wish to acknowledge the assistance I received from HM Coroner for the Western District of Dorset. I must also thank the Governor of Dorchester and his staff, for their help and cooperation.

The man was troubled and struggling to cope with difficulties in communicating his feelings to those around him. It may well be that he had Asperger's syndrome, a complex condition that makes interaction with other people problematic. The man was both vulnerable and hostile, often at the same time. His behaviour whilst in custody presented obstacles for those who had to care for him. He appears to have struggled to make sense of the prison world in which he found himself, and staff were unable to reach through the barriers he erected.

I have found this to be a particularly sad story. I make four recommendations.

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

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SUMMARY

On 2 December 2006, the man was convicted of arson with intent to endanger life. He was remanded in custody for pre-sentence reports and taken to HMP Swansea. At Swansea, the man was seen by a nurse on reception. He disclosed that he was an alcoholic and had been prescribed anti-depressants. He did not express feelings of wanting to harm himself. The man was regarded as a high-risk prisoner in terms of sharing a cell, because he expressed racist and homophobic views during his induction interview. The induction officer concluded that he would probably find it difficult to settle into a prison regime.

The man's behaviour was regarded by staff as strange. At times, he would remain in his cell and cover his head with a blanket. He was referred to the in-reach mental health team. He was examined by a forensic psychiatrist and prescribed an anti-psychotic drug, haloperidol, to calm him and control his aggression.

The man was assessed on behalf of his defence team by, a Consultant Forensic Psychiatrist. The psychiatrist's opinion was that the man was vulnerable to depression. He appeared to have very poor coping strategies for dealing with the frustration and anger that arose from his personality difficulties.

On 2 February 2007, the man was sentenced to 18 months imprisonment and was taken to HMP Bristol. He would have been released on 30 August 2007. Although the man had spent short periods in custody on remand five years previously, it was his first custodial sentence. The man asked to see an advice worker to discuss his past alcohol consumption but, when she attempted to see him in his cell, he hid under his bedclothes and shouted for her to go away. He refused to take the haloperidol and was prescribed amitriptyline instead.

After being assessed as a category C prisoner, the man was transferred to HMP Guys Marsh on 8 March. The man shared a cell with other prisoners despite previous Cell Sharing Assessments. He kept himself to himself and rarely associated with other prisoners.

Guys Marsh operates an Incentives and Earned Privileges Scheme (IEPS), a three-tier system for encouraging and rewarding positive behaviour in custody. The man was at the standard level, which is the middle tier. He was downgraded to basic on 27 March 2007 for refusing to work. Following this, the man was offered another job on the prison farm and returned to work. This did not last, and he was dismissed for failing to attend work regularly. He was again downgraded to basic on 18 June.

On 30 June, the man took an overdose of his amitriptyline tablets, an anti-depressant that can cause drowsiness as a side effect. He was taken to hospital. An Assessment, Care in Custody and Teamwork (ACCT) document was initiated by staff. (This is part of a system that supports and cares for prisoners who are at risk of self-harm or suicide.) Later that day, the man had to be restrained by the prison officers who were escorting him to the hospital after he attempted to punch nursing staff. The man told other officers that he wanted to harm a senior officer (SO) and would do so when he was released if necessary.

The man returned to Guys Marsh the next day. He was moved to the segregation unit, as it was felt he could not return to his usual wing after making threats to the senior officer's safety. He told an ACCT assessor, who saw him on his return to Guys Marsh, that the overdose had been a cry for help as he had been bullied by staff and prisoners. The man was in the segregation unit for four days. His conduct remained challenging. He often covered his head with a blanket and refused to talk to staff. The Guys Marsh's General Practitioner (GP) became concerned about the man's behaviour, especially when he saw copies of two complaint forms the man had made, alleging that the senior officer had made death threats against him and encouraged prisoners to kill him. The GP arranged for the man to be transferred to HMP Dorchester for a mental health assessment.

The man continued to exhibit problematic behaviour at Dorchester. He would stay in his cell and cover his head with bedclothes, and turn his back on staff. He was fixated in his conversation with the belief that he had been persecuted at Guys Marsh.

On 13 July, the man was seen by a second psychiatrist who thought that the man was displaying behaviour consistent with Asperger's syndrome (a condition that manifests itself in difficulties with communication, behavioural and social interaction), but was not at risk of self-harm or suicide. The man's ACCT was closed that day and a post-closure review was arranged for 20 July. The man would not speak to the Safer Custody Manager who was leading the review, so it was postponed to 27 July.

On 24 July, the man's application for early release under the Home Detention Curfew scheme (which allows prisoners to be released early provided they comply with certain conditions) was turned down.

During an early morning roll count on 27 July, the man was discovered suspended from his cell window by a bed sheet. The ligature was untied as it was too thick to cut. When the man was placed lying down, it was clear that rigor mortis had set in so staff decided not to try to resuscitate him.

Two notes were found on the man's bed. One read: "The night guard and inmates killed me the night of 26-7-07 and got rid of my body in refuge truck." The other said: "The night guard killed me with a knife after 4.30am."

An inquest took place on 9-10 April 2008. The jury returned a narrative verdict that it was not possible to determine if the man intended to take his own life as his disturbed state of mind may have led him to a cry for help which went "tragically wrong." The Coroner wrote to Guys Marsh following the conclusion of the inquest to confirm that the prison would look at the man's written complaints which were not previously investigated.

THE INVESTIGATION PROCESS

1. My investigator visited Dorchester twice. She met the Governor and was given access to the man's prison records, including his medical records, statements from staff and other documentation concerning the aftermath of the man's death. My investigator also visited Guys Marsh to interview staff.

2. Notices to staff and prisoners announcing the investigation were displayed around the prison. My investigator met with representatives from the Independent Monitoring Board and the local branch of the Prison Officers' Association to offer them the opportunity to raise relevant issues.

3. My investigator contacted Dorset Police. The police are content that there were no suspicious circumstances and no third party involvement in the man's death.

4. One of my family liaison officers made contact with the man's family. On reading a draft version of this report, his family commented that they had contacted Swansea, on learning that the man had been taken there, to say that he had Asperger's syndrome and would not be able to survive in prison. They noted that comparatively little was recorded about the man's time at Guys Marsh given that his behaviour was said to be difficult. They were concerned about the length of time it took for the man to see a doctor for a mental health review. They expressed concern about the seeming reluctance of the Prison Service to acknowledge that the man had Asperger's Syndrome. At the inquest into the man's death, the man's parents also spoke about the distress they had felt when an unidentified member of staff at Guys Marsh had spoken to them in an insensitive manner about the man's overdose.

5. A clinical review was requested from Dorset Primary Care Trust (PCT). I am grateful to them for carrying this out.

6. HM Coroner for the Western District of Dorset was informed of the nature and scope of my investigation and provided with a copy of my draft report. After the conclusion of the inquest, the Coroner wrote to Guys Marsh. He said he took it that the man's complaints would be investigated and that he would be told of the outcome. Guys Marsh commissioned a principal officer on 28 April 2008 to carry out the investigation. The principal officer completed his investigation report on 10 November 2008. He concluded that there was no evidence to support the allegations made by the man.

HMP DORCHESTER

7. HMP Dorchester is a small Victorian prison in the centre of Dorchester which holds up to 260 prisoners. It is undergoing a major programme of modernisation and refurbishment, due to be completed in December 2008. Dorchester is a local prison, which means it receives adult men and young offenders who are remanded in custody or sentenced to imprisonment by the courts of Dorset and the South West. It holds approximately equal numbers of remand and convicted prisoners.

8. The main prison buildings are compact. Prisoners are held in four wings, three of which radiate from a central hub. A and B wings hold remand and convicted prisoners, C wing operates mostly as a first-night centre, and D wing provides accommodation for those segregated for their own protection or for the good order of the prison.

9. Her Majesty's Chief Inspector of Prisons, Ms Anne Owers, inspected Dorchester in April 2004 and this was followed up by a short unannounced inspection in April 2007. Her inspection report described a:

> "… small, old overcrowded local prison – holding around two-thirds more prisoners than it should. In spite of the considerable pressures, managers and staff had made progress in some key areas … Support for those at risk of suicide or self-harm demonstrated a multi-disciplinary approach and an in-depth knowledge of prisoners at risk … Relationships between staff and prisoners remained good, though proactive personal officer work was under-developed."

Her report continued:

> "The management of suicide and self-harm prevention was good. The quality of assessment, care in custody and teamwork (ACCT) documentation showed a depth of knowledge of prisoners in crisis. However, as at the previous inspection, prisoners could not access Listener (peer supporters) at night."

In light of the Chief Inspector's findings, I have been pleased to learn that by the end of April 2008 prisoners in crisis will be able to see a Listener on a 24-hour basis.

10. Healthcare at Dorchester is commissioned by Dorset PCT. Dorchester also provides 12 places for 24 hour in-patient care for prisoners at HMYOI Portland, HMP Guys Marsh and HMP The Verne. These are lower security prisons where those facilities do not exist. (These prisons are known as the Dorset prison cluster.) The 2007 report from the Chief Inspector of Prisons recommended that the policy of prisoners keeping their own medication in-possession at Dorchester (as opposed to collecting it daily from the healthcare centre) should be reviewed, with a view to increasing the number of prisoners receiving medication in this way. It also recommended that there should be a documented risk assessment for in-possession medications. In contrast, most

11. The 2007 annual report by Dorchester's Independent Monitoring Board (IMB) said the prison had a record of which it should be proud. The IMB said that Dorchester had continued to improve in every area. In relation to the safer custody of prisoners, it described the operation of ACCT as increasingly effective in picking up early warning signs of prisoners at risk of self-harm.

12. Since I took over responsibility for investigating all deaths in prisons in England and Wales in April 2004, there has been one self-inflicted death at Dorchester. This occurred in 2005. I made several recommendations as a result of that investigation and they were accepted by the Prison Service. None has particular relevance to the man's death.

KEY EVENTS

13. On 2 December 2006, the man was remanded in custody for pre-sentence reports after being convicted of arson with intent to endanger life. Whilst drunk, he had set fire to a sofa in his flat and then gone out to a pub. He telephoned the police to let them know about the fire.

14. The man was taken to HMP Swansea. On reception at Swansea, the man was interviewed by a healthcare worker. This is a normal procedure for all newly received prisoners so that any health concerns can be identified and addressed. In response to set questions, the man said that he had seen his doctor in the last few months for depression and had been prescribed librium and amitriptyline. In response to questions on substance use, the man said that he did not use drugs but was an alcoholic. He said he had not drunk for the previous four days. He was asked whether he felt like harming himself and replied that he did not. The box to indicate 'nil of note' regarding appearance was ticked.

15. The man was asked standard questions as part of a Cell Sharing Risk Assessment (CSRA). He disclosed that his previous offence involved issues of racism, described himself as a person who got angry or frustrated quickly, and said he would not want to share a cell with a gay prisoner. As a result, the man's risk to others was assessed as high and he was given a single cell. The man was interviewed by his wing manager the next day. The man told him that he had fought with two cell mates at a previous prison. The wing manager wrote in the man's record that, although the man did not come across as a violent man, he was very strange. He put in place a risk-minimisation plan which meant the man would remain as a high-risk prisoner until he had been assessed by a mental health nurse. The man had an induction interview, which is designed to explain important information about the day-to-day running of the prison to new prisoners. The interviewing officer wrote a summary of initial observations that said: "a bizarre individual who expressed racist and homophobic views during interview, but was polite and compliant. Will probably find it difficult to settle into prison regime." The man's father told my investigator that when he learnt that the man had been sent to Swansea, he telephoned the prison to say that his son had Asperger's Syndrome and would not be able to survive. However, there is no written record of his call or its contents being logged.

16. On 16 December, the man was described in his record as displaying odd and paranoid behaviour and as being difficult to communicate with. He was "aggressive and abusive" when unlocked for his evening meal.

17. According to the man's clinical record on 17 December 2006, Swansea's healthcare centre received a request from a member of staff on the man's wing for a mental heath assessment. On 18 December, the man completed a referral form for the Counselling Assessment Referral Advice and Throughcare Service (CARATS) which offers prisoners support with substance misuse issues. He wrote that he wanted to give up drinking for good and stop reoffending. On 22 December, the man was seen by a mental health nurse

18. The man was seen a few hours later by a Specialist Registrar in Forensic Psychiatry. The man said that he should not be in prison and that he had been "going with the wrong crowd" which led to him getting into trouble. The forensic psychiatrist's notes in the clinical record describe the man as irritable, with paranoid beliefs against his lawyer and the judge. The man denied hearing voices or having thoughts of harming himself. The forensic psychiatrist drew up a care plan to continue observation in the healthcare centre, to stop amitriptyline, prescribe 5mg of haloperidol (an anti-psychotic drug which produces a calming effect and controls aggression), and to follow up in two weeks.

19. On 28 December, the man's clinical record noted that he was wrapped in a blanket on his bed and would not respond to staff. Later that day he would only respond in monosyllables and would not make eye contact. The next day, when in the healthcare centre for interview, the man faced away from staff, would not communicate verbally, and after several minutes he left the room. He was seen to talk to other prisoners, so it was thought best to leave him on an ordinary wing rather than take him to the healthcare centre. A request was made for him to see a psychiatrist as soon as possible.

20. The forensic psychiatrist saw the man later that day, but the man refused to come out of his cell or to speak. The psychiatrist sought information from wing staff as to the man's behaviour. He learnt that the man did not exhibit hallucinatory behaviour but stayed in his cell, was regarded as 'strange', and there had been one instance when he had been aggressive for no apparent reason. The man's care plan was that his behaviour should continue to be monitored. He was prescribed procyclidine (an anti-psychotic drug used to treat the side effects of other anti-psychotic treatments) should there be side effects from the haloperidol.

21. The man's GP contacted Swansea on 29 December, after a request for more information. The GP said that the man had a history of behavioural problems dating from 1984. In 2002, the man had seen him about long-standing insomnia. In May 2006, the man had been referred to his local alcohol service for alcohol problems. In June 2006, the man was referred to his local community mental health team, but the team did not feel he met its criteria.

22. On 1 January 2007, the man's behaviour on normal location was observed by a nurse who noted in his clinical record the observations of an officer who had managed to establish a relationship with the man. The officer told the nurse that the man would:

> "… engage with only a few people … he is very talkative @ [at] times – then he will disengage, retreat to his cell and cover his head with a blanket … content of conversation will be driven by him, any attempt to change the subject he will return to what he wishes to talk about."

23. The man had a one-to-one session with a CARATS worker on 15 January about his past alcohol consumption. Although he was referred to a wing-based alcohol awareness group, he did not attend it although he continued with one-to-one sessions.

24. On 19 January 2007, an entry in the man's clinical record said that there was no evidence of depressive illness. The man had not expressed thoughts of self-harm and there was no evidence of psychosis. The man was seen by the psychiatrist on 25 January for the purposes of preparing a psychiatric court report at the request of the man's solicitor.

25. The man told the psychiatrist that he struggled to fit in at school and described behavioural problems. He had been placed in care aged 14 as his parents could not manage his truancy from school. He had moved away from home and trained as a painter and decorator but this work was interspersed with long periods of unemployment. He had become depressed in his mid-twenties following the breakdown of a relationship. He had been prescribed amitriptyline, but he found it to be ineffective. The man said he consumed up to eight pints of beer and a number of shorts a night and, although he had tried to stop drinking periodically, he had not managed it for more than a few months. He had experienced withdrawal symptoms in the past when he stopped drinking. The man acknowledged that his consumption of alcohol was a factor in his offending and said he intended to abstain from alcohol in the future.

26. The psychiatrist's opinion was that the man's:

> "… account of his early life is consistent with a diagnosis of conduct disorder. His behaviour as a teenager and in adulthood is consistent with marked avoidant and dissocial personality traits. The man's presentation as an adult has been strongly influenced by his persistent and harmful use of alcohol … The man has suffered from depression intermittently in his adult life … I regard his personality as being vulnerable to depression. He appears to have very poor coping strategies for the frustration and anger which arise from his personality difficulties."

27. The psychiatrist concluded that the man did not: "currently suffer from a mental disorder of a nature or degree to warrant a hospital disposal in this case."

28. On 2 February, the man was sentenced to 18 months imprisonment at Swindon Crown Court. He was taken to HMP Bristol and the next day was referred to Bristol's mental health team for an assessment of his depression. The man told the mental health nurse who saw him on reception that he had refused to take haloperidol and procyclidine, the anti-psychotic drugs prescribed previously, because they made him feel ill. The man was assessed as not being at risk of

29. Due to his breach of community rehabilitation orders in the past and his current offence, the man was assessed on 9 February as not suitable for an open prison.

30. The man was given a job in the kitchen, but had to be removed due to mental health and 'racism issues', although his prison record does not elaborate on what these were.

31. On 19 February, a CARATS worker attempted to see the man but he hid under the bedcovers and shouted at her to go away. He said that he was not interested, but refused to get out of bed or say why he did not want to engage with her. The CARATS worker emailed the man's probation officer to say that she would contact the man again in four weeks time to see whether he would change his mind.

32. The man made another application to CARATS on 27 February. He was seen on 6 March and discussed his drinking habits in detail. A care plan was drawn up for him to attend an Alcoholics Anonymous group on the wing, have one-to-one sessions, and make contact with a local group in preparation for his release. The man was asked about issues of self-harm and suicide, but said that they were not applicable to him.

33. On 7 March, a third nurse wrote an entry in the man's clinical record concerning the additional records that had been received from the man's GP. She concluded that the man's primary problems were alcohol abuse and personality/anger management and, as he was due to be transferred to HMP Guys Marsh, he should be discharged from the mental health services team.

34. The man was transferred to Guys Marsh, a category C prison in Shaftesbury, on 8 March. He was seen by a healthcare worker on reception. As no particular health issues were identified, the man did not see a GP. He was also interviewed by an officer as part of Guys Marsh's arrangements for managing new prisoners, but no self-harm concerns were identified. A CSRA was completed, but previous CSRAs appear not to have been consulted as the 'no' box was ticked in response to the question about racist or homophobic crime. The question on unpredictable/unexplained aggression was also answered 'no'. The man's risk of harm to others was assessed as low and, though he said he would prefer not to share a cell, he was told that he would initially have to.

35. The man's CARATS file was suspended on 16 March as he had been referred to an alcohol worker and did not have problems with other drugs.

36. On 25 March, a comment was written in the man's Record of Events that he had settled on the wing and was in a triple cell. The note: "does not associate with others often" was also in the record

37. Guys Marsh, in common with all prisons, operates an Incentives and Earned Privileges Scheme (IEP). There are three levels: basic (which is the lowest), standard and enhanced (the highest). The scheme rewards well behaved prisoners with greater access to privileges and services. Misbehaviour leads to warnings and eventual downgrading. The man started on standard but was downgraded to basic on 27 March for refusing to work. His record does not expand on the circumstances surrounding his refusal. When the man was told the decision of the Regression IEP Board he replied: "I might find a job but not at the moment." The man was offered a job working on the prison farm on 28 March, to which he agreed. On 29 March, the man attended work but on Friday 30 March he would not go to work, saying that he wanted to speak to his probation officer as he had not heard from her. From Monday 2 April, the man returned to work. After an IEP review on 12 April, he progressed back to standard.

38. The man completed an application on 21 May for release on Home Detention Curfew (HDC). He wanted to return to Oxford and asked to be able to reside at Approved Premises (a hostel managed by the National Probation Service). He had been eligible for HDC since 18 April.

39. On 23 May, the man saw a doctor for a mental health review. The man said that he was sleeping better and was working on the prison farm. The doctor prescribed amitriptyline and cetirizine tablets, which the man said he wanted to continue. On 29 May, the man was prescribed more amitriptyline and cetirizine.

40. The man's attendance at work gradually diminished and he was dismissed from his job at the farm for failing to attend regularly. A comment in the man's Record of Events written on 17 June read: "Doesn't work. Doesn't associate. Doesn't speak unless absolutely necessary. Basic prisoner, probably remain so until discharge." The man told the Regression IEP Board that he did not like his job. He was downgraded to basic on 18 June. This meant that he would be allowed a limited range of activities and would only be permitted association with other prisoners twice a week.

41. My investigator interviewed the senior officer, a manager on Wessex wing, and asked him what the man's behaviour was like. He said:

> "Keeping himself to himself and not mixing with a large group of prisoners who are on the wing. He would often sit in his cell and watch telly in the evening and not associate with other prisoners. Staff interacted with him as much as they could and obviously keep a close eye on him because we felt that he was unstable as well, where he's on medication. Staff on my wing were particularly good at that, they'd give

him support ... my staff are better, not trained, but understand it perhaps a little bit more."

42. The senior officer said that, occasionally, the man would "shout and rave" and then would become quiet again. He was withdrawn, seemed to have a mental disability and spent a lot of his time sleeping. He did not think that the man had been bullied or victimised and felt that staff would have picked this up if it had been the case. Asked if it was possible that the man was withdrawn because he was being bullied, the senior officer replied that he was not being bullied to his knowledge and there was no foundation to the man's allegations that death threats had been made against him. The senior officer added that, although the man had been downgraded to basic under IEP and therefore was not entitled to have a television, he had allowed the man to have one because he thought it would alleviate his loneliness. My investigator asked the senior officer if he had ever been asked about the allegations on the man's complaint form. He replied that he had not.

43. On 20 June, the man was prescribed 28 amitriptyline tablets and 28 cetirizine tablets in-possession. Comments in the man's Record of Events around this time describe him as polite, well behaved, quiet and "keeping himself to himself". On 24 June, the man asked about finding a job. It was arranged that he would start an education course on 2 July. Although there is no record of the man's television being removed, a second officer rote in the man's Record of Events on 27 June that he had been given back his television because he would be starting the education course.

44. On 28 June, a Public Protection Panel meeting was held to discuss the man's release plans. Panels plan for the risks associated with the release of possibly dangerous offenders under Multi-Agency Public Protection Arrangements (MAPPA). (This is a three-tier system with offenders graded between level 1 (relatively low risk), level 2 (medium to high risk, but not imminent) and level 3 (high risk).) The man had previously been assessed as MAPPA level 2. The meeting was attended by a senior probation officer and two public protection probation service officers. It considered a report written by the man's probation officer, that collated information about his behaviour, mental health, attitudes and thinking. It revealed that the man had attempted to take his life by taking pills at a friend's house a year previously. The report identified risks associated with the man's impending release at the end of August in terms of anger management and alcohol misuse. It concluded that the man presented a high-risk of harm to the public.

45. The man telephoned his father on 29 June at 7.38pm. He was heard by a third officer to say that he was being forced to take valium and was hallucinating, feeling paranoid and felt that his life was under threat. The officer wrote his observations in a Security Information Report (SIR) which was evaluated on 2 July. No other action was taken.

46. At 7.25am on 30 June, a fourth officer arrived on the wing as the first day member of staff. He began a roll count of the wing. When he got to the man's cell, the man tapped on his door observation panel and said that he wanted to

47. A fifth officer arrived on Wessex wing at about 8.10am. At about 8.25am, the man rang his cell bell and the officer answered. The man told him that he had taken an overdose of 50-55 amitriptyline tablets about ten minutes previously. The man walked immediately to the healthcare centre with the officer, but then appeared disorientated quite quickly. The officer gave healthcare staff empty packets of amitriptyline found in the man's cell. According to the man's clinical record, most of the tablets appeared to have been freshly removed. The man appeared distracted and had a pattern of standing up, touching the desk and then touching his hair. He gave the impression that he had a learning disability. The man told staff there that he had taken the tablets at 8.00am and that he "wanted to end it" because he was not getting on with other prisoners because they called him a "nutter".

48. The man's pulse and blood pressure were taken. It was decided he would need to go to the Accident and Emergency Department of the local hospital as he was becoming very drowsy and had to be roused. An emergency ambulance was called and the man was treated in the ambulance before being taken to Yeovil District Hospital with a sixth officer and a Physical Education Officer. Guys Marsh regarded the man's condition as serious and his family were told of his overdose by telephone. The man's family told my investigator and Family Liaison Officer that when Guys Marsh telephoned them, on asking whether the man would be alright they were told that he "deserves what he gets." The comment left them feeling helpless, angry and distressed. They did not know the identity of the person who had spoken to them.

49. The man was treated in the Intensive Therapy Unit. When he moved to another bed, he became aggressive. Both officers described their actions in Use of Force forms, completed after they had returned to the prison. They said that the man became agitated and abusive to them. They tried to de-escalate the situation by talking to him to calm him down, but the man struck out at the nursing staff and at the physical education officer with a clenched fist. He was restrained by both officers taking hold of his arms and applying Control and Restraint techniques, pinning him to his bed. After what was described by the physical education officer as "a short struggle", the man became compliant.

50. A seventh and eighth officer took over the task of guarding the man in hospital. The seventh officer submitted a SIR on 1 July. It said that, throughout their time at hospital in Yeovil, the man had made threats to the first senior officer's life. The man said that, if he did not get him in Guys Marsh, he would wait for the SO after his release to find out where he lived. The man added that, if his

51. On 1 July, the man returned to Guys Marsh. The discharge information accompanying him said that the man was not suffering adverse effects from the overdose. He had been monitored for 24 hours, was stable and should miss one day's dose of medication. He was placed on Tarrant wing, which is a segregation unit where a small number of prisoners may be located for reasons of good order or discipline, or in their own interest. The Registered General Nurse (RGN) assessed whether the man was suitable to stay in Tarrant wing by using an Initial Segregation Safety Algorithm. This asks standard questions to which the person conducting the assessment has to answer 'yes' or 'no' in the form of a flow chart. The RGN concluded that there were no healthcare reasons not to segregate the man at that time. The man was segregated under Prison Rule 45 in his own interest, although there is no indication that the man had asked for this. The form giving the reason for his segregation stated that it was: "… pending an investigation into allegations and threats you have made towards the first senior officer." It authorised his segregation until 3 July.

52. The RGN wrote in the man's clinical record that she:

> "… spoke with the man who told me he felt well, had no injuries and was pleased to be in seg [sic] unit. Advised to drink plenty of fluids and rest. The man neither engaged, or held little eye contact with me during our conversation, and frequently went off conversation tangent returning to previous allegations of bullying by senior wing officer … Discharged from hospital without psychiatric assessment as reportedly demonstrated threatening behaviour towards hospital nursing staff. Algorhythm [sic] completed, advised he will see the prison doctor tomorrow am, and RMN input also."

53. Due to the man having taken an overdose, an Operational Support Grade (OSG) was asked to see him in her role as an assessor for the ACCT process. (ACCT is an interactive case-management support system that identifies and cares for prisoners at risk of suicide and self-harm. It provides for a prisoner's risk to be assessed and for individual case reviews to be held with staff who know the prisoner's circumstances best.)

54. The OSG visited the man in Tarrant wing to assess his situation, and wrote his answers in the ACCT document in the assessment interview section. The interview took place in a meeting room, and the OSG was accompanied by another officer due to concerns about the man's aggressive behaviour at the hospital the previous day.

55. The man told the OSG that he had experienced several problems when he was on Wessex wing. He said that he was being bullied and harassed by prisoners, had been physically abused, and had received death threats. He added that some of his belongings had been taken and he had been bullied by staff. Asked why he had taken the overdose, the man replied that it was a cry for

56. Asked whether he had attempted any other acts of suicide or self-harm in the past, the man replied that he had taken an overdose two years previously. At interview, my investigator asked the OSG for more information about the man's reply. She said that the man did not want to say much about why he had taken the overdose, and said he did not know why. The man denied having any current thoughts or plans to commit suicide and said he wanted to be alive. My investigator asked about the man's demeanour, the OSG replied:

> "He certainly was quite happy to talk to me. I did find it slightly difficult talking to him. He made very little eye contact. He would stare towards the ceiling and off to one side, very occasionally glance at you. And he quite often would break out into laughter at strange times. He'd be talking about violence and [said] if he wasn't in prison that he may have dealt with this situation in a different way and then he would break out laughing and then repeat himself quite a lot."

57. The OSG told my investigator that, nevertheless, the man had seemed coherent and insisted that he had been bullied. He had named two or three prisoners involved and said that another prisoner, who had been released, had looked out for him on the wing. The man felt that the problem was on Wessex wing and that he wanted to be transferred to HMP Erlestoke, in Devizes, which was nearer to his family. The OSG completed an SIR giving details of the officers and prisoners the man had named. The intelligence assessment section of the report was completed by a security officer who suggested that the man be interviewed and should not return to Wessex wing. A governor, whose signature is illegible, commented on the form that the man was awaiting a mental health assessment, was not communicating, and could not be interviewed with any success.

58. A case review took place immediately after the man's assessment interview. The man attended along with a governor, a senior officer whose signature is unclear, and the OSG. The review team concluded that the man's risk of self-harm was raised and that an urgent referral for a mental health assessment should be made. They decided that the man should be observed every 30 minutes. Concerning the allegations that the man had made about bullying, the review team referred them to the security department for investigation and asked the man to complete a complaint form.

59. On 2 July, a nurse from the in-reach mental health team went to see the man. He put his head under his blanket and would not talk to her. However, two hours later, the man asked to see her so she went back to talk to him. The man gave the nurse an overview of his life, talking about his alcoholic history, his relationship breakdown, and subsequent offending behaviour. On 3 July, a case review was held about the man. The nurse and the man's case manager, attended but the man refused to do so. It was decided that the frequency of the man's observations should be raised to every 15 minutes, his case would be

60. Later that day, a Segregation Review Board considered the man's circumstances. The review took place in the man's cell, as he would not leave the cell to attend it. The documentation says that the man was being held in the segregation unit for his own protection. It described his behaviour since the previous review on 1 July as "not communicating with staff at all" and set the behaviour target for him to progress out of segregation that he should "abide by seg [sic] rules". A note was made that the man was awaiting a mental health assessment. The board decided that segregation should continue and would next be reviewed on 16 July.

61. On 4 July, the ongoing record in the man's ACCT document described him as being relatively chatty. At 3.30pm, the man cleaned his cell and appeared to be a "little more sociable". At 4.20pm, the Community Psychiatric Nurse (CPN) visited the man in his cell with the mental health in-reach team nurse. According to the ACCT document, the man immediately covered himself with a blanket. They offered him verbal reassurance for about ten minutes that they were there for his benefit, but he would not speak to either nurse. An ACCT review took place that day involving the man, his case worker and a senior officer who had agreed to attend. The man's behaviour was described as "very talkative". He said that he had no intention of harming himself and asked about his possible release on HDC, an early release scheme for prisoners serving under four years. The man agreed not to cover his head with a blanket. The review decided to reduce the frequency of observations to once an hour, with at least one documented conversation in the morning and the afternoon. The next ACCT review was scheduled for 11 July with a member of staff from the healthcare centre to be present.

62. On 5 July, the man reverted to hiding under his bedclothes. The prison doctor saw the man at 9.30am. The man would not speak to the doctor and stood staring at the wall. The man told a ninth officer that he wanted to be left alone and did not want to eat "shit" food.

63. At 12.10pm, the prison doctor wrote in the man's clinical record:

> "Variable presentations, occasionally withdrawn, unwilling to speak to staff, hides under his blanket, other times he seems fine, asking for his tobacco, communicating normally, was bullyed [sic] at work, unable to assess his mental state due to lack of engagement, my impression is that there might be an element of depression, he has very poor social skills and possibly needs a formal IQ testing. I was never able to elicit any psychotic features, but I would not rule it out especially that he used a lot of drugs in the past."
>
> "We're in a situation where we cannot make out what the exact problems are, I believe in-reach team were involved (no entry) but he refused to engage. In view of the serious amitriptyline overdose and for the patient's own interest and the prison justified demand for a clearer

course of action, it was agreed that transfer to Dorchester would be advisable. We would be grateful for their in-reach intervention and advise on appropriate course of action. Dr has kindly accepted his transfer."

64. The Prison Service's complaints procedure allows prisoners to make written complaints which are posted by them into a dedicated sealed box to which wing staff have no access. The box is emptied daily by the Complaints Clerk who logs each form and assigns it a serial number. The Clerk then directs the form to an appropriate member of staff for a response. If the complainant is unhappy with the response, there is an appeals process. The man made two complaints on formal complaint forms (Form Comp 1) on 5 July. The man's first form read:

> "The SO from Wessex House has been making death threats to me, trying to get me to kill myself, getting other prisoners to attack and threaten me and exstort [sic] money from me or blackmail me. Getting 1 prisoner to steal soap, shower gel, razors, gel, body lotion and stamps from me."

65. In response to the section on the form that asks what the complainant would like to be done, the man said: "I was told they were letting all the prisoners out to murder me by the 8-7-07. To put a stop to all this madness and hassle completely."

66. At the top of the form, the man wrote: "I would like this matter reported to the police". He followed this up with another form which said:

> "The staff on Wessex House were helping the SO with all his badness. They also said a £10,000 contract has taken out on me to kill me. And the other prisoners will do it for him. The staff were also threatening me with a knife."
>
> "I was told by a member of staff that the SO threw 3 of my solicitor letters in the bin."

67. The man's complaint forms were not issued with a serial number and he did not receive a response. At 12.58pm, the prison doctor placed a copy of one of the man's complaint forms in his clinical record. He commented in the record in capital letters: "please refer to patient's complaint letter, there are obvious delusional ideations about officers wanting to kill him."

68. Later that day, the man was transferred to Dorchester for observation in the healthcare centre as a 24-hour in-patient. He was placed in an observation cell monitored by a closed circuit television camera. The man was told that he was only at Dorchester for a mental health assessment and would still be a Guys Marsh prisoner. The man's clinical record said that he made good eye contact and responded during conversation. The man remained on hourly observation as he was still on an ACCT document.

69. A fourth nurse attempted a mental health assessment the next day but the man refused to engage with him except to say “no” or “fine”. The nurse queried in the man’s clinical record whether he was exercising a degree of manipulation.

70. On 8 July, the man asked for a razor at 1.00pm. He was told it was not possible at that time as it was lunchtime, but when he was offered one at 3.00pm, he would not respond. Staff entered his cell and shook him and then he covered his head with a sheet, but did not say anything. Later, the man was seen following his nightly routine by washing and folding his clothes in the same precise manner.

71. The fourth nurse saw the man on 9 July to continue the mental heath assessment. The man said that he did not have current thoughts of self-harm. He described his overdose at Guys Marsh as a cry for help and a way to move to another prison. He talked about alleged persecution by the first senior officer and other prisoners, and would not speak about any other topic. The fourth nurse’s notes said that the man’s thinking was concrete and rigid. He queried whether the man might have a possible mental illness, learning disability or an “Asperger’s type disorder”. The man agreed to move out of the healthcare centre to normal location, but the fourth nurse commented in his notes that the man’s ability to engage socially was extremely limited. He did not listen to others when they spoke, ignored direct questioning, and talked over other people unless repeatedly told to listen to what was being said.

72. An ACCT case review was held the same day. The reviewers described the man as spending a lot of time in his cell not communicating. Talking to him was “one-sided” as he would only talk about people at Guys Marsh whom he felt had treated him badly. The man had not expressed any thoughts or actions of self-harm since arriving at Dorchester, and was starting to engage with staff and have brief conversations with other prisoners. It was decided to reduce the frequency of his observations to twice a shift (i.e. morning, afternoon and evening) and four times during the night as he. The next ACCT review was set for 13 July.

73. On 10 July, an entry in the man’s Record of Events read: “… declined association, declined lunch no reason given, refused to engage in any conversation.” The man was asked by a fifth nurse how he was. The man was lying on his bed reading but, when the nurse spoke to him, he covered his face with the book.

74. The man was seen by the prison doctor, a psychiatrist, on 13 July. He also found that the man thought in a rigid manner, failed to acknowledge social cues, and did not maintain good eye contact. He considered the man’s presentation consistent with Asperger’s syndrome. He could not see a rationale for keeping the man in healthcare. Shortly afterwards, an ACCT review was held which the man attended along with two of the nurses The man’s level of risk was identified as low and, as he said he had no thoughts of suicide or self-harm, his ACCT was closed. A post-closure review was scheduled for 20 July.

75. On 16 July, the man submitted a complaint form concerning his trainers which had been left behind at Guys Marsh when he was transferred to Dorchester. The man met with a CARATS adviser on 17 July. CARATS wanted to see him as he was new to Dorchester and had arrived there after his overdose.

76. The second psychiatrist wrote to the man's mother on 17 July, asking for some background information on her son so that he would be able to arrange appropriate support as there had been concerns about how he was managing at Dorchester. One of the man's brothers faxed the second psychiatrist a medical report written about the man in 2005 by a Consultant Psychiatrist and Clinical Director for specialist services with the Oxfordshire Community Mental Healthcare Trust. The psychiatrist described the man's history and presentation as compatible with a diagnosis of Asperger's Syndrome. He singled out four features in particular – "a lifelong and profound inability to integrate with his family and peers in school and work settings …profound difficulties in understanding other people's feelings … marked clumsiness in childhood … recurrent misuse of telephones (involving calls to emergency services and more recently to those who upset him, long documented in his psychiatric records) since childhood is perhaps suggestive of such a tendency." He added that formal assessment of the man for Asperger's Syndrome would probably best be undertaken by a specialist in learning disability.

77. The man received a response dated 20 July that Guys Marsh staff had looked for his trainers and were unable to find them, and that the man was responsible for looking after his own property. On 20 July, a comment in his Record of Events read: "chooses to engage in only activities on the unit very infrequently, not very communicative or social person." A post-closure ACCT review was due to take place, but the man would not speak to the Safer Custody Manager, who was leading it. It was rescheduled for 27 July.

78. On 21 July, it was agreed that the man would not be returning to Guys Marsh. He was described as: "withdrawn and almost hermit-like, but can be very talkative when he wants to!" The man moved from the healthcare centre that day to the first night centre on C wing as a temporary measure, as it had a single cell available. The man was still regarded as high risk for cell sharing purposes.

79. A first night centre officer described the man's demeanour to my investigator. She said that the man was very withdrawn and would often refuse meals. If she brought food into his cell, he would turn his back to her and not make eye contact. The man would clean his cell and have a shower, but would not go out to exercise with other prisoners. The man spent four days in the first night centre. Some days he would talk to staff and be quite loud; on others he would say nothing.

80. On 24 July, the man's application for early release under the HDC scheme was turned down by the Deputy Governor (The HDC scheme allows prisoners serving under four years the possibility to be released early provided they wear an electronic tag and comply with a curfew.) The grounds for refusal were that the man's "risk of re-offending presents an unacceptable risk to members of the

81. When the first night officer told the man on 25 July that he would be moving to B wing, the man was quite happy to go. The man was allocated cell B2-02. It was opposite the staff office on B wing and near to the hub of the prison. The man saw his doctor that day. According to his clinical record, he said that he did not want to be prescribed amitryptiline again because it "messes up his head." He said that "the whole system was out to get him" and "how everybody was pissing him off."

82. On 26 July, the man attempted to telephone his parents' home at 8.02am but the prison telephone had not been activated. Between 10.25am and 10.34am he made two short telephone calls to his parents' home, lasting just under two minutes each. In the afternoon, he rang his parents' number at 3.12pm and then made two short calls to his solicitor.

83. Dorchester operates a system where A wing and B wing prisoners have the opportunity to socialise (associate) on alternative evenings from about 6.30pm to 8.30pm. On the evening of 26 July, B wing prisoners were locked in their cells at about 5.00pm after having their evening meal. At about 7.30pm, the man rang his cell bell. The tenth officer opened the man's door and asked him if he was alright. The man replied that he was and asked about noises he could hear. Having been reassured that it was the sound of the prisoners on A wing having association, the man accepted the officers explanation and shut his cell door.

84. Two OSG's took over night duty from the day staff. The third OSG was interviewed by an officer from Dorset Police on 1 August. The OSG told the officer that, at about 9.00pm, he had conducted a visual roll check of the landing and had looked into each cell to make sure that a prisoner was present. He did not recall whether he or the other OSG on duty saw the man. He was confident, however, that all the prisoners had been accounted for and there were no problems.

85. At about 5.55am, the two OSG's reached B2 landing, having started to count the prisoners at about 5.45am. The third OSG opened the hatch on the door of the man's cell. He saw the man hanging from the window bars at the far side of the cell by a sheet. He turned away in shock and called the second OSG who was checking the cells on the other side. The second OSG looked through the man's hatch. Having confirmed what they had both seen, the two OSGs ran down to the nearby ground floor office where a second senior officer was based.

86. The second OSG then went into the healthcare centre office which was adjacent. He told the staff nurse and the Healthcare Assistant that a prisoner was hanging. The second senior officer and an eleventh officer ran upstairs and tried to open the man's cell. This was difficult at first because the man had placed his cell furniture (a table and two wooden cabinets) between his fixed bed and the cell door as a barricade so that the door would not open easily.

87. The man was suspended by a bed sheet wrapped around his neck twice and threaded through the meshing over the window. His feet were touching the ground. The second senior officer described the man to the police as being very cold and stiff when he tried to lift him up. The senior officer supported the man's weight whilst the eleventh officer tried to cut the ligature. It was too thick to be cut by the ligature-cutting tool the officer was carrying, so he had to untie it by hand. The man's wrists appeared to have cuts on them but there did not appear to be a large amount of blood in his cell, although the sheet had blood on it. The man's head was turned to the side in a fixed position and his skin colour was grey.

88. The man was lowered to the floor of his cell. The staff nurse checked for the man's pulse but was unable to find one. At interview, she told my investigator that advanced rigor mortis was present and it was obvious that the man was dead. She decided not to attempt resuscitation.

89. An ambulance was called at 6.19am. At 6.30am, paramedics arrived and declared the man dead. When police arrived at 8.00am, they found the HDC refusal notice on the man's bed. They also found two used envelopes. On one was written: "The night guard and inmates killed me the night of 26-7-07 and got rid of my body in refuge truck." On the other was written: "The night guard killed me with a knife after 4.30am."

90. Once the necessary administrative procedures following the man's death had been completed, a governor, and the chaplain, left Dorchester at 10.00am to break the news of the man's death to his parents. They arrived at the family home in Oxford at 12.50pm. The chaplain has remained in touch with the family.

91. A hot debrief was held at Dorchester on 28 July. (The purpose of a hot debrief is to bring together all staff who had been involved in the immediate aftermath of an incident or tragedy.) It enabled the staff to discuss how the man's death had been handled and air any issues that had arisen as a result. The hot debrief was chaired by a governor and attended by representatives of the Staff Care Team. All relevant staff attended, except the third OSG. .

92. A Notice to Prisoners was displayed around the prison to tell them of the man's death. Prisoners were reminded that they could speak to a Listener if they were upset by what had occurred. (Listeners are prisoners trained by the Samaritans to support their peers experiencing anxiety or distress by talking with them.)

93. On 30 July, a post mortem was performed. It described superficial lacerations found on the man's wrists and a ligature mark around his neck. It concluded that the man's death was caused by hanging. A toxicological report did not detect any drugs in the man's blood and urine.

94. My investigator asked the staff she interviewed about the degree of support they received from Dorchester in the aftermath of the man's death. They spoke highly of the Staff Care Team and the level of concern displayed by their colleagues. However, one member of staff did feel let down by the PCT which did not make personal contact with her directly. (She said she was happy with the support offered by the prison's Staff Care Team, which had made her feel valued.) My investigator was unable to interview the third OSG as he left the Prison Service within a few weeks of finding the man.

95. An inquest into the man's death took place at Dorchester County Hall on 9-10 April 2008. The jury returned a narrative verdict that it was not possible to determine if the man intended to take his own life as his disturbed state of mind may have led him to a cry for help which went "tragically wrong."

96. The Coroner wrote to the Governor of Guys Marsh on 24 April 2008 to say he took it that the man's complaints would be investigated and that he would be told of the outcome. Guys Marsh commissioned a principal officer on 28 April to carry out an investigation. Its Terms of Reference did not include other matters mentioned by the man's family during the inquest.

97. The principal officer interviewed the first senior officer and submitted written questions to eight officers who worked regularly on Wessex House who might have come into contact with the man. The principal officer completed his investigation report on 10 November 2008. He concluded that there was no evidence to support any of the eight allegations the man made concerning the first senior officer or staff on Wessex House. My investigator was provided with the investigation report on 23 January 2009.

CLINICAL REVIEW

98. A clinical review of the healthcare the man received in custody was carried out on behalf of the South West Dorset PCT. The clinical reviewer comments that:

> "The man had an unusual personality, that he had problems with alcohol and found relationships difficult. I suspect that the second psychiatrist was right in thinking he suffered from Asperger's syndrome, which is part of the autism spectrum of disorders. There is no cure for the syndrome. I believe it would fall into the category of personality disorders which are widely felt not to be amenable to medical treatment. During the time he was detained, he was examined by three consultant psychiatrists at different times and for different reasons. None of them found signs of either depression or psychosis."

ISSUES

99. The man was clearly troubled. Although he had been in prison for a short period on remand five years before his death, he had not actually served a prison sentence before. Even the best run prisons with the most motivated staff can prove a challenging environment for a new prisoner. I am impressed with the care and support that Swansea showed to the man. He was appropriately assessed in terms of cell sharing and a risk minimisation plan was put in place. The man was referred to appropriate agencies, such as CARATS and alcohol services, that could help him to acknowledge and address factors that had led to his offending. When it became obvious that the man had mental health problems, he was referred promptly to the in-reach mental health team for assessment and his GP was contacted for more information. The first officer was asked by healthcare staff about the man's behaviour and was able to offer an informed response. The wing observation book was used by the forensic psychiatrist as a source of information. This multi-disciplinary consultation was good practice.

100. Similarly, when the man was taken to Bristol after sentencing, his GP was asked for more specific information. The man's security categorisation was considered in a timely fashion and, just over a month after being sentenced, the man was sent to a category C prison.

101. Having arrived at Guys Marsh, the man was assessed as low risk and allocated a shared cell. This was despite previous cell sharing risk assessments that highlighted the risks associated with the man's homophobic views and racism. I am not aware of when this error was rectified, but it points to the risks inherent in not corroborating existing information on a prisoner.

102. The man was able to take an overdose of a prescribed drug. I am concerned that he was able to keep in his possession significant quantities of tablets, despite the fact that his behaviour was self-isolating and anti-social. The man's overdose was regarded as serious by Guys Marsh. He was taken to hospital by emergency ambulance and his parents were told. I have previously investigated the death of a prisoner at Guys Marsh where, although he did not take an overdose, a quantity of medication was found in his cell. Whilst I appreciate that most prisoners can sensibly be left to take their own medication as prescribed, and that this promotes a degree of independence, there may be circumstances when it is appropriate to limit the quantity of tablets a prisoner can have at any one time. After seeing my draft report, the prison doctor commented that "Generally speaking, the risk assessment for having "in possession" medication is assessed by the prescriber, which in the case of the man was myself. In his medical notes there were two separate mental health assessments, one done on 2 May 2007 and the other on 23 May 2007, the first of which stated that there was no current suicidal ideation and the latter commented on the fact that he was "sleeping better, enjoys his work at the farm and had a good appetite." Whilst it is possible to assess risks, the process is dynamic and the risks change depending on the variable ongoing events."

I recommend that the Governor of Guys Marsh and the PCT review the prescribing protocol for in-possession drugs in the light of overdoses at Guys Marsh.

103. Opening an ACCT document after it was confirmed that the man had taken an overdose was good practice. This allowed prison staff at hospital to make appropriate entries at an early stage.

104. After the draft version of this report was given to the man's family, they spoke of their feelings of distress on learning that the man had taken an overdose and had been taken to hospital. The man's mother said she had learned of the news after receiving a telephone call from an unidentified male member of staff at Guys Marsh. When she had asked whether the man would be alright, she said she was told that he "deserved what he got." This comment added to their distress. I am sorry that this matter has not been resolved to the family's satisfaction.

105. On the man's discharge from hospital, he was taken to Tarrant wing, the segregation unit. Going back to Wessex wing was seen as undesirable given the threats the man had made to the first senior officer, the nature of the allegations he had made, and the attempt to assault nursing staff. I am troubled, however, that Guys Marsh seem to have recognised that the man was vulnerable but then kept him in conditions that were likely to heighten his sense of isolation.

106. Paragraph 4.1.2.1 of Prison Service Order (PSO) 2700 on Suicide and Self-Harm Prevention, which was in force at the time of The man's death, states:

> "Prisoners who are at risk of suicide or self-harm must not be routinely held in the segregation unit under Rule 45 GOOD (YOI Rule 49) unless, exceptionally, they are such a risk to themselves or others that no other suitable location is appropriate. Such prisoners must only be placed in a segregation unit in exceptional circumstances, or where all other options have been tried, but considered inappropriate, and only where it is possible to provide the degree of continual care identified as necessary in the prisoner's care plan. A case review must be held as soon as possible to take account of events leading up to the decision to segregate. If the decision is taken to locate prisoners at risk of self-harm within the segregation unit this must be for as short a time as possible, and the temporary nature of this must be reflected in the care plan."

107. My experience of investigating deaths since 2004 shows that prisoners are at many times greater risk of taking their own lives in a segregation unit than on normal location. Indeed, the revised PSO 2700, which had to be implemented in all prisons by 1 April 2008, makes the powerful point that: "a disproportionate number of prisoners who kill themselves do so in segregation units, many of them within 24 hours of being located there."

108. The man was regularly observed, but he was covering himself with a blanket and refusing to talk to staff. This behaviour was difficult to address within the controlled environment of a segregation unit. I note that the segregation review held on 3 July 2007 sanctioned the man's segregation until 16 July, an extraordinarily long time for a prisoner who had just returned from hospital after trying to kill himself. I doubt that the segregation unit should have been used in this way, except for a short respite. I sense that Guys Marsh was initially at a loss as to what to do with the man but I am heartened it was recognised that keeping the man there was not in his best interests, and that his transfer to Dorchester for assessment was speedily arranged.

I recommend that the Governor of Guys Marsh ensures that the prison complies with the provisions of PSO 2700 in considering whether it is appropriate for prisoners who have harmed themselves to be kept for extended periods in the segregation unit. A copy of this report should be shared with all members of his senior management team.

109. Whilst in the segregation unit, the man wrote two complaint forms alleging he was the subject of death threats and he was being bullied by staff and prisoners. My investigator noticed that neither form had been given a serial number. The explanation she was given by a governor was that when the Complaints Clerk read them she was unsure what to do given their contents, so sought advice from a governor. In the meantime, arrangements were being made for the man to be transferred to Dorchester so the forms were left pending.

110. I recognise that Guys Marsh faced a perplexing situation, given what the man had written. Nevertheless, it is important that all complaints forms are logged and given serial numbers so that they can be traced and confidence in the system can be maintained.

111. It was the responsibility of Guys Marsh, rather than my investigator, to explore whether the claims the man made on his complaint forms held substance. I am disappointed that no investigation took place at that time. The man's language may have seemed outlandish, preposterous even. Nevertheless, at the heart of it, he was alleging that he had been bullied and that staff and other prisoners were complicit in stealing his belongings. These were serious allegations.

112. My investigator asked the first senior officer whether he had been asked about the man's claims. He had not. He refuted any claim that the man had been mistreated.

113. My investigator obtained the man's property card to see whether he was missing any of his property. Apart from some bank cards that were put in the safe for safe-keeping, the only item on it was a pair of blue trainers which were later the subject of the man's complaint form.

114. Whilst on the face of it, the man's complaints were far-fetched, the entry in his clinical record on 5 July alludes to him having been bullied at work. It is conceivable that this could have explained why he did not want to attend work,

115. The prison doctor referred to the man's "delusional ideations" and I have seen nothing whatsoever to suggest that staff ill-treated him. Indeed, allowing him a television when on the basic level of the IEP, and therefore not entitled to one, was an expression of humanity that was good practice. All the same, the ability of prisoners to make complaints, unjustified or not, about their treatment is a hallmark of an open and decent prison system. No matter how unlikely Guys Marsh considered the man's claims to have been, they should have been properly recorded and investigated**.** I am pleased that the man's complaints were eventually looked into.

I recommend that the Governor of Guys Marsh ensures that all complaints are properly recorded and investigated.

116. It was appropriate to send the man to Dorchester for assessment. While he was there, his pattern of behaviour continued in engaging with staff on one occasion and then covering himself with a blanket and refusing to talk. Given that the man did not harm himself after arriving at Dorchester, nor express thoughts of doing so, it was a reasonable decision to close his ACCT document.

117. I am satisfied that the staff who attended after the man was discovered hanging acted promptly and with compassion. I am in no doubt that they found the man's death a distressing experience. I am pleased that they found the Staff Care Team supportive to their needs. I am concerned that a member of the healthcare team felt that she had not been adequately supported by the PCT. Healthcare staff, although they are an integral part of HMP Dorchester, are employed by Dorset PCT. It is important that they retain their connection with the PCT and vice versa.

I recommend that the PCT reviews the processes for supporting its staff working at Dorchester who have experienced the death of a prisoner.

118. Once the man was found, the nurse's decision not to attempt resuscitation because rigor mortis was present was entirely acceptable. Examination of the man's cell after his death showed that two notes were left on his bed along with a copy of the HDC decision. I cannot know whether these documents were linked in some way to the act of hanging. Given his perceived level of risk on release as evidenced by the MAPPA meeting on 28 June and the offence he

119. The clinical review concludes that the man probably had Asperger's syndrome. His odd mannerisms and rigid thinking point to a condition for which, unfortunately, there is no cure. He had been seen previously by psychiatrists who had not found signs of psychosis, but had prescribed medication for depression. It was not disputed by any staff who met the man that he did not appear 'quite right'. I am struck by his own observation to a probation officer that, after splitting up with his partner, he had neither felt normal nor happy again. The sad story of the man's life and death is that, despite their efforts, prison staff were unable to reach through the barriers he erected and he was unable to communicate his distress.

RECOMMENDATIONS

To the Governor of Guys Marsh:

I recommend that the Governor of Guys Marsh and the PCT review the prescribing protocol for in-possession drugs in the light of overdoses at Guys Marsh.

After consideration of the draft report, the Prison Service accepted this recommendation. It commented "this has been completed and a new protocol is now in use. The Medical Officer has adopted the Dorset and Somerset Prison Partnership in-possession policy."

I recommend that the Governor of Guys Marsh ensures that the prison complies with the provisions of PSO 2700 in considering whether it is appropriate for prisoners who have harmed themselves to be kept for extended periods in the segregation unit. A copy of this report should be shared with all members of his senior management team.

After consideration of the draft report, the Prison Service partially accepted this recommendation. It commented "We agree that it is essential to fulfil the requirements of PSO 2700 in relation to the segregation of prisoners that are actively self-harming. The recommendations of the report have already been relayed to the SMT and particular attention has also been drawn to the specific section on the segregation of the man and the requirements of PSO 2700.
However, we do believe that the segregation of the man in these particular circumstances was appropriate. The investigator appears to take the view that Segregation Units are for prisoners solely under punishment. Our experience at HMP Guys Marsh is that this is not the case. Unfortunately, on occasion, individuals are segregated in their own interests, for safety and protection.

The unit was in this instance the most appropriate temporary placement for the man, given the deteriorating state of his mental health and pending a transfer to HMP Dorchester for assessment. He was located in the segregation unit after being restrained on an escort after he attempted to assault members of the nursing staff. He had also made a number of serious allegations against a senior officer and it was felt that he could not safely be accommodated on normal location.

It was never the intention to keep him for a long period in segregation conditions, but establishments have no authority to automatically transfer to without medical sanction and had to negotiate the move with the PCT and HMP Dorchester.

I recommend that the Governor of Guys Marsh ensures that all complaints are properly recorded and investigated.

After consideration of the draft report, the Prison Service accepted the recommendation and commented "These complaints were brought to the immediate attention of Senior Managers by the complaints clerk which led to the man's case being the subject of some immediate scrutiny. Events had moved on by this time, move the man, for his benefit, to Dorchester prison hospital where he could receive

more specialist care. The complaint forms themselves were indeed used as evidence of the need for this transfer.

The man's complaints should, nevertheless, have been investigated and this was an error of judgement on our part which served to cast doubt on the credibility of the complaints system itself, and no doubt left members of the man's family, and others, wondering if there had been any substance to them.

We have now made it clear that all complaints will be investigated fully for the protection of the claimant, and also simply because it is the right thing to do. We very much regret that it did not happen in this case".

To Dorset PCT:

I recommend that the PCT reviews the processes for supporting its staff working at Dorchester who have experienced the death of a prisoner.