Investigation into the circumstances surrounding the death of a man at HMP Wakefield on 11 August 2004

Prisons and Probation Ombudsman
for England and Wales

March 2006

This is the report of an investigation into the death of the man who died on 11 August 2004 at Wakefield prison. The man was found hanging from the window bars of his cell in the segregation unit, shortly after midnight.

The man was but a young man when he died. I offer my deepest sympathies to his family, particularly to the man's mother, who I know from my enquiries was very close to her son as he was to her. I have great respect for the dignity the family has shown.

One of my investigators led the investigation from my office. The senior investigating officer was a Prison Service Governor. He was assisted by a Principal Officer. I am grateful to them all.

I am grateful to the staff at Wakefield and Manchester for their assistance. I am also grateful to the local police who, in carrying out their own enquiry, assisted my investigation team and shared all available information.

Finally, I would like to thank the Prison Health Commissioning Manager for the Wakefield West Primary Care Trust, who conducted a Clinical Review.

Stephen Shaw CBE **March 2006**
Prisons and Probation Ombudsman

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Summary

This is the report of an investigation into the death of a man at Wakefield prison. The man was 28 when he died on 11 August 2004. He was found hanging from the window bars of his cell in the prison's segregation unit.

The man was no stranger to the criminal justice system and had spent several periods of time in custody for a range of offences. He lived in Manchester and had a close relationship with his family: his mother and daughter in particular.

The man had been charged with four counts of attempted murder and three of possessing a firearm with intent to endanger life, offences alleged to have occurred in his home town. Due to the seriousness of the offences, the man had been given the highest security status, category A.

The man's victims were thought to have associates in HMP Manchester. Because of his category A status, the possibility that he would help the police identify his accomplices, and the fear of retribution from the victim's relatives, the Prison Service moved the man from Manchester to HMP Wakefield.

On the 5 February 2004, the man arrived at Wakefield. During initial health screening procedures, the man said that he had self-harmed in 1998 by making a cut to his wrist. He told the drug workers that he had a drug and alcohol history.

The man was held on the remand wing at Wakefield, as he awaited trial. On 13 March, the man was placed on an open F2052SH (suicide and self-harm monitoring procedures), after feeling suicidal, threatening to cut himself and for making ligatures. The suicide and self-harm form was closed on 8 April.

On 12 July, the man alleged that one of the staff at Wakefield was harassing him. He said that the officer had issued threats against him and had allegedly assaulted him in a cell at Crown Court during an incident - at a court appearance that day - for which the man had been charged under the Prison Rules.

On 1 August, the man was moved back to Manchester for his trial. He was sentenced to 20 years imprisonment on 4 August and stayed at Manchester until his return to Wakefield on 6 August.

At the prison disciplinary adjudication relating to the events of 12 July, the man pleaded guilty to abusing the officer and accepted the officer had not assaulted him. As a result of this disciplinary hearing, along with one for failing to take a Mandatory Drug Test on 9 August, the man was moved to the segregation unit on 10 August.

Despite the presence of good policy documents, there are a number of issues raised by this investigation. Wakefield needs to address a variety of matters, particularly in its relatively new role as an establishment that holds unconvicted prisoners.

The independent Clinical Review suggests that the man received a high level of clinical care whilst at Wakefield, although, there remain areas for improvement. The Clinical Review specifically highlights the training and development of staff.

This report makes seven recommendations.

Investigation Outline

A Prison Service Governor was the Senior Investigating Officer. He was assisted by a Principal Officer (PO). The investigation was co-ordinated by one of my investigators.

The investigators visited the prison and were shown the areas where the man would have been, including reception and induction, the healthcare unit, the segregation unit and the wing on which the man was located.

They issued a notice to staff and prisoners inviting anyone with information relating to the man's death to make themselves known to the investigation team. A number of prisoners came forward, as did a member of staff.

At both HMP Wakefield and HMP Manchester, the investigators spoke to the Chairs of the Prison Officers' Association and Independent Monitoring Board, the prison chaplains, and various members of prison staff. They formally interviewed ten members of staff and relied upon statements made to the police for two others. Additionally, 15 prisoners were interviewed. Two prisoners declined to assist the investigation.

Wakefield gave the investigators full access to all the documentation surrounding the man's time in prison. The police also provided copies of the documents and statements in their possession. The investigators obtained some further information from the probation and court services.

The investigators and the lead-investigating officer from West Yorkshire Police met the man mother and brother, with the family's solicitor.

Finally, the investigators commissioned the Prison Health Commissioning Manager for the Wakefield West Primary Care Trust, to conduct a clinical audit of the man's care while in prison.

Background

The man

The man was born on 26 June 1976 in Manchester. He had 13 previous convictions dating back to 1990. These convictions represented 34 offences.

Apart from periods on bail and remand, the man's last recorded sentence of custody was served at HMYOI Deerbolt, from which he was released on licence on 3 November 1995.

Wakefield Prison

Wakefield holds mainly life sentence prisoners, with the focus on serious sex offenders sentenced to four years or more. It recently took on a remand function for potential category A prisoners. This unit is located on Bravo wing, where the man was placed for the majority of time.

The prison provides workshops and an education department, offering both full and part time education. The programmes department offers a range of offending behaviour courses including FOCUS (Anti-drug taking programme), the Sex Offender Treatment Programme and the Enhanced Thinking Skills programme.

On the date of the man's death, the prison roll was 553. The population broke down as:

Life Sentence Prisoners	404
Determinate Sentence Prisoners	139
Category A prisoners	91
Potential category A prisoners	10

The roll on F wing (which includes the segregation unit and close supervision centre) was 19 and there were 11 prisoners at Wakefield on open F2052SH documents.

Wakefield was last subject to a Security and Standards audit in June 2004, at which time it received a good rating. A more detailed review of the findings of this audit, in respect to the man's death, is contained later in this report.

View of Her Majesty's Chief Inspector of Prisons

The Chief Inspector conducted a full inspection of Wakefield in October 2003. Relevant findings are set out below.

Segregation Unit

HMCIP made three specific recommendations regarding the segregation unit:

1) Prisoners located in the segregation unit should receive daily access to showers.

   This is now the case in the segregation unit and was so when the man was located there.

2) The medical officer should visit all prisoners in the segregation unit on a daily basis.

   This has been implemented for some time. A healthcare professional (nurse or doctor) sees every prisoner in the segregation unit daily.

3) A monitoring system should be implemented to ensure that all sections of Rule 45 (segregation under Good Order and Discipline) documentation are completed appropriately.

   Wakefield has implemented a series of management checks to ensure these documents are completed correctly.

HMCIP made some other general comments about the segregation unit, which was described as a place where prisoners were closely supervised and movements were tightly controlled. Documentation was generally completed to a good standard, and appropriate monitoring of prisoners' physical, emotional and mental well being took place.

The Chief Inspector's report raised concerns at the number of prisoners making allegations of intimidation or bullying. She acknowledged that alleged assaults had been subject to appropriate levels of investigation, but registered disquiet about the number of complaints made by prisoners.

Prisoner Disciplinary Procedures

HMCIP reported that they saw no evidence of intimidatory behaviour towards prisoners who had been escorted to the segregation unit for adjudications. The number of adjudications for a prison the size of Wakefield was low. They observed that adjudications were conducted in a respectful manner and at a pace to suit the individual needs of the prisoner. Prisoners were given every opportunity to present their account of alleged incidents, call witnesses and contact their legal advisors. There were some minor housekeeping points, but generally HMCIP gave a very positive account of the operation of the adjudication procedures.

Only two recommendations were made:

1) On receiving an adjudication punishment, prisoners should be issued with written details explaining the appeal process.

   This has been incorporated into the local adjudication procedures at Wakefield.

2) Where pleas of mitigation are made, they should be taken into account by the adjudicator when considering a punishment.

   Tariffs including possible mitigating circumstances are raised at the regular adjudication meetings.

Anti-Bullying

HMCIP concluded that the systems and procedures put in place to deal with bullying were thorough and appeared to work effectively. Prisoners were actively involved and most staff had a good knowledge of the anti-bullying strategy. The Suicide Prevention and Anti-Bullying team dealt with investigations efficiently and ensured that the victims received adequate support. However, the sound casework being carried out by members of the team would be enhanced if they were given the opportunity to participate in specialist training. The absence of programme work was seen as a weakness.

Three recommendations were made:

1) An annual prisoner survey on bullying should be carried out. The results should inform all service developments in this area.

   This has been accepted by the prison and will take place. A number of other prisoner surveys, including the Measurement of the Quality of Prisoner Life (MQPL) are also undertaken.

2) Members of the Suicide Prevention and Anti-Bullying team should participate in specialist training relevant to their role.

   A review of the training needs for SPAB team members has taken place. Additional training courses have been identified as suitable to enhance this role.

3) Prisoners identified as bullies should have the opportunity to participate in programme work.

   The prison also accepted this, and prisoners who have been identified as bullies or possible bullies will not automatically be refused access to treatment programmes, but will be individually risk assessed.

Preventing Self-Harm and Suicide

The HMCIP team said that, “Prisoners at risk of self-harm and suicide were well managed by a multi-disciplinary team at Wakefield. A strong leadership style and much good practice was evident.”

Three recommendations were made:

1) Care should be taken to record accurately and in detail the content of each case conference in the F2052SH (the document used to monitor those at risk of suicide or self-harm).

   This has been accepted by the establishment which will task managers to check this on their routine reviews.

2) Support plans for prisoners subject to F2052SH procedures should be specifically tailored to meet the needs of the individual.

   Again this has been accepted by the establishment which will task managers to check this on their routine reviews.

3) Information obtained from the final management check undertaken on the closure of an F2052SH document should be fed back to the Suicide Prevention Committee to inform future policy and decision making.

   The prison also accepts this recommendation and this information is now fed through the Committee.

HMCIP also noted two areas of good practice:

1) Suicide Prevention and Anti-Bullying officers interviewed all new receptions upon arrival at Wakefield to assess their risk of self-harm to themselves and to others.

2) The Head of Residence conducted a final management check on all closed F2052SHs to check quality. Areas of concerns were followed through, with the Head of Residence personally advising staff of the standards expected.

Security and Standards Audit

The investigators reviewed the Final Report of a Combined Security and Standards Audit held at Wakefield in June 2004. This is a report published after a comprehensive audit from the Prison Service Standards Audit Unit. (Standards Audit Unit is part of the internal audit arrangement providing assurance to line managers and the Director General on the performance of public sector establishments.) Wakefield will be audited against Security Standards each year and against all other Standards every other year.

Wakefield scored as follows:

- 87% Standards
- 88% Close Supervision Centre
- 92% General Standards (Critical Baselines)
- 92% Security

In respect of the standards that have specific relevance to this enquiry, the audit produced the following results:

Adjudications

All prisoners receive the Notice of Report (F1127) with enough time to prepare for the adjudication. The adjudicating governor records all relevant information. There was one case in which an issue relating to legal representation had been omitted. However, as this had been dealt with on appeal to the Deputy Director General's office a year ago and there has been no recurrence, it was not treated as non-compliant.

Complaints Procedure

All prisoners have easy access to the Request / Complaints (R & C) forms in open and confidential access formats. These are kept in all accommodation areas alongside the posting boxes. These boxes are opened on a daily basis and this is recorded by the R&C clerk on the register, along with reply dates. There were a small number of R&C's that did not meet the timescale, but a 99% return rate is commendable by any standard.

Safer Establishments

An Operational Manager has been appointed as the Anti-Bullying Co-ordinator. No evidence was found that any unexplained or non-accidental injuries have not been investigated and action taken as a result. The Healthcare Centre (HCC) is the only area of the establishment that has multi-occupancy rooms. It is imperative that cell sharing risk assessments are properly completed and considered prior to prisoners being allocated into these rooms.

Segregation of Prisoners

A staff selection policy is in force for the Segregation Unit, F Wing. All authorisations for the use of segregation have been properly completed by the appropriate grade of Operational Manager. There are some gaps in the recording of "Governors Rounds", although each prisoner held in the segregation unit is seen by a member of the Healthcare Department daily. Three Segregation Safety Algorithms for prisoners currently held in F wing were not fully compliant.

Suicide and Self-Harm Prevention

Most baselines audited were found to be fully compliant, with only minor action identified for those that were not. Evidence was found of one prisoner not being seen by a doctor until three days after arrival. All cases of identified risk, or actual self-harm, resulted in the activating of F2052SH procedures.

Measurement of the Quality of Prison Life

The Measurement of the Quality of Prison Life (MQPL) is a confidential survey of prisoners developed by the Prisons Research Centre at the University of Cambridge. It is now an essential component of the performance measurement tools used by the Prison Service, and represents a quantitative measure of the qualitative aspects of prison life. The survey is carried out by a research team of psychologists from the Standards Audit Unit to assess prisoners' perception of their quality of life within establishments.

The survey results at Wakefield tend to support some of the findings of the inspection by HM Chief Inspector of Prisons. They show that there is good work going on with prisoners to address offending behaviour and that the prison is clean with reasonable facilities for prisoners. There are, however, tensions between some prisoners and certain staff, who are seen by prisoners to be disrespectful and failing to meet the needs of the individual.

Chronology of Events

30 January 2004 – 10 August 2004

The man was initially arrested on 30 January 2004. He was charged with two counts of attempted murder and appeared at Magistrates' Court on 2 February. He was remanded into police custody, later being charged with a further two counts of attempted murder and with three counts of possessing a firearm with intent to endanger life. He was further remanded in custody and was sent for trial at Crown Court, making five further appearances before his trial commenced on 2 August 2004.

Two of the four charges were for crimes against members of a particular family, whose associates were thought to be in prison in HMP Manchester. Due to the nature of the charges, which involved the use of firearms, the man's security category was assessed and he was, made a potential Category A prisoner. On the strength of this, and the possibility that he would help the police identify his accomplices, he was taken to HMP Wakefield. Wakefield had only recently taken on the role of holding remand and untried prisoners who were subject to Category A.

On 5 February, the man arrived at Wakefield where he was located in the Health Care Centre (HCC) as required by the local Suicide Prevention Policy. The following day, he was reviewed under the Suicide Prevention and Anti Bullying procedures and moved to B wing where the remand prisoners are located. Here he again underwent Suicide Prevention and Anti Bullying assessments and an induction interview. The man had no immediate problems or concerns, other than getting in touch with his family. However, during an interview with the establishment's Suicide Prevention and Anti Bullying team, the man said that in the past he had been subject to bullying albeit not in prison.

During initial health screening procedures, the man said that he had self-harmed in 1998, making a cut to his wrist. However, he said that this was not a concerted effort more a 'cry for help'.

A member of the prison CARATS team assessed the man shortly after his reception to Wakefield. (CARATS provide a drug counselling, referral and advice service.) Reports indicate that he was quite open and willing to discuss his previous drug and alcohol history and was willing to address these issues whilst in custody.

CARATS reports say that the man's drug misuse dated back 15 years, using cannabis daily. His use of cocaine and ecstasy was less regular, although quite substantial, mainly on weekends or at social gatherings. The main problem highlighted was alcohol abuse. The man said that he had tried several times to cut down but had failed to do so.

The man was located on B wing, the remand unit, from 6 February to 13 March, during which time he displayed a reasonably positive approach and

attitude. He was placed on adjudication during this period for a positive Mandatory Drug Test, but the charge was subsequently dismissed.

On 13 March, the man rang his cell bell and said that he was suicidal and would “slash up”. He was located in a “safer cell” in the HCC, which was constantly monitored by CCTV, and an F2052SH was opened.

On 14 March, whilst located in the HCC, the man commenced a “dirty protest”. During this episode, the man used his inhaler to “give himself a buzz” but later that day destroyed the inhaler. The inhaler was then taken off him and from then on only issued to the man on request.

On 15 March, he rang his cell bell and told staff that he had removed the elastic strip from his underpants and made a noose. He quickly handed this over to the staff. On 16 March, the man ripped a blanket and fashioned a ligature which he fastened around his neck. When staff challenged him, he again handed over the ligature. These actions were accompanied by shouting and ringing of the cell bell, ensuring staff were aware. However, he then went on to make another ligature. At 3:20pm the man ceased his dirty protest, then showered and was relocated to a clean cell in the Segregation Unit. The Safety Algorithm was completed by a doctor, but not countersigned by a governor grade. However a Governor signed the Rule 45 paperwork, authorising segregation at 4:00pm that day.

On 17 March, the man was adjudicated upon for offences against Health and Safety. On 18 March, he was subject to adjudication for failing to comply with unit rules and was punished with seven days at half pay.

Also on 18 March, the man said that he had swallowed a razor blade after making a small laceration to his left wrist. He first refused treatment, but later agreed to allow the medical staff to treat him. He was seen by a doctor who recommended he be taken to an outside hospital for x-ray, but as a non-emergency case. The man made a further small cut to his thigh that afternoon. On 19 March he was escorted to hospital and received treatment for the alleged swallowed razor blade, but no blade was recovered.

On 24 March, the man was moved to another cell and given a television. The man’s attitude changed for the better and he told staff that he was feeling much brighter and in better spirits.

Between 19 and 31 March, the man remained located on F wing and his behaviour improved to an acceptable level with no further incidents of note.

The officer on night duty on 29 March in the segregation unit when the man asked for his inhaler, refused to provide it until the day staff came on a short time later. The officer on night duty recalls this clearly and admits that he did not give the inhaler to the man as the day staff were due on very shortly. He said that they would be able to deal with this issue, as they were fully aware of the circumstances surrounding the man’s medication. The Segregation Unit Observation book records this incident as occurring at 7:00am. This would be

only a matter of minutes before the day staff would relieve the night duty. He had previously give the man his inhaler (on 27 March), as this request had occurred during the night.

On 31 March, the man moved back to B wing. Following a settled period, coupled with an improved attitude and increased interaction with wing staff and peers, the man's F2052SH was closed in his absence on 8 April.

He was further reviewed seven days later and then fourteen days later. The Head of Residence formally reviewed the quality of monitoring, and the recording of events in the F2052SH booklet, on a management check sheet.

The man spent the following months located in B wing's remand unit. He received reasonably positive reports from unit staff throughout this period. It appears that he was a regular user of the gymnasium and exercise periods. He also received several visits from his solicitor.

On 12 July, the man alleged that the officer who had been on nights (29 March) assaulted him in the cell area of the Crown Court. In evidence, the officer recalled the incident. He said that the man asked him for a light, to which the officer replied that neither he nor the other member of staff (a PO from Manchester) smoked or had any matches. The officer said that the man then became abusive and threatening, even asking the officer to come into the cell to settle the matter. The officer also recalls a member of the man's legal team asking him for his identity details, as a complaint would be made of assault on the man. In fact, no formal complaint was received from the man's legal team; nor did the man raise the matter by any of the other formal complaint channels.

The officer placed the man on a disciplinary charge for being abusive.

He works in the Operations Department at Wakefield, where he is a Category A vehicle driver / navigator. His main duties would take him out of the prison driving prisoners to court or to other prisons. Apart from being on duty in the court cells, he would have few dealings with the prisoners on the escort. The officer would have little regular contact with prisoners on the living units, apart from occasional duties on the wings, and he would be on the roster for night duty. There is no evidence of continued contact between the officer and the man after this incident, and none to suggest that the officer assaulted the man or treated him unprofessionally at any time.

On 1 August, the man was transferred to HMP Manchester for the commencement of his trial at the following day. On reception at Manchester, the man was located in the segregation unit for his own protection. A Segregation Safety Algorithm was completed by a nurse and the decision confirmed by a Governor. No medical concerns were raised and the man was deemed fit for segregation.

The man was taken to court on a daily basis. On 4 August, he was sentenced to 20 years imprisonment. On 6 August, the man returned to Wakefield and

was located in B wing. Between 6 and 9 August, prison staff documented that the man was shocked at the length of his sentence, and that "it would take sometime to sink in". However, the staff did not consider the man to be a self-harm risk.

On 9 August, the man was selected to take a targeted drug test. He refused to take the test which requires the prisoner to give a urine sample. There had been intelligence on the man, suggesting that he was involved in the provision of drugs at Wakefield. the man was placed on a disciplinary report.

On 10 August, the man was taken to F wing (the Segregation Unit) for two adjudications:

1. Rule 51, Paragraph 22 – Uses threatening, abusive or insulting words or Behaviour. This related to the incident at Crown Court. The hearing of this charge had been delayed on three previous occasions, the first two on 14 and 22 July, to allow the man to seek legal advice, and again on 30 July due to one of the witnesses being unavailable. The officer attended the hearing to give evidence. The man pleaded guilty to this charge and admitted that the officer had not assaulted him. The charge was proven and a punishment of 28 days stoppage of earnings at 50% was imposed.

2. Rule 51, Paragraph 20 – Disobeys or fails to comply with any rule or regulation applying to him. The man had refused to attend the Mandatory Drugs Testing Suite for a drug test. The man pleaded guilty to this charge, and when asked why he had refused the order he said, "I didn't sleep until 5:00am and I haven't had any drugs, I'm on voluntary testing". The charge was proved, with a punishment of seven days cellular confinement (CC), exclusion from work, loss of association, loss of occupations in cell, and loss of possessions in cell.

The man was located in cell F3 –11, and was subject to hourly checks, which commenced at 12:00 noon.

A Segregation Safety Algorithm was completed by the locum prison doctor. He confirmed that the man was not at risk and could be made subject to CC. After the man's death, the locum prison doctor wrote a memorandum to the Governor, dated 11 August, confirming that he did not consider the man to be at risk of self-harm, but saying that he thought that the man would be located in one of the cells which has continuous camera monitoring as he thought was standard practice. This is not recorded on the safety algorithm.

In a statement to the Police, the locum prison doctor said that whilst the man did not display any signs of anxiety he advised staff that he did not believe the man and that he told staff to put the man in a cell with camera cover. The doctor says that he recorded this in the man's Medical Record. However, there is no record of any such entry.

If the doctor had any concerns over the man, he would have been expected to complete the safety algorithm and to advise the adjudicating governor that the

man was not fit for CC. Also, he would have been expected to advise that the man should be placed under the care of the F2052SH protocols or that the man should be located in the Health Care Centre. The man had previously been located in HCC, following an earlier self-harm attempt.

There is no evidence to suggest that the doctor had articulated his concerns about the man to staff. Unfortunately, the locum prison doctor was not available to be interviewed by the investigation team.

Discovery of the man

There is evidence of hourly checks made by F wing staff, commencing at 12:00 noon on 10 August, the last recorded entry being at 11:01pm. There are no entries in the Staff Observation Book to indicate any notable actions or changes in the man's mood or behaviour. Indeed, there is only one entry in the Staff Observation Book on F Wing for the whole of 10 August.

In evidence, an officer on night duty remembered carrying out these hourly checks, saying that at 10:00pm, the man, "was sitting on his sink with his feet on the chair, looking out of the window. There was nothing wrong with that because a lot of them do. At 23:00pm, in the same position, he turned round, acknowledged me, gave me a wave."

The night duty officer said that he returned to the cell at approximately three minutes past midnight, and saw the man hanging with a ligature around his neck.

The night duty officer explained that he attempted to rouse the man by shouting and kicking the door, but to no avail. He then went to the wing office and contacted the orderly officer, by telephone. The night duty officer then contacted the control room, which in turn alerted the paramedics and later the police.

On receiving the telephone call, the Orderly Officer summoned two officers from other posts and attended F wing. This is consistent with the local policy. It took seven or eight minutes to arrive at the man's cell.

Once the other officers had arrived, the night duty officer broke F wing's sealed key pouch and opened the cell door. As a security measure, staff on nights do not routinely carry cell keys. Instead they are held in a pouch, which is sealed. The seal must be broken to access the keys and this must be formally recorded. The two officers that responded lifted the man, easing the pressure from the ligature, which was fashioned from a bed sheet. The night duty officer cut the ligature using ligature scissors. The man was then placed on the cell floor on his back.

At this stage, a Healthcare Officer arrived. His initial assessment was that the man "was pale in colour, with evidence of cyanosis in the facial area. No breathing, no pulse and pupils were dilated".

The officers who responded commenced CPR. At 12:16am, paramedics arrived at the establishment and were escorted to F wing where, they continued the resuscitation attempt. The paramedics ceased CPR at approximately 12:40am.

In the meantime, the control room contacted the duty governor, and the duty doctor. The duty governor arrived at 12:46am and the doctor at 12:55am. Both attended the cell. At 1:10am, the doctor pronounced the man dead.

When staff left the cell at about 1:10am, orderly officer locked it and told staff that the cell was to remain sealed, as it constituted a possible crime scene. He confirmed that nothing had been removed from the cell.

At 1:51am, the police were informed and immediately informed the Coroner. At 2:15am, a Police Constable from West Yorkshire Police arrived, followed at 2:25am by Detective Constable Cadman. At 3:00am, a Detective Sergeant and Scenes of Crime Officer arrived at the prison.

The undertakers took the man's body from the establishment at 4:54am, and the establishment was secured at 4:59am.

Prison staff, the National Operations Unit and Press Office were contacted according to the establishment's contingency plans.

Prisoners' and Staff Views

There is a remarkable consistency in the views of both staff and prisoners about how the man presented himself in public. He was, to those who came across him, a fairly self confident young man, slightly cocky, who gave the impression of being anti-authority and generally "prison wise". He did not give the impression of being an individual who would allow himself to be bullied or harassed, either by prisoners or by authority figures. This picture is one which, in the main, would be supported by his family.

It is clear that staff and prisoners thought that the man did not constitute a risk of serious self-harm and certainly not suicide, despite his self-harm attempts in March 2004, and being on a F2052SH form 13 March to 8 April.

The prisoner who probably knew the man best was with the man at Wakefield and Manchester. Indeed he shared a cell with the man at Manchester. He claims that the man was generally in good spirits and mixed well with most staff and prisoners, but was susceptible to mood swings when things did not go his way. He did not particularly like being at Wakefield due to the high number of sex offenders located there, a point the man made publicly. He also did not like being at Wakefield because it made it difficult for his family to visit.

The prisoner recalls at least two occasions when the man reacted angrily to being denied access to a radio and to a light for his cigarette. The man's response was hostile and volatile, but the prisoner says these outbursts were short-lived and the man would quickly regain his composure and return to a more reasonable relationship with staff and prisoners. Staff who knew the man generally endorse his conduct.

A B wing officer knew the man reasonably well. Apart from the man being slightly immature and having the odd "blow up" if he did not get his way, he said the man was a reasonable prisoner who did not present as being particularly difficult to staff. At that time, there were no personal officers assigned to specific prisoners. The Incentives and Earned Privileges assessment of the man, and the F256C Conduct Report prepared for the adjudicator, support this.

The B wing officer said that, if anything, the man would be more likely to sulk and certainly did not react with physical violence. However, he would add the odd threatening comment about his contacts on the outside, and told staff that they should not forget that he was in for firearms offences. These comments were seen as bravado not serious threats.

Whilst both men were at Manchester, the prisoner who was closest to him claims the man appeared to be fine although concerned about certain aspects of his case. He expected a long sentence but, given that he did not regard himself as the main culprit, and no one had died, he thought that he would receive about eight to ten years. There is little doubt that he was shocked by the sentence of 20 years imprisonment.

The man was, to a great extent, consumed by the effect that his incarceration would have on his family, and on his daughter and mother in particular. The prisoner who was closest to him says that the man kept returning to this, time after time, despite his efforts to keep up his spirits. The man showed particular concern for his mother and dwelt on the point that he would not be in a position to help her should she became ill, coupled closely with the fact that his imprisonment itself might well have a negative impact on his mother's health.

Whilst the prisoner who was closest to him said the man never exhibited any signs of self-harm or suicide, he believed that underneath his rather brash exterior the man had real doubts about his ability to cope with the effects that his sentence would have on his close family. The man also showed this frailty to the wing SO, who can recall the man crying his cell in the segregation unit. She is unable to remember the date, but it was before the man was sentenced and during a conversation about the man's mother. She did not consider it necessary to open a F2052SH.

Another prisoner who knew the man well was an elderly prisoner who has spent a considerable period in custody, the last eight years of which at Wakefield. He acted to some degree as a father figure to the man, who would seek him out for advice. They met in the HCC and later on exercise. He describes the man as being troubled and fidgety, with considerable nervous energy.

The man explained that he had come to an agreement with the police whereby, if he were to assist the investigation, this would mitigate the sentence he would be given at court. According to this prisoner, the man considered this would mean nothing more than 12 years. The 20 year sentence was described by as "a year for every bullet fired". The man still gave the impression that he could handle this and would have the sentence reduced on appeal. This prisoner thought that this was a smokescreen and, in reality, the man was not as resilient as he would wish people to believe.

There are recurring themes about the man, as detailed by prisoners. These include the heavy sentence, being so far from his family and the 'difficulty' with the officer on the escort.

A number of prisoners were particularly critical of the "culture" amongst some staff at Wakefield. All prisoners said that the prison had a considerable number of staff who treated prisoners well and did their best to help them. However, some prisoners said that a minority of staff did not want to work constructively with prisoners and appeared to go out of their way to make life more difficult.

A prisoner thought that staff should have responded differently to the man's situation. Given that he had just been given a very long sentence, and that the man had been seen talking to the Samaritans, they should have given the man some latitude and not gone ahead with the adjudication on 10 August.

Another prisoner held the view that the man should have been offered more assistance, as he thought that the man was suffering from clinical depression. Even if staff could not identify a mental health issue, they should have been able to detect that the man was having difficulties in coping with his situation. Another prisoner was particularly critical of the environment at Wakefield and in particular a range of uniformed staff who he said "ran the prison" for their own benefit, regardless of management's instructions. He cited an example of how staff had allegedly flouted the express orders of the Governor. He made great play on the incident with the officer at court and told the man "that he should take it all the way". He admitted that there was many good staff at Wakefield, but the bullies and rogue elements amongst their colleagues overshadowed them. (The investigation team are unable to confirm any of these allegations. They are reported here because they formed part of the evidence to this inquiry.)

Three prisoners made specific reference to the Segregation Unit at Wakefield. They described it as an intimidating place, where prisoners are over controlled and can be subject to over zealous behaviour by staff. However, two other prisoners declared that they have not encountered any difficulty with either prisoners or staff in the Segregation Unit.

Although there are differing views about the culture at Wakefield and whether sufficient attention was given to the man's perceived problems, not one of the prisoners suggests that the man had been subject to any inappropriate actions by staff whilst he was in the Segregation Unit.

Non-Medical Assessments

The following assessments were made about the man during his time at Wakefield.

Anti-Bullying Questionnaire

This form is self-completed by the prisoner and is returned to the Programmes Department (Psychology) for evaluation.

The man completed and returned this form which was undated. The man said that he had been subject to bullying at Wakefield. He specifically mentioned two occasions where he had been badly treated by the officer who placed him on report, once because he was refused his inhaler, even though he required it, and once when he was at court. The man claimed nothing was done about the bullying and said that it did not always pay to report this activity, as there was a risk of suffering further retribution.

Cell Sharing Risk Assessment

This form is completed at all prisons before prisoners are placed in shared cells. It was completed at Manchester when the man returned for the start of his trial. The assessment was dated 1 August. Based on answers from the man and his available records, the man was assessed as a medium risk to others (no immediate risk but situation to be reviewed regularly).

The HCC assessed the man as low risk (no current indication / evidence of risk, suitable for multi-cell occupation). It was noted that he had previously self-harmed, but stated that although depressed he was not suicidal, and the medical officer should review him. There is no evidence that this took place. However, he was assessed by the doctor, on 6 August, on his return to Wakefield. The assessment expressed no concerns.

Risk Assessment for Court

Completed on 1 August, this is information for staff escorting a prisoner to court or transferring to another prison. The assessment records that the man should continue to be treated as a “Standard Risk Cat A prisoner” without any requirement for special measures. It contains details of:

- a general security assessment,
- behaviour in prison,
- physical security of court,
- any criminal and offence issues,
- visiting arrangements,
- specific factors of concern, including escape history,
- and analysis of the assessment.

Suicide Prevention and Anti-Bullying Proforma

Completed on 6 August on the man's return to Wakefield from Manchester after sentencing, this form records that:

- an at risk of self-harm procedure F2052SH was not open,
- the man had a history of self-harm,
- the man had never made a serious attempt on his own life,
- he had no history of being a bully, but had been a victim of bullying outside of prison,
- there was a history of drug abuse,
- there were no current health care screening problems identified.

The assessment adds that the man had been on remand at Wakefield and had been sentenced to 20 years on 4 August. The assessment said that he was feeling a little depressed, as he realised that he was going to miss out on his children growing up. The man was not on a F2052SH, but said that he would not do anything stupid because of his children. The assessor reported good eye contact with the man, who was also very talkative.

F Wing / CSC Behavioural / Activity Risk Assessment Record

This is a local form, completed on 10 August, devised to set the staffing levels required to supervise specific prisoners during specific activities. It is used more in respect of prisoners who are held in the Close Supervision Centre and segregation unit.

It sets out the control measures in place and identifies any potential hazards and actions to minimise risk. In respect of the man, it notes he was newly sentenced, and would need to be monitored on a regular basis and given ongoing support by staff. The assessment puts the risk factor as low, the probability of any hazard as low and the severity of any hazard again as low. It also records that the man should be given a "pool" radio, his canteen goods and access to books and writing material. He should also be monitored hourly.

The investigation team were told by the present Governor of Wakefield that this form was not in fact completed on 10 August 2004, but that staff had been ordered to complete the form, by the unit manager, the day after the man's death. On 9 August 2005, the Governor began a full internal disciplinary investigation.

There is, however, ample evidence that the man received the identified actions to minimise risk, i.e. he was monitored hourly and had access to the items mentioned. Should the man have survived, the HCC staff would also have seen him daily. The assessment was to some extent superfluous, as the man had never constituted a serious control problem and did not require additional staffing or special conditions to be unlocked, take exercise or at mealtimes.

CARATS

This is an assessment process to determine the level of substance misuse by a prisoner, and to offer support and guidance on how prisoners can manage and curtail their addiction.

The man co-operated with the CARATS workers and told them of his misuse of various drugs during an interview on 25 February. He had used cannabis, cocaine, and ecstasy. He said that he did not take heroin, neither did he inject any drugs. The man said that drug misuse had caused depression, panic attacks and anxiety.

The most significant misuse was of alcohol, which caused the man to suffer from alcohol poisoning, gastric enteritis, weight loss and ulcers. The misuse of alcohol was considered to be the man's main problem.

He said that he benefited from continued family support, and that he would be willing to do drug related courses whilst in prison if convicted but, at that time, did not wish any intervention by the CARATS team.

Life Sentence Planning

This is a short assessment, designed to identify prisoners who by nature of the offence, may be given a life sentence. The man completed this on 11 February, when he said that he felt relaxed and safe in comparison to life "on the out". He gave details of his offence and that he intended to co-operate with the police investigation. He confirmed that he was not subject to the self-harm procedures, but admitted that he had attempted self-harm some seven years previously following a split with his girl friend. He also recalled an incident when he was felt depressed whilst in Wymott prison. The man expressed no concerns about his current location on the remand wing and did not require any specific support.

The man gave information that he currently had no co-accused, but that he would be giving the police information to assist them to arrest his accomplices.

It is clear from the range of assessments completed on the man that he had problems of substance misuse and had bouts of anxiety. On occasions, this manifested in sporadic, but somewhat token, episodes of self-harm. He did not present to anyone as being liable to sustained and serious self-harm and definitely not suicide. This is certainly the view of those who knew the man in custody and that of his family.

Segregation Safety Algorithm

These documents are completed on every occasion a prisoner is placed in the segregation unit. Either a registered nurse or doctor must complete parts A and B. The final decision as to whether an individual is deemed suitable for location in the segregation unit or to be subject to a punishment of cellular

confinement is made by a governor grade. These forms were completed as follows:

18 February	9:50 am	Completed by a nurse, pre-adjudication. Governor adjourned the adjudication and authorised the man to be held under 24hr watch (CCTV) to monitor his behaviour.
16 March	3:45 pm	Completed by a doctor, but not countersigned by a governor grade. However, a governor signed the Rule 45 paperwork authorising segregation at 4:00pm, that day.
14 July	9:40 am	Completed by a nurse and confirmed by a governor. The man was deemed fit for segregation and no concerns were raised.
1 August	9:30 am	Completed by a nurse and again the decision confirmed by a governor. No medical concerns were raised and the man was deemed fit for segregation.
10 August	9:25 am	Completed by a nurse and countersigned by governor. This was prior to the adjudication and it confirmed that the man had no issues or concerns and did not require HCC intervention.
10 August	10:25 am	This was the second algorithm completed on that morning. This time the form was completed by a doctor, to confirm that the man was not only fit to be held in the segregation unit but was also fit to undergo cellular confinement, if imposed at the adjudication. The doctor noted that the previous algorithm discounted any HCC intervention, that there was “no compelling reason not to segregate”, and that the man should be afforded access to HCC, chaplain and a governor each day. A governor again confirmed this position.

As referred to in page 21 of this report, the doctor wrote a memorandum to the Governor following the man’s death.

Medical Care

The Prison Health Commissioning Manager at Wakefield West Primary Care Trust, conducted the clinical review as follows:

- Review the quality of assessments regarding the man's mental and physical health.
- Review the appropriateness of any treatment that was given to the man, for his mental and physical health.
- Review the appropriateness of his location / accommodation particularly the levels of observation.

Quality of Assessments

The clinical reviewer considers that the mental health assessments carried out by the prison's healthcare team were of a high quality and carried out by appropriately qualified healthcare practitioners i.e. Registered Mental Nurses. Similarly, all other clinical assessments undertaken by both nursing and medical staff were also of good quality and the assessors were appropriately qualified to complete these assignments. He notes that there is effective multi-disciplinary team working which is evidenced from interview and a review of the records.

The implementation of the procedures for the prevention of self-harm, as described in the F2052SH instructions was appropriate at the relevant times.

Treatment for Mental and Physical Health

The clinical reviewer concludes that the prescribed and given treatments were appropriate and well considered. No additional clinical treatments or psychiatric referral (to specialist mental health trust psychiatrists) would have been appropriate or indicated at the material time.

Appropriateness of Location / Accommodation

The man's various prison locations were appropriate at that time, i.e. appropriate utilisation of the HCC, followed by location in the Segregation Unit following the man's "dirty protest".

The man was comprehensively clinically assessed whilst in the HCC. HCC staff intervention and relocation to the segregation unit was appropriate on all occasions.

The decisions taken to determine observation levels in the HCC and the Segregation Unit were well considered and appropriate. From interview and examination of the records, the staff consistently carried out the agreed observation levels.

The clinical reviewer's audit of the man's clinical care strongly suggests that the man received a high quality of both physical and mental health

interventions from the staff at Wakefield. He was not an individual with serious or chronic mental health issues. He was also in reasonable physical health.

Despite the very positive overview of the man's clinical treatment, the reviewer makes six recommendations.

1. All members of the HCC team should be up-dated on their Emergency Aid training.

2. Members of the Segregation Unit should be competent in Emergency Aid.

3. Sufficient members of both the HCC and Segregation Unit teams should be trained in the proficient use of defibrillators.

4. The F2052SH at Risk of Self-Harm Policy and Procedures need to be reviewed and updated at a National level. *The investigation team noted that the F2052SH is being replaced with a new protocol, the Assessment Care in Custody and Teamwork (ACCT). It improves on the F2052SH procedures by concentrating on a more individualised "case work" approach to the management of prisoners who may be a risk.*

5. The Segregation Unit should consider the introduction of an effective key worker system. *The investigation team noted that all High Security prisons have been required to implement new Segregation Unit strategies which must, amongst other things, focus more closely on the individual needs of the prisoner, and include key workers and case management conferences. The new procedures must be in place by the end of 2005.*

6. HMP Wakefield needs to develop its mental health services to ensure the current good practices can improve and modernise, to ensure equivalence to that which is available to the general public.

In addition, the reviewer notes four areas which he considered of good practice:

1. Good mental health assessments and Segregation Safety Algorithms. *It has not been possible to further investigate and review the precise process of clinical decision making as to how the doctor arrived at his decision to authorise segregation because it has not been possible to either interview him or substantiate and corroborate his comments in his letter to the Governor. All gleaned evidence both within prison documents and through interviews with prison staff indicates to the contrary the doctor's comments in his letter to the Governor*.

2. High quality CARATS assessment, in particular the man's alcohol problems.

3. Good decision making, in terms of the man's location whilst at Wakefield.

4. Both HCC and Segregation Unit staff treated the man in a very professional and caring manner.

Issues Raised by the man's Family

The man's mother has raised concerns about the man's arrest, his time in custody and the trial. The man's brother, returned to these points and raised some new matters in a letter dated 16 April 2005.

My investigators did not look into the issues relating to the man's arrest and other matters which are to do with the conduct and outcome of the trial, as these were not considered to be within my remit. Nor have they looked into questions about the formal identification of the man, which is a matter for the police and the Coroner.

I hope that most of the issues raised by the family are covered elsewhere in this report. However, those matters not dealt with elsewhere are set out below:

The man's brother raises the question of a visit booked for the man's solicitor, on 15 July at 1:45pm. This was refused by officers, claiming that the man did not want to see her, despite her office receiving a phone call from the man at 9:00am that morning explicitly stating he wanted a visit. The man said that he was convinced that prison officers in his wing (B wing) were going to deny him access to his legal team. The man insisted he had not cancelled the visit. The man wants to know what further steps were taken after his solicitor complained.

The Governor of Wakefield wrote to the man's solicitors, on 22 July, advising them that it was the man who had refused to attend the visit, even after being informed on two occasions that he had a legal visit booked. Staff on B Wing recorded in the Staff Observation Book that the man had refused the visit. A Security Information Report (S.I.R.) had been submitted by an officer on 15 July which states:

"On 15.7.04 this inmate) refused to attend a special visit. I asked him why he had refused and he told me it was to drop staff "in the shit". He said he had been mistreated at court and was going to tell his solicitor we never offered him a visit. I asked him why he was doing this and he said he was about to ring his solicitor to ask why she had not turned up. He then said that would teach us a lesson when we were up in front of the judge for refusing him a visit."

The man's brother said that, on 19 July, another appointment was made for his solicitor, a week in advance and for the whole day of 26 July, as she was becoming increasingly worried that his trial was approaching. Despite giving a week's notice, she was informed on 23 July that the prison was unable to accommodate all day visits, due to staff shortage. When she suggested a morning visit, she was told the prison was fully booked. Yet strangely she booked an all day visit. Coincidentally, it appears that the man had misbehaved on the previous two days 22 and 23 July. The man wanted to know if any further action was taken.

The Governor replied to the man's solicitors on 2 August acknowledging that the all day visit had indeed been cancelled. This had been due to the necessity to divert staff to cover heavy court escort commitments for the day in question. The Governor went on to explain that the all day legal conference facilities were over and above the normal legal visits arrangements, and were a local initiative to assist prisoners and their legal teams. However, this would be dependent upon sufficient staff being available to operate this facility, which is in a different location to the main visiting area. Routine legal visits would be booked through the usual procedures and would generally be based on a first come, first served basis. Once full, all other requests would need to be declined. It would appear that the all day facility was cancelled at short notice and the normal legal visits were fully booked.

It is worth noting that the pressure on legal visits at Wakefield would have increased dramatically after the prison took on the role of holding prisoners on remand or awaiting trial. Previously the prison only accommodated sentenced prisoners.

The period between the end of March and the man going back to Manchester at the beginning of August was a comparatively settled time for him and he had received other legal visits during the period.

The man's brother wishes to know if it is the usual practice for sheets to be in the cells in the segregation unit and, if so, where is the bedding now.

It is normal for sheets to be part of the bedding in the segregation unit cells. All items in the cell were retained in the cell and handed over to the police for forensic examination and retention or disposal.

The family have requested to see the footage of the CCTV coverage of the segregation unit.

The Detective Inspector in charge of the case is in possession of the CCTV footage and arranged for the various views from different cameras to be compiled to provide as accurate an overview as possible. The Inspector has shared this with the family and solicitor.

Finally, the man's brother cites various Home Office reports and news items, suggesting that Wakefield has a history of self-harm and suicide, especially in the segregation unit. He and his family are determined to uncover any foul play which they believe the man was subject to at Wakefield. The family believe that the man did not willingly take his own life.

A key issue raised by the man's brother is that they do not believe that the man would willingly take his own life, and consider there has been malpractice at Wakefield. The police have ruled out any suspicious circumstances or criminal activity. This report has considered the way Wakefield looked after the man during his time in custody, and whether this was fair and reasonable.

Findings and Conclusions

The man was 28 years of age when he died at Wakefield. He was a young man, who had considerable experience of the criminal justice system and of periods in custody. At the beginning of 2004, he found himself arrested for serious offences which included the use of firearms.

The charges the man faced were serious, and resulted in him being assigned to the highest security level when brought into Prison Service custody. I judge that the decision to make the man a Category A prisoner was appropriate and commensurate with the charges he faced.

There is evidence that at least one of the victims of the man's offences had connections with a family who had associates in Manchester prison. There appears little doubt that the man would have been at risk of physical attack at Manchester. The decision to move the man to the nearest alternative establishment, Wakefield, was correct.

On arrival at Wakefield, the man was located in the HCC for the first night so that an initial assessment could be completed prior to him being moved to a general wing. The assessment suggested that he presented no problems of risk to himself or other prisoners, so he was moved to the remand wing.

This is good practice for all new remand admissions.

The man adapted fairly well to his location on B wing and was seen as a reasonable, if sometimes volatile, prisoner. An officer knew the man pretty well, but states that at that time there were no personal officers assigned to specific prisoners. Wakefield had done some considerable work on this subject, having formally reviewed its Personal Officer Scheme in April 2004. However, this does not appear to have ensured that all prisoners have Personal Officers.

Recommendation: All prisoners, including those on remand, should be assigned designated Personal Officers, and the role of the Personal Officer should be explained to prisoners.

The man first exhibited signs of distress on 13 March when he told staff on B Wing that he was feeling suicidal. The response of staff was to open a F2052SH form and to make him the subject of additional monitoring and support. This was a timely and proportionate response to the man's feeling of anxiety. The man was also moved to the HCC and located in a "safer cell", which was constantly monitored by CCTV.

The following day, the man commenced a dirty protest. On 15 and 16 March, he made ligatures which he handed over to staff. His actions were accompanied by shouting and ringing of the cell bell, ensuring that staff were aware. Later that afternoon, the man ended his dirty protest. Once showered and wearing clean clothing, he was relocated to the Segregation Unit still under close monitoring. The Rule 45 paperwork for this period of segregation

was signed by a governor grade, but the Segregation Safety Algorithm was not. As these documents were completed at about the same time, this appears to be an oversight rather than the man being segregated without any authority.

During this period in the HCC and Segregation Unit, the level and quality of care for the man was very high, despite the dirty protest, the shouting and dysfunctional behaviour. This is confirmed by the Clinical Review.

On 18 March, the man claimed to have swallowed a razor and made some small cuts to his body. He was seen by the doctor who recommended that he be taken to outside hospital for x-ray, but as a non-emergency case. The man made a further small cut to his thigh that afternoon. He was taken to hospital on 19 March for an examination. No trace of a razor blade was found.

The man was moved back onto his normal wing, B.2, on 31 March and appeared to settle down well, although he was still being monitored under F2052SH procedures. After a series of reviews, the man was taken off the F2052SH on 8 April. There were then seven and 14 day reviews, and a check by the Head of Residence.

During this very difficult period for the man, there is considerable evidence to confirm that the man was treated professionally and compassionately by the various staff who managed him.

The process of seven day and 14 day checks after the closure of the F2052SH booklet is good practice, as is the documented quality review by the Head of Residence.

On 12 July, the man said that he was assaulted by am officer, with whom he had previously had a run in whilst in the segregation unit, over access to his inhaler. The man alleged that the officer assaulted him in Crown Court. The officer flatly denied this allegation. The man's solicitors said that they would be lodging a formal complaint on behalf of the man. This complaint was never received and neither did the man invoke any of the other complaint procedures.

At the adjudication on 10 August, the man pleaded guilty to abusing the officer and admitted that the officer had not assaulted him. There is no other evidence which suggests that the officer had assaulted the man or that he had acted unprofessionally towards the man at any time.

On 4 August, the man was given 20 years imprisonment by the trial Judge. There is no doubt that a sentence of that length was a significant blow to the man. The man was initially taken from court to Manchester, where he was located in the segregation unit. Although unhappy with the sentence, the man did not display any suicidal or self-harm tendencies to staff at Manchester.

The man was returned to Wakefield on 6 August. Again, the man did not present to staff as an individual who was contemplating any injury to himself.

The Suicide Prevention Strategy and Policy Document says that category A remand prisoners who return from trial with a life sentence should be made subject to the F2052SH procedures, monitored closely and consideration given to whether they should be located in the HCC, as a precaution.

I consider that this is good practice.

Recommendation: The Governor should consider reviewing the instruction, "Any remand category A prisoner receiving a life sentence will have a F2052SH opened and be placed under consideration as to whether or not to locate in the Healthcare Centre as a precaution", to include those prisoners who receive long determinate sentences.

On 9 August, the man was selected to take a targeted drug test. He refused to take the test which requires the prisoner to give a urine sample. There had been previous intelligence suggesting that the man was involved in provision of drugs at Wakefield. The man was therefore placed on disciplinary report.

The following day, the man was taken to the segregation unit to face this charge and the one for abusing the officer which had been held over from a previous occasion. The man pleaded guilty to both charges and claimed in mitigation that he did not wish to take the drugs test because "he had not slept until 5:00am and that he had not taken drugs, as he was on a voluntary testing compact". The man was given seven days cellular confinement. This would be completed in the segregation unit.

The conduct of the adjudication raises no procedural issues and the punishments given for the two charges are in line with the normal tariffs.

The man had been subject to two Segregation Safety Algorithms that morning. One was completed by a qualified nurse, the second shortly afterwards by the doctor. Both assessments concluded that the man had no presenting problems or difficulties which would preclude him being located in the segregation unit, and that he was fit for the punishment of cellular confinement. Staff interviewed said that the man give no indication that he was at risk that morning.

The next day, the doctor told the Governor that he believed that the man would be located in a cell with camera cover. In a statement to the police, the doctor claimed that he told staff that the man should be put in a cell with camera cover, and that he recorded this in the medical record. There is no other evidence of this.

Healthcare guidelines say that record keeping is an integral part of clinical care, providing a tool of professional practice and one that should help the care process. Good record keeping ensures:

- High standards of clinical care
- Continuity of care

- Better communication and dissemination of information between members of the inter-professional team
- An accurate account of treatment, care planning and delivery
- The ability to detect problems and changes in the patient's condition at an early stage.

From the available documentation, the doctor did not make any written entries regarding specific instructions to staff about the location and level of observation the man should be subject to. The failure of clinicians to make adequate entries in the medical record means that the quality of care can be compromised. In the case of the man, it meant he was not placed in a cell with CCTV cover, as the multi-disciplinary team were not aware of this need.

All medical staff completing a safety algorithm must be clear as to which type of cell and under what circumstances a prisoner will be held in segregation unit, before completing the document. It is important that, when medical staff have any concerns about the safety of a prisoner or have identified any risk factors, this is clearly articulated to the staff in the segregation unit. This must be written on both the safety algorithm and in the prisoner's medical record.

Recommendation: Medical staff who complete the segregation Safety Algorithm should be reminded that they must satisfy themselves that they fully understand which type of cell and the conditions under which the prisoner will be held, prior to signing the algorithm.

Recommendation: Medical staff should be reminded that if they have any concerns about a prisoner, or have identified any possible risk factors, they must articulate these clearly to the segregation unit staff and record this in the Segregation Safety Algorithm and in the relevant Inmate Clinical Record.

The man was located in cell F3-11 in the segregation unit. He was monitored on an hourly basis. There are no comments or observations made in the staff observation book for that day, apart from an entry that all was quiet. This officer was the last to see the man alive, as he did his hourly check at 11:00pm. He recorded that the man acknowledged him and waved. It was on his next check that he discovered the man hanging by a ligature from the cell windows. The night officer alerted the night orderly officer who, with assistance, went to F wing and initiated the contingency plans via the control room.

F wing at Wakefield is situated against the front wall of the prison, next to the administration building. It is separated from the main prisoner living units by a series of gates and security fencing. The night orderly officer would be located in the main prison for the majority of his duty period.

It takes between about six to eight minutes to move from the main prison. The time taken depends upon having a dog patrol in place and movement through the centrally controlled electrically locked gates. With the assistance of two officers, entry was made to the cell, the man was cut down and

resuscitation was started. The paramedics arrived at about 12:16am and attempts to revive the man continued but to no avail. The doctor pronounced the man dead at 1:10am.

The response to the discovery of the man and the follow up action was well managed by the night orderly officer and the staff on duty, including the Duty Governor. The contingency plans appear to have been well executed, although the police were not informed until 1.51am, 40 minutes after death had been certified. The cell had been properly secured and remained so until handed over to the police at 2:15am.

On confirmation of the death, the police should be informed immediately. This should be expressly written into the contingency plans and the responsibility should be that of the officer in charge of the control room. It should not require the presence of the duty governor or other senior manager to activate this instruction.

Recommendation: The contingency plans should be altered to specify that "Upon confirmation of the death of a prisoner, the control room should immediately report this to the police".

The segregation unit is isolated from the main prison. This means that emergency access, particularly medical assistance, will be delayed due to its location and the number of security barriers which must be overcome. The unit is austere, having cells positioned on only one side of the house block, unlike all other living units in the prison. F wing also holds prisoners held under Prison Rule 46, who are part of the Close Supervision Centre system. In this case, staff followed local policy and are not criticised for the delay in entering the cell.

It may be that the segregation unit part of F wing would be better located within the main prison. This would provide for easier access by staff to provide the necessary support to and monitoring of those held in segregation. It would certainly ease emergency intervention. In addition, it may assist in removing a degree of the mystique surrounding the current segregation unit simply by improving its accessibility.

I realise that this may not be achievable, but should be given due consideration by the Governor and the Deputy Director General. If moving the segregation unit is not feasible, then due consideration should be given to having suitably qualified medical staff (nurses) on duty in the unit during nights or able to access the unit quickly.

Recommendation: The Governor and the Deputy Director General should consider the appropriateness of the current location of the segregation unit within Wakefield, and the Governor of Wakefield should consider the feasibility of a qualified nurse being part of the night complement on F wing or healthcare staff having prompt access to the unit in the event of an emergency.

Whilst prisoners raised general matters of concern about life at Wakefield, the investigators found no evidence that the man was mistreated, either at Wakefield or in the short time he was at Manchester.

I am very concerned, however, to learn that there is evidence that a local risk assessment form which purports to have been completed on 10 August was not in fact completed until after the man's death. The Governor has launched an investigation into these allegations which are very serious indeed.

Wakefield West PCT has provided a clinical review into the care the man received whilst at Wakefield. However, the report did not address the way in which the doctor assessed that the man was fit for cellular confinement. The Chief Executive may wish to look into the clinical review process, with a view to improving the quality of reviews to ensure that all the issues are appropriately reviewed.

Recommendation: I recommend that a copy of this report is sent to the Chief Executive of the PCT so that he may consider the conduct of clinical reviews to ensure that all the issues are covered.

The Programmes Department received a self-completed questionnaire from the man. He said he had been subject to bullying and mentioned two specific occasions. It is of concern that there is no evidence that this was formally investigated. Such information should be promptly shared with the Suicide Prevention and Anti Bullying team.

Whilst I do not believe the life sentence planning had any bearing on the outcome of the man's case, I question its use in his case. The man was not expecting a life sentence, in fact he was expecting between eight and twelve years. Furthermore, the offence for which he was charged would not have attracted an automatic life sentence. Completing a life sentence planning document for a prisoner not expecting such a sentence, if found guilty, would do little to help their mental state during an already emotional time.

Recommendations

1. The Governor and the Deputy Director General should consider the appropriateness of the current location of the segregation unit within HMP Wakefield, and the Governor of HMP Wakefield should consider the feasibility of a qualified nurse being part of the night complement on F wing or healthcare staff having prompt access to the unit in the event of an emergency.

2. All prisoners, including those on remand, should be assigned designated Personal Officers, and the role of the Personal Officer should be explained to the prisoner.

3. The contingency plans should be altered to specify that, "Upon confirmation of the death of a prisoner, the control room should immediately report this to the police".

4. Medical staff who complete the segregation Safety Algorithm should be reminded that they must satisfy themselves that they fully understand which type of cell and the conditions under which the prisoner will be held, prior to signing the algorithm.

5. Medical staff should be reminded that if they have any concerns about a prisoner, or have identified any possible risk factors, they must articulate these clearly to the segregation unit staff and record this in the Segregation Safety Algorithm and in the relevant Inmate Clinical Record.

6. The Governor should consider reviewing the instruction, whereby "Any remand category A prisoner, receiving a life sentence will have a F2052SH opened and be placed under consideration, as to whether or not to locate in the HCC, as a precaution", to include those remand prisoners who receive long determinate sentences.

7. I recommend that a copy of this report is sent to the Chief Executive of the PCT so that he may consider the conduct of clinical reviews to ensure that all the issues are covered.

Good Practice

1. Suicide Prevention and Anti Bullying team officers interview all new receptions upon arrival at HMP Wakefield to assess their risk of self-harm to themselves and to others.

2. The Head of Residence conducts a final management check on all closed F2052SHs to check quality. I also welcome the process of 7 day and 14 day checks after the closure of the F2052SH booklet. Areas of concern are followed through, with the Head of Residence personally advising staff of the standards expected.