Investigation into the circumstances surrounding the death of a man at HMP Wymott in February 2005

Prisons and Probation Ombudsman for England and Wales

February 2006

This is a report into the circumstances of the death of a man at HMP Wymott in February 2005. The man was found hanging in the prison's Segregation Unit where he was serving a punishment of seven days cellular confinement. A ligature had been fixed in the cell window. He was 28 years old.

My colleagues and I would like to extend our condolences to the man's family and to all those touched by his sad and untimely death.

The investigation was carried out on my behalf by my colleagues, a Senior Investigating Officer and an Investigating Officer. A clinical review of the man's health care at Wymott was conducted by the Assistant Clinical Advisor to the North West Prison Health Development Team of Chorley and South Ribble Primary Care Trust.

I would like to thank the then Governor of Wymott and his staff for their co-operation and assistance with this investigation.

This is an important report on the death of a young man who, troubled by the death of his brother, wanted to transfer to a jail in the South of England close to his father with whom he had become reconciled. For reasons this report explores, that transfer never took place.

The man's death was the second to have occurred in Wymott's Segregation Unit in two years. My report makes nine recommendations.

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

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Summary

1. The man was sentenced to a total of six years imprisonment on 27 November 2001 for offences of assault and grievous bodily harm. It was not his first time in custody. He would have been released on 4 November 2005.

2. The man had a long history of illegal drug misuse and problems with alcohol since he was a teenager. He also had some previous mental health problems and risk of self harm.

3. The man was first sent to HMP Forest Bank where he made contact with CARATS (drugs services) to address his drug use and had regular appointments with them. These continued when he was transferred to HMP Wymott in March 2003.

4. In late September 2003, the man's brother, his only sibling, died after taking his own life. The man was referred twice for bereavement counselling after talking to a nurse about how upset he was feeling. The Health Care Centre was informed that the bereavement counsellor had left and there was no one currently available.

5. In January 2004, the man had an appointment with a doctor where it was noted that his health had been affected by his brother's death. He was not eating or sleeping well and it was possible he was suffering from mild depression. As a result, he was referred for a mental health assessment which took place on 11 February. The man told the mental health nurse that he wanted to sort out his problems. The nurse noted in his medical record that she would speak to the doctor concerning treatment. However, there is no follow up to this entry in his medical record.

6. The man had always lived in the Greater Manchester area. His parents separated when he was young, but after re-establishing contact with his father in 2004 he decided that on release he would like to live with his father and his father's partner in Essex. On 16 July 2004, he made an application to move to HMP The Mount, a category C prison in Hertfordshire.

7. On 27 November, the transfer clerk at Wymott noted that she had not received a reply from The Mount to the man's application. She believed she sent a standard memorandum to the man's wing asking him to indicate whether he wished to make another application. She did not receive a reply.

8. The man wrote to his mother and her partner on 1 January 2005 to say that another transfer application had been sent on 27 November.

9. On 7 January, the man was given a total of 42 added days to his sentence for two offences against prison discipline - having opiates in his urine between 21 and 26 November and for refusing to provide a sample

of urine on 20 December. He appealed against receiving 21 added days for refusing to provide a sample of urine. He considered the punishment to be harsh compared to other prisoners.

10. On 1 February, the man told his CARATS worker that he had been offered bereavement counselling a year after he had requested it and this had brought back memories of his brother's death which he was finding hard to cope with. Later that day, he decided with another prisoner on C wing, prisoner A, that they would both refuse to be locked in their cells that evening. They wanted to go to the Segregation Unit so that they would be transferred out of Wymott. They were both taken to the Segregation Unit as planned.

11. Whilst in the Segregation Unit, the man told prisoner B, a prisoner in a cell next to him, that he had been in trouble on C wing because he had bought a bag of heroin but could not afford to pay for it. He also spoke of wanting to be transferred nearer his family in Essex.

12. On the evening of 2 February, six prisoners in the Segregation Unit flooded their cells and some smashed their wash basins and toilets. According to prisoner C, a prisoner in a cell next to the man, the man told him that he did not want to take part in the disturbance because he did not want to jeopardise his transfer to a prison nearer his family. The man was named by staff as one of the prisoners who had flooded his cell with water and he was placed on disciplinary report, as was prisoner A. Prisoner C admitted flooding his cell. He was not placed on report. The man denied flooding his cell.

13. On the morning of 3 February, six prisoners, including prisoner A, were transferred from the Segregation Unit to other prisons. The man, however, remained at Wymott.

14. In the afternoon, the adjudication hearings into the man's alleged breaches of prison discipline began. He received seven days cellular confinement for refusing to be locked in his cell on 1 February, but the adjudication for flooding his cell was adjourned for the Independent Adjudicator. Prisoner B said that he last spoke to the man after the hearing at about 4:30pm. He said the man was angry for being placed on report for something he said he did not do and for which he might get additional days added to his sentence. In contrast, the man thought it unfair that his friend, prisoner A, who had smashed up his cell got both a transfer and no adjudication.

15. At approximately 5:30pm, prisoner C spoke to the man out of his cell window. He said that the man seemed a little depressed after the adjudication but did not get the impression that he would harm himself.

16. At approximately 5:40pm, two wing officers opened the man's cell door to give him his evening meal. They found the man hanging from his cell window having used a bed sheet as a ligature. Other officers and

nursing staff attended immediately and Cardio Pulmonary Resuscitation was started. However, no vital signs were detected and despite the prompt arrival of paramedics, the man was pronounced dead late in the afternoon. Police attended the prison and were satisfied that there was no third-party involvement.

17. As Wymott is in Lancashire, the Governor of Wymott asked the police service in the area where the man's mother lived to tell her of her son's death. Despite assurances that they had done so, when the Governor telephoned her it was clear that she had not been informed by the police and the Governor was obliged to deliver the news of the man's death over the telephone.

18. Both of his parents said they understood the man had accumulated debts whilst in prison for cannabis and the use of a mobile telephone. The father was sending money to various addresses to pay his son's debts.

19. A post mortem examination took place on 4 February. It found that the man's death was due to hanging, that there were no marks of violence and that there were scars on his left wrist indicating previous attempts at self harm.

20. My report makes a number of recommendations, which include raising the profile of the anti-bullying strategy, reviewing the way transfers are administered, and restoring the credibility of the transfer system so that the Segregation Unit is not seen as a route for a move out of the prison.

Investigative Process

21. The Senior Investigating Officer conducted a preliminary visit to HMP Wymott on 9 February 2005 and returned on three subsequent occasions with an Investigating Officer from my office. They were given access to the man's prison records including his medical record. My investigation team met the Governor of Wymott and representatives from the Independent Monitoring Board and Prison Officers' Association to offer them the opportunity to raise relevant issues. They also visited the cell where the man had died and spoke to staff on duty in the Segregation Unit.

22. Notices to staff and prisoners announcing the investigation were displayed around the prison, although my investigators saw no notices in the Segregation Unit itself or in the Visitors Centre. Visitors Centre staff told my investigators that they had not been told about the man's death from the prison but, rather, had learned of it after seeing it mentioned in the local newspaper.

23. The man's family were offered, and accepted, the opportunity to contribute towards the investigation process. One of my Family Liaison Officers accompanied each of my investigators on separate visits to the man's parents.

24. A clinical review was requested from Chorley and South Ribble Primary Care Trust (PCT).

HMP Wymott

25. HMP Wymott is a medium security prison near Preston. It holds 1,040 sentenced prisoners. The site consists of two largely separate populations of Category C prisoners (for whom high levels of security are not considered to be necessary) and vulnerable prisoners who are protected from others largely due to the nature of their offences.

26. At the time of the man's death, healthcare services at the prison were provided by nursing staff employed by the Prison Service, although the Head of Healthcare is employed by Chorley and South Ribble PCT. Wymott prisoners who need in-patient facilities are accommodated in the Healthcare Centre at HMP Garth which is situated next to Wymott. There was one Registered Mental Nurse (RMN) at Wymott in February 2005, although the prison was in the process of recruiting three more. The mental health in-reach service was based at Garth. If prisoners at Wymott require mental health services, they have to make an appointment to see the doctor, who would refer them to the RMN, who in turn would make a referral to the in-reach team if necessary.

27. The most recent report on Wymott by HM Chief Inspector of Prisons (HMCIP) is dated December 2003. In summary, it said that "Wymott was overall a safe … and well-managed prison, providing work for almost all its prisoners, and moving ahead swiftly on the resettlement agenda."

28. The previous death in the Segregation Unit at Wymott occurred on 26 May 2003. There are some similarities between the death of that prisoner and that of the man who is the subject of this report. Neither had been identified as being at risk of self harm at the time of their deaths, both had previous closed F2052SHs and there were delays in contacting their next of kin due to lack of clarity from the police.

Events leading up to the man's death

Forest Bank

29. On 23 April 2001, the man was remanded in custody on a charge unrelated to that for which he was subsequently convicted and sentenced. He was taken to HMP Forest Bank and seen by a nurse as a newly received prisoner. A First Reception Health Screen form was completed after his arrival. The man was asked about his mental health. He said that although his brother had attempted suicide, he personally had not tried to take his life previously. The man admitted, however, that when he was 19 he had been sectioned under the Mental Health Act in a hospital for eight weeks, suffering from depression. He had cut his wrists after a relationship with a girlfriend ended. He was referred for counselling by Forest Bank. However, it appears he was then released on bail.

30. On 24 September, the man attended the Magistrates' Court, charged with assault and grievous bodily harm. He was remanded in custody. Whilst in the court cells, he told the Drug Referral worker that he felt suicidal because he was going back to prison and that he had tried to hang himself in the past. An F2052SH booklet was opened at court. He was placed in a shared cell and observed every 15 minutes. The F2052SH accompanied him back to Forest Bank. He was assessed by a doctor as not having suicidal intent and observed every 30 minutes on an ordinary residential wing as he did not wish to go to the Healthcare Centre. A case review was held at Forest Bank on 30 September. As he had not shown any signs of self harm or thoughts of suicide, the F2052SH was closed.

31. On 10 October, the man made an application to see CARATS (Counselling, Advice, Referral, Assessment, Throughcare Service) which is the service available in every prison in England and Wales which provides help with tackling addiction and drug use.

32. On 27 November, the man was sentenced to a total of six years imprisonment.

33. On 30 November, at his own request, the man had a full CARATS assessment. He said that although he had been drug free for the previous two months, he first drank alcohol when he was 14 years old and would drink some lager and half a bottle of spirits a week. At 15, he began to smoke two to three cannabis joints a day. He took six ecstasy tablets a month when he was 18, and began to use cocaine monthly when he was 21, and had not been drug free until he had come into custody. He admitted to using heroin in prison in the past and that he had not sought help previously for his drug use although his General Practitioner was aware that he used drugs. He estimated that he had spent about £60 a week on drugs and that his offending behaviour began aged 15 when he either offended to fund his drug habit or committed

offences whilst under the influence of drugs. He acknowledged that his family relationships had suffered as a result, and that he would show violent behaviour towards his family if he was not given money to spend on drugs. He said that his family were not drug users but his friends were, and he found it difficult to resist when drugs were offered to him.

34. On 14 January 2002, the man's Record of Events states that he was due to be relocated in the detoxification unit after failing a second voluntary drug test. There is no evidence in his medical record that he underwent detoxification.

35. On 24 April, he was found guilty at an adjudication hearing for contravening prison discipline by receiving drugs from a visitor. He was given a punishment of an additional 24 days in custody. On 25 July, a Security Information Report was submitted which said that the man was being supplied with cannabis.

Wymott

36. On 9 August, the man was transferred to Wymott. On 11 December, in a CARATS appointment, he said that he had been drug free since arriving and that he no longer wanted to be in a circle that focussed on drugs. On 21 January 2003, during another CARATS appointment, he spoke of thinking about not returning to Leigh as he did not want to fall back into bad habits.

37. On 10 February, the man was transferred from Wymott to HMP Risley, another category C prison. On 4 March, he was transferred back to Wymott after an officer at Risley recognised him as a neighbour.

September 2003 – death of the man's brother

38. In late September, the man's brother, who was his only sibling, took his own life. The man was escorted to the funeral on 6 October. He told CARATS that he had spoken to a prison Chaplain and that he had used cannabis twice for comfort.

39. On 7 October, the duty nurse contacted someone at Cruse, the organisation that works with the bereaved. She wrote:

> "Please could you arrange to see this man? I have seen him today in Lifestyle Clinic where he was quite upset and painted a very tragic picture of family tragedies over the years. His mother [sic] died eight months ago and he feels that his way of coping so far is to block it out of his mind. Can you help him?"

40. The letter clearly was erroneous in referring to the man's mother, instead of his brother, as having died. Also, the date of the bereavement was eight days previously rather than eight months.

41. A hand written note on the letter dated 6 November 2003 stated that the officer at Cruse had resigned and nobody else was available at present.

42. On 16 October, a note was made in the man's medical record that his brother had died the week before, possibly due to suicide, and that the man was having difficulty coping. He did not have thoughts of self harm and was prescribed chlorpromazine.

43. On 19 October, the duty nurse wrote a second referral to the officer at Cruse:

> "Please could you arrange to see the above mentioned prisoner? His brother died approximately four weeks ago (possible suicide). He saw the doctor a few days ago and said that he felt like he was going to explode. When I suggested your services he seemed quite keen and the doctor, prisoner and I felt that your input would be valuable to aid him coming to terms with his bereavement."

44. A copy of the letter in his medical record has "the officer resigned nobody available at present" written on it.

45. On 25 October, an officer found heroin in an envelope which had been posted to the man.

46. On 17 November, the man had an appointment with his CARATS worker who noted that he was unhappy, did not want to do Reasoning and Rehabilitation (R and R, an offending behaviour course), and wanted to leave Wymott either by being recategorised or by going to the Segregation Unit.

47. The man had a CARATS appointment on 15 December and admitted the previous week had been difficult because it would have been his brother's birthday. It was noted, though, that his attitude seemed to have changed and that he now wanted to do R and R.

Events in 2004

48. On 9 January 2004, a prison officer noted in the man's Record of Events that the grieving process for his brother had hit him and he had asked to see someone from chaplaincy. The officer said in interview after the man's death that the man had been on her residential unit, E wing, at the time of his brother's death. He used to speak to her about his brother. She had arranged for a Listener, a prisoner trained by the Samaritans, to talk to the man and knew that he also had contact with the chaplaincy.

49. On 29 January, the man saw the prison doctor. It was noted in his medical record that his was not eating or sleeping well and that his mood was low due to his brother's death. The doctor queried whether he was suffering from mild depression. As a result, the man was referred to the mental health nurse for a mental health assessment. The assessment

took place on 11 February. The assessment noted that the man's mood, appetite and sleep patterns had gradually worsened since his brother's death the previous September. The man said that he felt lethargic, had no motivation, had lost interest in things and had lost weight. He said he would like to sort out his problems and would consider medication and counselling. The nurse's feeling was that the man was suffering from reactive depression and that he would benefit from some counselling and medication to elevate his mood. She noted in his medical record that she would speak to the prison doctor concerning this. There is no follow up to this entry in his medical record.

50. On 19 March, the man's CARATS record said that he was in a good frame of mind and he was doing a gym course that he enjoyed. He had a number of subsequent CARATS appointments. He was seen to be drug free, positive in outlook, and not using hard drugs.

51. On 5 May, a Security Information Report was submitted following the man telling an officer to "watch his back" after he was sacked from his cleaning job on E wing.

52. In his CARATS session on 15 June, the man mentioned being considered for early release on parole.

July 2004 – Transfer application

53. On 16 July, the man made an application to move to HMP The Mount, a category C prison in Hertfordshire, as he wanted to move nearer to his father with whom he would be living on his release.

54. On 21 July, the man decided that he no longer needed CARATS as he had been drug free for a significant length of time. He agreed to his file being closed.

55. On 18 August, the man received notification that parole had been refused on the grounds that he needed to do further work on domestic violence and cognitive skills.

56. On 26 August, the man's personal officer completed a risk assessment to consider him for a lower category prison. He did not recommend downgrading as he said the man's risk had not reduced due to previous Security Information Reports. On 2 September, the man was given a job working in the food servery on C wing. On 18 October, he was given three days cellular confinement in the Segregation Unit and 21 days stoppage of earnings at 50% as a punishment for fighting with another prisoner. As a result, he lost his job in the servery.

57. On 4 November, a Security Information Report (SIR) raised by an officer commented that the man was amongst several prisoners on his wing who during Canteen (the weekly opportunity for prisoners to buy personal items, toiletries or food stuffs) had bought a large amount of stamps and

nothing else. The report speculated that stamps were the new currency to buy drugs and to pay for unauthorised mobile phones.

58. On 27 November, the Executive Officer who deals with transfers noted that she had not received a reply from The Mount concerning the man's application. At interview, she said that she would give a prison from a month to six weeks to reply and, depending on her workload, she would make enquiries. But as The Mount was not a prison she had had much to do with, she did not chase up the man's application. She said that she would have sent a standard memorandum to the man's wing saying that no reply has been received from the prison, and asking if the prisoner wished to make another application or apply to another prison. The onus was on the prisoner to respond. She did not receive another application from him.

59. On 2 December, the man was placed on report for having opiates in his urine between 21 and 26 November. His case was adjourned until 7 January 2005 to be heard by an Independent Adjudicator (a district judge who hears adjudications and has the power to impose added days) at a date to be fixed.

60. On 20 December, the man refused to give a urine sample and was again put on report, with the case adjourned to 7 January.

2005

61. On 1 January 2005, the man sent a letter to his mother and her partner. He wrote "my transfer papers got sent on the 27 November so I'm expecting to find out soon where I'm going. With a bit of luck it will be soon. I've put in for local discharge. A jail in Essex. Chelmsford."

62. In fact, there is no evidence that a transfer application for HMP Chelmsford was sent on that date. The man had either misunderstood what had happened to his transfer application or he had been misinformed.

63. On 7 January, the adjourned adjudication from 2 December was resumed. The man pleaded guilty and the Independent Adjudicator imposed a punishment of 21 additional days in custody. On the same day, he also received another 21 added days to run consecutively from the previous adjudication for refusing to provide a urine sample on 20 December.

64. On 18 January, the man made an application to see a CARATS worker and have his file reopened.

65. On 27 January, the man appealed about being given 21 additional days for refusing to provide a sample of urine. He complained that the punishment was unduly harsh as three prisoners from his wing had also refused to provide a sample at the same time and they were given only

14 additional days. He wrote that he had submitted an appeal on 7 January but had been told on 27 January that there was no record of this.

66. On 29 January, the man wrote his last letter to his father and father's partner saying that he would send a Visiting Order to them and asking for some photos taken of the family at Christmas. The mood of the letter appeared to change and he ended, "These screws fucking hate me, I'd love to be left in a locked room with them one at a time …"

67. On 1 February, the man was seen by a CARATS' worker. He said that he had been offered bereavement counselling a year after he had requested it and this had brought back memories. (The investigating team were unable to find any record of a later offer of counselling.) He was finding it hard to cope. He said that his family were in Essex but his father was asthmatic and found the journey too long to make visits. The CARATS' worker noted in the man's record:

> "Both these issues have undermined his determination to change. He asked for a transfer down south. This has not happened."

68. A further appointment was made for 8 February.

69. Later on the evening of 1 February, about half an hour before evening association was due to finish on C wing, the man and his friend, prisoner A, decided that they would refuse to be locked in their cells at the end of association. Prisoner A told my investigators that he and the man reasoned that, as they both wanted transfers to other prisons and did not seem to be making any headway, they would refuse to "bang up" and would go to the Segregation Unit as they knew that it was their best chance of getting a transfer. (Prisoner's A statement states that it was 31 January but I am satisfied that it was 1 February.)

70. At approximately 7:45pm, the man told a wing officer he was refusing to be locked in his cell on C wing. He said that he wanted to see the Senior Officer as no-one was listening to him and he wanted to be transferred out of the prison.

71. The wing Senior Officer (SO) was on duty on C wing that evening. She did not normally work on C wing and was there solely to cover that particular evening. According to the SO, the man said to her that he wanted to go to the Segregation Unit. When she asked him why, he said it was because his transfer had not been sorted out. He said he had seen a governor about his transfer previously and had been told to give it a month. The month had expired so he was intent on going to the Segregation Unit. The SO told him that she worked in the transfer department and, if he gave her the chance, she would find out what had happened with his transfer request if he stayed on C wing. The SO said the man was insistent that he wanted to go to the Segregation Unit despite her trying to persuade him otherwise. At interview, she said that

he seemed frustrated and was determined. She did not feel that anything she could have said to him would have changed his mind.

Wymott Segregation Unit

72. Wymott's segregation unit contains 16 cells, one of which has CCTV and is used for prisoners who need constant observation. Another is a special cell for prisoners under restraint and a third is used by a prisoner orderly. In effect, this leaves cellular accommodation for only 13 prisoners. It is small unit carved from the end of a larger wing with cells located on the longer sides of the unit and an adjudication room, kitchen area and shower along the centre of the unit. There is no office for staff, so the administrative day-to-day running is done by staff in full hearing of the prisoners. The last inspection report from Her Majesty's Chief Inspector of Prisons (HMCIP) on Wymott was positive about the good relationships between staff and prisoners in the Segregation Unit and the caring approach the inspectorate team had witnessed. But it highlighted the poor quality of records monitoring the physical, mental and emotional state of prisoners and added:

> "There was no evidence of any plans being devised to enable prisoners who were held in the unit for reasons other than punishment following adjudication to return to normal location. Indeed, it was clear that prisoners saw the segregation unit as a route through which they could engineer transfer to other establishments if they did not like being at Wymott."

The man's arrival in the Segregation Unit on 1 February

73. The man arrived in the Segregation Unit at 7:50pm escorted by two officers. He was not under restraint and was placed in cell S1-03. Prisoner A was also taken to the Segregation Unit from C wing and placed on the other side of the Segregation Unit to the man in cell S1-15. A Segregation Safely Algorithm, a risk assessment health care flow chart, was completed at 8pm by the mental health nurse to determine whether the man was suitable to be detained in the Segregation Unit. It noted that an F2052SH had been opened on the man in September 2001. He was assessed as suitable for segregation and the duty governor completed the authorisation on 2 February at 11:40am.

74. The Segregation Unit Daily Log records that the unit started the day with nine prisoners, rising to 15 and ending the day with 11, six of whom were there for reasons of Good Order or Discipline (GOOD). The governing Governor visited the unit and endorsed the daily sheet to show that he had spoken to all staff and prisoners. The sheet also records that there was no Senior Officer on duty in the unit that day.

75. Prisoner B, who was in cell S1-02 next door to the man, spoke to him through his cell window or the heating pipes and they chatted frequently in this way. He said that the man told him he was in trouble on C wing

because he had bought a bag of heroin but could not afford to pay for it. The man mentioned that he wanted a transfer to Essex to be closer to his family but felt that officers had been ”fobbing him off”.

2 February

76. On 2 February, the Segregation Unit held 13 prisoners, five of whom were there for reasons of Good Order or Discipline. The man was placed on report under Prison Rule 51 paragraph 22 for disobeying a lawful order from the wing officer to be locked in his cell on 1 February. The man was given a Notice of Report on 2 February telling him that the adjudication hearing would take place on 3 February.

77. The doctor on duty visited the Segregation Unit at 9:30am on 2 February on a routine daily visit to see all the prisoners. He saw the man and no concerns were noted. In the afternoon, the man was given an opportunity, which he accepted, to have a shower and to go onto the exercise yard. He asked whether he could have his belongings brought across from C wing. His Record of Events says that the duty SO from C wing said he would try to arrange this.

Evening of 2 February

78. Prisoner D, a prisoner in the Segregation Unit that evening, told my investigators that prisoners in the unit shouted across to each other that they wanted to smash their cells up after the broadcast of a football match. He said he did not take part but some water came under his cell door which he cleaned up himself.

79. According to the Control Room daily log, at 10:00pm, the communications room was informed that prisoner A was "smashing up" in the Segregation Unit. The night orderly officer was informed and four staff, known as the Intrusion Team, were asked to go to the unit. At 10:50pm, the communications room was told that an additional three prisoners, including the man, had deliberately flooded their cells and had been placed on report. The duty governor was informed at this time that there had been an incident.

80. Prisoner B, who was in the cell next door to the man, told my investigators:

> "The man had nothing to do with it. Several of the other prisoners were shouting 'let's smash up' and some were joining in shouting 'I'll do it’. I did not join in but I was listening to what was being said. The man had a mate in the Seg who had come from C wing with him at the same time. The mate called out ‘let's get involved, we'll all get shipped out quicker’. When the staff came and found the unit flooded they asked the man if he had flooded his cell. He was laughing and said 'yes'. This was meant only as a joke to wind up the staff but he was placed on report. He was upset when he was placed on report. I had lots of

water in my cell and I did not even take part. I mopped up gallons of water which came under my cell door and in the end had to put a towel under the door to stop any more water coming in."

81. Prisoner C, a prisoner in cell S1-04, on the other side of the man's cell, said that he spoke to the man that evening through his window and told him that he was flooding his cell. Prisoner C told my investigators that the man said he did not want to take part because he wanted his transfer to be done properly so he could be closer to his family in Essex. Prisoner C was not placed on report for flooding his cell.

82. Prisoner E, a prisoner employed as a cleaner in the Segregation Unit, told my investigators that the man did not flood his cell. He said that part of his job the next day was to clean the cells that had been flooded and, whilst some water did get under the door, he was not asked to clean out the man's cell.

83. One of the officers from the Intrusion Team, told my investigators that when he arrived at the Segregation Unit the whole floor was covered in water, and the water needed to be switched off because it was still running. He added:

" … there was rowdy behaviour from four of the inmates because they'd actually smashed their cells, they'd smashed their sink, they'd smashed the toilets … The man hadn't done that. All he'd done was flooded his cell. He hadn't sort of smashed any furniture or anything like that and he was quite quiet to be honest, he wasn't sort of shouting or anything like that."

84. The officer said that he did not actually see water running from the man's taps. His cell floor was covered in water but he looked "perfectly fine" and he was sitting on his bed. He did not speak to the man. Asked whether he was satisfied that the man had flooded his cell, he said that there was too much water in the cell for it to have flowed in from outside so he knew from experience that the man had flooded his cell.

85. The officer said that two prisoners in the Segregation Unit who had taken part in the flooding and cell smashing incident said they wanted to get out of Wymott and behaving like that seemed to be the only way to achieve a transfer. The officer placed six prisoners on report, including the man, for their actions. He told my investigators that he was aware of prisoners using the Segregation Unit as a means to leave Wymott, but did not think it was an effective tactic as other prisons would not want to take a prisoner from the Segregation Unit.

86. My investigators found out about the events on 2 February from the IMB rather than a governor. When the Governor was asked whether he thought that they had any relevance to the man's death the next day, he replied that he did not think so.

3 February

87. On the morning of 3 February, there was one senior officer, and six officers on duty in the Segregation Unit. This was more than the usual staffing of the unit which was normally an SO and three officers. There were 13 prisoners, five of whom were there for reasons of Good Order or Discipline, two for their own protection, three (including the man Strike) were awaiting adjudications and one was serving a punishment of cellular confinement. The reasons for the two remaining prisoners being on the unit were not recorded on the Segregation daily log.

88. The SO told my investigators that the man's cell was still flooded in the morning so he accepted that the man had done it. The night staff had left the Segregation Unit staff a list of six names of prisoners they said had been involved. The SO said that the day had been hectic because there had been a lot of cell damage from the night before, the unit was flooded and there were a number of adjudications to get through. Nevertheless, all the prisoners were offered a shower, some breakfast and exercise. He said that staff cleared out debris that could have been dangerous but, as there were no other cells to locate those prisoners, they remained in their cells. As the senior officer, his priorities for the morning were ensuring that the prisoners had their daily entitlements, that the unit was clean, dry and safe and to make sure the transfer of prisoners in damaged cells was carried out in line with the wishes of the governor responsible for organising the transfers.

89. The second wing officer was one of the officers on duty on 3 February from 7:45am until 8pm. He was familiar with the man, having known him from working on a previous wing. The officer told my investigators that the daily routines of the unit were disrupted because of the previous night's events so everything happened later than usual. He remembered seeing the man that morning and he seemed "no different than normal".

90. At 9:11am, another Segregation Safety Algorithm was carried out. It found that the man was suitable to be in the Segregation Unit. Prisoner B remembered the man kicking his cell door, complaining that he had not been given any breakfast. Prisoner B thinks the man did have breakfast after all. The Segregation Unit Daily Sheet states that the man had a shower and exercise during the morning. At 11:00am, the man was issued with a Notice of Report as the officer from the Intrusion Team had placed him on report for flooding his cell the night before.

91. Prisoner B said at interview that, on 3 February, the prisoners who had smashed their cells were certain that they would be moved from Wymott. He understood from overhearing staff on the unit that the man was not considered for immediate transfer from the Segregation Unit because he was on the margins of the incident.

92. During the morning, Wymott arranged the transfer of seven prisoners from the Segregation Unit to other prisons. Three went to HMP

Manchester, two to HMP Birmingham, one to HMP Preston and one to HMP Risley. The damaged cells were then classed as out of action until they could be repaired. At about 11:00am, prisoner A was told that he was going to Birmingham. On his way out of the unit, he stopped briefly outside the man's cell to tell him that he was being transferred to Birmingham. The man replied that Birmingham would have suited him and that they should keep in touch. Prisoner A told my investigators that he had been placed on report for damaging his cell but the charge had subsequently been dismissed because the wrong cell number had been written on the adjudication documentation.

93. At 11:35am, the Chair of the Independent Monitoring Board (IMB), visited the unit as part of his normal duties. He was not aware that the cell smashing and flooding had occurred until he went into the Segregation Unit. The IMB Chair was told by two governors who were in the unit that all the prisoners who had been involved in the previous night's disturbance had been transferred out. He was surprised to see that a prisoner who had been in the unit since 20 November was still there. As there were several cells which could not be used, this meant that there was no room for new prisoners in the unit. He described the man's cell as serviceable and saw on the unit roll board that there was a marker next to the man's name which he understood to indicate that the man was going to be transferred. The man did not raise any concerns with the IMB Chair.

94. At 1:50pm, the Roman Catholic Chaplain, visited the unit. She spoke to several prisoners including the man. He seemed fine and gave her no cause for concern.

95. At 2:00pm, the second duty governor arrived on the unit to conduct adjudications. At 2:01pm, the man's adjudication into charge 117/05, flooding his cell on 2 February, began. The report written by the officer from the Intrusion Team to the Governor said that when he got to the Segregation Unit at about 10:10pm on 2 February, he found that the man had flooded his cell. The officer therefore turned off his water and placed him on report. The man pleaded not guilty and the governor remanded the case for an Independent Adjudicator.

96. At 3.55pm, the adjudication for refusing to be locked in cell on C wing started. The second duty governor was again the adjudicator. The man pleaded guilty and agreed that he had refused to "go behind his door". When asked why he had refused to do as the officer had asked, he said that he had put in a transfer application last June but successive governors had not solved the issue. The adjudicator found the charge proven and gave the man the punishment of seven days cellular confinement, seven days loss of private cash, association, publications, radio and possessions in cell. At 4:00pm, the duty governor signed the Segregation Algorithm to authorise the man's segregation for seven days cellular confinement.

97. The second wing officer had been in the adjudication room for both of the man's hearings. He said that the man did not seem perturbed by the punishment of seven days cellular confinement but was not happy with the charge of flooding his cell being heard by an Independent Adjudicator. The man had told him that he was frustrated with the lack of progress with his transfer.

98. The SO said that after the adjudication hearings, he escorted the man back to his cell at around 4:20pm or maybe slightly earlier and spoke to him for a few minutes at his cell door. The man told him that he had not been part of the group who had flooded and damaged their cells the night before. He insisted that the water in his cell had flowed in. The SO described him as being unhappy and a bit upset but not overly so, and he saw nothing to give him cause for concern.

99. Once the man was back in his cell, prisoner B spoke to him through the heating pipes. Prisoner B said:

> "I remember that the man was agitated and upset that his case had been referred to an Independent Adjudicator - as it would mean more days in prison for him. I tried to reassure him that it would be okay but he was angry and bitter. He was annoyed that he had been placed on report when he hadn't done anything wrong whereas his mate [prisoner A] got a transfer and no adjudication."

100. Prisoner B put the time he last spoke to the man at about 4:20pm. The man asked him for three cigarette papers and prisoner B passed these to him through a gap around the heating pipe. About ten minutes later, prisoner B said he heard a sound like a bang which he thought was the man's locker and heard the evening meal being served by the officers. (In fact my investigators have established from other documentation that the evening meal was served just before 5:40pm.)

101. Prisoner C told my investigators that the man seemed a little depressed after the adjudications. The man told prisoner C that he "didn't need all this shit". Prisoner C said that he last spoke to the man about ten minutes before the evening meal was served when the man said "I'm sick of this". Prisoner C did not feel there was anything he could say to him, but he did not get the impression that he was going to harm himself.

102. Two officers were on evening duty in the Segregation Unit. In his memorandum to the Governor following the man's death, the third wing officer said that between 4:00pm and 4:30pm, he checked on the prisoners in the Segregation Unit. At 5:30pm, he and the orderly went to the main kitchen to collect the food trolley. They returned shortly afterwards and both officers and the orderly officer began to serve the meals to each prisoner. The third wing officer opened cell S1-03 at approximately 5:40pm and saw the man hanging from his cell window by a ligature made from a bed sheet. He described to one of my

investigators how the man was almost sitting at the back of the cell with his feet barely above the ground.

103. The third wing officer contacted the communications room to summon emergency medical assistance whilst the second wing officer cut the ligature from the window. The principal officer (PO), who was responsible for responding to incidents, arrived in the Segregation Unit within a half a minute. He felt for the man's pulse but could not detect one. The prison officer arrived shortly afterwards and they moved the man away from the back of the cell so they could attempt resuscitation. At 5:41pm, the staff nurse and the healthcare officer (HCO), who is also a qualified nurse, got to the Segregation Unit with the emergency bag. They felt for a pulse but were unable to find one. The staff nurse checked the man's pupils with a pen torch and found they were fixed and dilated. He removed the ligature from around the man's neck. The HCO described the man's appearance as white with blue lips. He was not breathing.

104. At 5:43pm, the HCO and the staff nurse began Cardio Pulmonary Resuscitation, assisted by the PO and the prison officer. Paramedics were telephoned at 5:44pm. They arrived in the unit at 5:57pm but were unable to revive the man. At 6:10pm, the paramedics, the HCO and the staff nurse agreed that the man was beyond help and ceased resuscitation efforts. Lancashire police attended the prison and were satisfied that no third party was involved in the man's death. The PO and the Roman Catholic Chaplain then spoke to each prisoner individually in the Segregation Unit and told them that the man had died. A staff hot debrief took place at 7:25pm. A critical incident debrief took place on 1 March.

Contact with the man's family after his death

105. On his reception to Forest Bank, the man had named his mother as his next of kin. As Wymott was some distance from her home, the Governor of Wymott asked the police service where the man's mother lived to inform the mother of her son's death. He told one of my investigators that his rationale for this was that she should be told before hearing the news inadvertently from any other source. He had intended to telephone the man's mother once the police had visited her, rather than break the news over the telephone. Two police officers from Lancashire Constabulary, who had gone to Wymott as a result of the man's death, telephoned the second police service in the Governor's presence and were assured that the mother was aware of her son's death. The Governor then telephoned her. Unfortunately, despite the assurances of the second police service, it quickly became clear to the Governor that the mother had not been told of her son's death and the Governor was obliged to tell her over the telephone.

106. The man's father visited Wymott on 6 February. His visit was not pre-arranged. He was met by a governor and the Chair of the IMB. According to the governor, the father still appeared dazed and shocked at his son's death. He wanted to know whether his son had been alive when he was found by the officers and whether he could have been murdered. He said that his son had received a "fat lip" a few weeks before his death but had not given him a reason for his injury. The man had asked both him and his wife to send £50 but they did not do so.

107. The funeral took place on 11 February. Wymott was represented by the Roman Catholic Chaplain.

108. My investigator visited the man's father with one of my family liaison officers. The father said that, when he went to Wymott, he had asked to see the cell where the man had died but had been told that he could not do so at the time. He had been expecting further contact from a governor at Wymott about arranging a future visit but it had not materialised.

109. My investigators asked the governor who acted as prison liaison officer about the father's concerns. The governor said that he had explained to him that he would have the opportunity to see the place where his son died once the Coroner's Officer had released the cell for use. He was told that he could contact Wymott at any time and the visit would be arranged. However, Wymott had not heard from him since. Wymott was dealing principally with the man's mother as both parents were separated and the mother had been named by the man as his next of kin.

110. When the man's belongings were returned to his mother, she was distressed to find that they contained photographs of the injuries sustained by one of the man's victims and wondered whether the prison had placed them there deliberately. My investigators raised the matter

with the governor who explained that the photographs had been part of legal papers which belonged to the man and, as such, the prison felt it was not in a position to remove particular items. It had not meant to cause any offence to the mother.

111. The man's father told my investigators that the man had asked him to send money to various addresses in the North West to pay his debts. The man had told them that these were for cannabis and the use of a mobile telephone. The father said that he had made several payments. He had cancelled his last visit to the man in order to afford to pay the money as he wanted to keep his son safe. The man had told him previously that another prisoner had punched him in the face but he had walked away to avoid a fight. With the father's agreement, my investigators have put the matter of the payments in the hands of the police.

112. All of the officers who knew the man well were asked if they had observed any bruising or injuries to his face in the days before his death. None of them recalled him showing any physical signs of bullying. Some officers mentioned that the time for meaningful contact between prisoners and officers on the wings had been reduced due to a lack of continuity in staffing. They said that this had been detrimental to building up good relationships with prisoners and made it difficult to spot issues quickly and deal with them effectively.

Contact with those who knew the man well at Wymott

113. My investigators spoke to prisoner F who told them that he knew the man well on C wing. He said that around the anniversary of the man's brother's death in September 2004, the man's behaviour changed and he did not seem to be as happy-go-lucky as he was previously. He was having difficulty coping and he did not appear to take as much care of himself as he had in the past. He had told prisoner F that he had made applications to see a governor, but nothing came of it so he had got himself placed on report deliberately so that he could see a governor and explain that he was having problems coping since his brother's death. According to prisoner F, although the man was placed on report three times and explained his situation, nothing was done to help him. Prisoner F said he knew that the man took drugs on occasion but would not have described him as having a drug habit.

114. He said that the man did not give any indication that he intended to take his life and, in fact, the man had spoken about how his mother had suffered following his brother's suicide. Asked why he thought the man might have ended his life, prisoner F concluded:

> "… I can say that it wasn't down to drugs and it wasn't just about the regime of the prison as such do you know, it was more to do with his brother's death than anything else … it was like he couldn't cope with the fact that his brother had taken his life and I think that's the main reason he went down the road he did. But I don't think he was thinking about family members at the time 'cos he wouldn't have put his mum through the same thing again because he loved his mum to bits … I think he was just thinking about his brother, wanting to be with his brother … it's nothing to do with drugs, that's just another easy way out, i.e he was on drugs so it must have been that ..."

115. My investigators spoke to the man's personal officer on C wing. He said that he and the man had a good relationship. He described the man as likeable and a sort of "Jack-the-lad". He knew the man had a drug problem and there were times on the wing when the man had appeared to be under the influence of drugs. He was also aware that the man had contact with CARATS concerning his drug use. He said that the man's behaviour began to deteriorate after he was sacked from his job in the servery in October 2004. The man had told him that a governor, had promised him a transfer but it did not happen. The man had said "I'm out of here, I'm not coming back" when he left C wing. His personal officer had assumed the man had wanted to leave C wing because of drugs debts, and suspected he might have been bullied, but had no evidence that this was the case. However, it was his impression that C and D wing had a growing problem of bullying whereas 12 months previously it had been negligible.

116. The personal officer had chatted to the man briefly whilst he was in the Segregation Unit. He thought the man had mentioned wanting to get out

of Wymott but could not recall the conversation clearly. He saw the man as being easily led and thought it conceivable that he might have got involved in the flooding incident as a way to speed up his transfer. After the man's death, he heard prisoners saying that the man had debts of about £200, that he was taking heroin, and had apparently taken his life because he could not get any heroin in the Segregation Unit. However, these were only rumours.

Post Mortem and Clinical Review

117. On 4 February, the man's post mortem examination took place. Its findings were that :

> "There was a ligature mark around the neck due to hanging. The constriction caused by this ligature would have prevented air flow to and from the lungs and the blood supply to and from the brain. It would have caused rapid unconsciousness and death. Analysis of post mortem samples of blood and urine excluded the presence of alcohol and drugs. The ligature mark apart, there were no marks of violence … there were scars to the inner aspect of the left wrist consistent with previous attempts at self harm."

118. Chorley and South Ribble Primary Care Trust's clinical review of the man's healthcare whilst in custody found that the man's medical record was poorly organised and difficult to follow. It noted that, whilst healthcare staff had identified the man's need for support after the death of his brother, the bereavement counsellor had left so no counselling was made available to him. There was no evidence that the man's mental health assessment of February 2004 was followed up.

119. The clinical review commented that there was no evidence of a defibrillator being used to resuscitate the man but that no act or omission by healthcare staff at Wymott contributed to his death. I understand that each wing cluster has since been provided with its own defibrillator, eliminating the need for healthcare staff to carry one between wings. The clinical review commended the HCO and the staff nurse for their prompt and appropriate action under difficult circumstances.

120. The Chairman of the Prison Officers' Association at Wymott, who was also one of the incident managers at the time of the man's death, discussed with my investigators the coded system of radio messages that Wymott uses when there is a medical emergency. He said "Code red" means any injury to do with blood, from a cut finger to something more complex. "Code blue" means any situation involving breathing, which could mean that a prisoner needed an inhaler or could be a more serious situation. He said there was no way of healthcare staff knowing how serious an incident was until they had arrived on the scene. Staff carrying a defibrillator and an emergency bag, and opening and shutting gates, could waste time rather than getting to the incident more quickly. He suggested that the coded system could be more specific.

Additional documentation considered

121. My investigation team looked at suicide prevention arrangements at Wymott. The minutes for the most recent Suicide Prevention meeting were dated 25 January 2005. The meeting highlighted the lack of counselling facilities and said that, although healthcare had in-reach, psychology and generic counsellors, their services were not generally known. Action was taken to draw up a more comprehensive list of the services available within the prison. Unfortunately, the investigation team were not able to meet with the Suicide Prevention Co-ordinator. Wymott's latest suicide prevention strategy was reviewed in October 2004. A self audit conducted on 9 March 2005 scored 81%.

122. My investigators asked for the most recent minutes of the Safer Establishment Meetings prior to the man's death. The minutes of the meeting held on 11 January 2005 showed that there were 24 open F2052SH's. The reasons given by prisoners for attempting self harm were broken down as "1 talking, 12 cannot get transferred, 7 depression and 5 others". Under the section headed "Listener Issues" it stated "g/h wings - there is a certain amount of bullying but it is thought these are prisoners who wish to be transferred". The Anti-Bullying Strategy had last been revised in July 2003. A Safer Establishments self audit conducted in October 2004 scored only 55%. Amongst the deficiencies noted were that Security Information Reports were not completed for alleged assaults, there was little evidence available of unexplained accidents, some reports of bullying were not being followed up by monitoring, and some staff and prisoners were not aware that there was an anti-bullying policy or who was the Anti-Bullying Co-ordinator. An action plan was agreed by the Governor on 19 November to conduct a re-audit. The results of that are not yet known.

123. Entries in the C and D wing observation book from 7 December 2004 to 1 February 2005 refer to two other prisoners refusing to be locked in their cells and preferring to be taken to the Segregation Unit. It also records that a meeting of wing managers was held to discuss this "increasing trend".

The man's transfer application

124. My investigators asked Wymott for its documentation concerning the man's transfer request. They were given a sample application for transfer but there was no copy of the man's actual application which had been sent to The Mount on 16 July 2004. His application was noted in the Non-discipline Transfer Log. At the bottom of the sheet, the line "No response after 28 days, inform the prisoner by sending slip back to wing" is printed. The Mount had no record of having received an application from the man.

125. My investigators were unable to find a copy of the notification the man should have been given from Wymott that no response had been received from The Mount. There was no record of it in his Record of Events or elsewhere on C wing. My investigators were given a copy of the memorandum that Wymott send to a prisoner's wing when their application for a transfer has been unsuccessful. It is addressed to the wing and has spaces for a prisoner's name, number and location along with the standard wording:

> "Your application to _____ has been unsuccessful. If you would like to try again or to apply to another establishment, please complete the relevant application form."

126. The Executive Officer who deals with transfers said that her unit would usually contact the receiving prison to prompt a reply to the request but, due to the pressure of work, this was not always possible. If no response had been received then the application transfer would be considered null and void. She said that she was not familiar with what wing staff did with memoranda once they were received, as she had not been on a residential wing. But the onus would be on a prisoner to make another application for a transfer if the original application had stalled.

Role of Segregation Unit within Wymott

127. Many staff and prisoners to whom my investigators spoke were aware that the Segregation Unit was being used as a successful conduit to obtain a transfer if one could not be secured by conventional means. The wing SO (who had been on duty on the evening that the man and prisoner A decided to go to the Segregation Unit) was asked whether the man had given her an indication of why he thought the Segregation Unit would be the means for him to leave Wymott. She replied that people had been going down to the Segregation Unit and getting transferred from there, and this was common knowledge. The second wing officer commented that, even while he was being interviewed, there were probably "half a dozen" prisoners in the Segregation Unit because they wanted to be transferred and it was not a new phenomenon to the staff who worked there. Their responses were by no means unusual amongst staff. In fact, one prisoner told my investigators that he was already planning the date he intended to go to the Segregation Unit if he did not get transferred out of Wymott.

128. The Segregation Unit is physically small for the size of prison it supports. On the morning of 3 February, out of a total of 13 cells available for general use there were six cells which had been deliberately damaged by prisoners following the night of 2 February and could not be used until they had been repaired. This damage was an incident of concerted indiscipline that should have been logged with the Prison Service's National Operations Unit (NOU). However, when my investigators contacted NOU for more details of the incident, NOU were unaware that one had taken place. The record of the incident which was placed on the prison's database on 4 February names four prisoners including the man and says:

> "in all 4 cells were damaged, sinks and toilets smashed. All prisoners involved were placed on report and were transferred from Wymott on Thursday the 3rd."

Conclusions and Recommendations

129. The man had served just over three years of his six year sentence and was due for release on 4 November 2005. The extent of his drug use varied. He had struggled throughout his sentence but, on occasion, he had also successfully sought help from CARATS in managing his drug use and considering the issues that underpinned it. On 21 July 2004, he asked for his CARATS file to be closed as he was leading a more positive life. He appeared buoyant, having recently applied for a transfer to be nearer to his father. However, by the end of the year, his optimism seemed to have faded and by the New Year he had been placed on report several times for drug related offences involving opiates. He had incurred some debt to one or more prisoners and had asked his family to pay for what he told them was cannabis and mobile telephone units. Prisoner B is clear that the man told him he had bought a bag of heroin on C wing, but could not afford to pay for it. The man's parents and their partners were not finding it easy to make financial payments to the external third parties. Indeed, his father had cancelled his last planned visit to see the man after deciding that keeping his son safe and paying someone £50 was worth more than the cost of travelling to Wymott from Essex. His father had seen him with a "fat lip" and the man did not offer an explanation. Even though no staff or prisoners could recall the man appearing as if he had been hit, more than one officer commented that they had increasing difficulty building up a consistent picture of prisoners because they had fewer opportunities to observe prisoners due to being detailed to work way from their designated work area.

130. The evidence relating to the man's debts means that, although there is no direct evidence of bullying, I have not been able to discount entirely the possibility that he was being threatened by another prisoner or prisoners and that this went unnoticed on C wing. I am concerned that, at the time of his death, the anti-bullying procedures at Wymott do not appear to have been as robust as they should have been. This may have meant that intelligence was missed, not only on the man but also for other prisoners, or not acted on because of a failure to give the issue of bullying sufficient priority.

    Recommendation: I recommend that the Governor takes steps to ensure that the profile of the Anti-Bullying Strategy is raised at Wymott with fresh impetus towards intelligence gathering and firm management of those prisoners who are suspected of bullying others.

131. The death of the man's brother in September 2003 had a profound effect on him. The man spoke to his friend, prisoner F, about his struggle to cope. He spoke to the prison officer, to his CARATS worker and to the Chaplaincy. He was willing to have bereavement counselling but, despite the applications from the duty nurse, it is not clear that he was told the outcomes of those applications. I am concerned that, because the CRUSE counsellor had left, the man was offered no professional

bereavement counselling despite him describing his pain as feeling as though he was going to explode. Wymott had a responsibility to deal with the man's anxieties appropriately. It is clear from his medical record that his health suffered as a result of how he was feeling. He had lost weight, his sleep was disturbed and he was thought to be suffering from reactive depression. Whilst it was recognised that the man should have a mental health assessment, after this was done in February 2004 there is no documentary evidence that it was followed up. I commend the efforts made by the prison officer in organising some wing-based support for the man, but it is clear that the man needed the expertise of a trained bereavement counsellor and he did not receive it. I cannot ignore the fact that the man appears to have hanged himself two days after telling the worker from CARATS that he had been offered counselling a year after he had asked for it, and that he was finding it hard to cope with the memories.

Recommendation: I recommend that the Governor reviews the availability of counselling services for prisoners to ensure that adequate provision is available to meet the needs of prisoners who have been bereaved.

132. The man was given a total of 42 added days to his sentence on 7 January. He clearly felt that he had been treated inequitably in comparison with other prisoners charged at the same time. From the accounts given by the prisoners the man spoke to shortly before his death, his feelings of injustice appear to have been compounded by the referral of his adjudication for flooding his cell to the Independent Adjudicator which may again have resulted in him receiving additional days. These feelings of unfair treatment, particularly when he was adamant that he did not take part in the Segregation Unit protest, were exacerbated by the knowledge that those who had misbehaved, including prisoner A (with whom he had agreed the strategy of getting to the Segregation Unit), had achieved their objective by being transferred to other prisons.

133. It seems that the man pinned his hopes on getting a transfer out of Wymott to The Mount. He applied for it in the correct way in July 2004, despite saying to his CARATS worker in November 2003 that he wanted to leave Wymott and would either be recategorised or go to the Segregation Unit. It is significant that the man told his mother in a letter dated 1 January that his transfer application had gone off. On the same date, the transfer clerk noted that she had not received a response from The Mount to the man's request. The man either misunderstood what he had been told about his transfer application or he was given incorrect information by a member of staff. Although he was supposed to have received a copy of the standard memo to say that his application had not been successful, there was nothing in his Record of Events to show that he had received and understood what he had been told. Nor is there a duplicate copy of the actual application, and The Mount has no record of having received it. The transfer process lacked clarity and copies of the

requests were generally not retained for reference purposes. I accept that the transfers' desk is a demanding role. But prisoners are entitled to be sure that their applications are passed on, received by the prison to which they want to transfer, and pursued by their current prison if nothing is heard. Prisoners should also be clearly told the outcome of the application, and there should be a record that this has been done thus creating a transparent process. In the man's case, he seems to have been left ill-informed and unclear about the progress of his application.

Recommendation: I recommend that the Governor reviews the administrative system for transfers from Wymott to ensure that:

- There are regular updates to prisoners on the progress of their application. The onus should be on Wymott to provide information rather than depending on prisoners to ask.

- Replies to prisoners about transfers are addressed to the prisoner themselves. A separate copy should be provided to the personal officer or a designated officer whose responsibility it should be to update the prisoner's Record of Events.

- Reasons for an unsuccessful transfer application are given to prisoners and that the standard reply proforma is redesigned to make the information it contains clearer to prisoners.

- The transfers clerk receives more support in her role from the daily designated Senior Officer. This should include forging links with residential wings, so that there is a clear understanding by staff and prisoners of the entire process of dealing with a transfer application.

134. The Segregation Unit occupies a pivotal role within Wymott. Its staff were described favourably by several of the prisoners and staff my investigators spoke to, especially those who were on duty the day the man died. Prisoners felt supported and cared for. This is heartening to hear as all too often segregation units are characterised (rightly or wrongly) as bleak and threatening.

135. However, it is unclear how long it has been perceived wisdom amongst prisoners and staff alike that one way to secure a transfer from Wymott is for a prisoner to refuse to be locked in his cell and, once taken to the Segregation Unit, stay there until a transfer is achieved. The last report from the Prisons Inspectorate in 2003 was unequivocal that prisoners saw the unit as the place to engineer a transfer. This criticism is as relevant then as it is now. It is plainly undesirable that on a daily basis up to half the prisoners in the unit could be there because they want to leave Wymott. I understand there are plans to extend the unit but, unless the underlying reasons for its role as a de facto clearing house and re-allocation centre are not tackled, the problem will only persist and magnify. The irony of the disturbances in the Segregation Unit on 2

February is that the prisoners who were perceived to have caused the most trouble were 'rewarded' by getting transferred, whereas the man was thought to have played a peripheral role and remained. In response to my draft report, the Prison Service commented:

> "… Wymott does not allow prisoners to simply refuse to return to their cells and disobey an order thereby being placed in the Segregation Unit, very often prisoners will commit an offence against discipline which require that they are then placed on report for adjudication. They then seek to use that by refusing to leave the Segregation Unit (which in itself can lead to further adjudications and potential awards being given). It is not unusual for prisoners to be located in Segregation Units because they are trying to manipulate a transfer which local management are not acceding to, and nor would they look attractive to a receiving prison If that were the case. In the case of those prisoners transferred out following the incident on the 2 February, that was done for operational reasons given the damage caused: whilst it would be perceived that the prisoner may have been seen as successful, there further location was to local prisons and the prospect of a lengthy wait before being reallocated to a training prison."

136. I maintain, nevertheless, that the perception and the reality that some prisoners have the upper hand in determining transfer allocations is damaging to Wymott. Urgent consideration needs to be given to restoring the credibility of the transfer system.

Recommendation: I recommend that the Governor and the Area Manager conduct a comprehensive review of the operation of transfers from Wymott with a view to enabling prisoners held in the Segregation Unit for reasons other than punishment to return to normal location.

137. My understanding of the flooding and damage to several cells in the Segregation Unit on 2 February is that, in line with Prison Service Order 1400, the incident was considered to be concerted indiscipline and should have been reported to National Operations Unit.

Recommendation: I recommend that the Governor reviews procedures for the reporting of incidents in the light of the events of 2 February and the man's subsequent death.

138. It was good practice that both the PO and the Roman Catholic Chaplain visited each prisoner in the Segregation Unit to tell them of the man's death.

139. I appreciate that the Governor wanted the man's mother to be told of her son's death as quickly as possible. Asking the police to make initial contact with her was a reasonable response but it depended on the police to carry this through. I am sorry that the mother learned of her

son's death over the telephone despite the Governor's attempts to make sure this did not happen.

Recommendation: I recommend that the Governor explore the possibility of asking a governor or chaplain at the nearest Prison Service establishment to break the news of a death to a family where they live some distance from the prison. I am aware of several cases where this has worked successfully. However, it is a practice that needs to be handled with sensitivity, having regard to the particular circumstances and the need to ensure the other establishment is fully briefed beforehand.

140. The mother was distressed that photographs of her son's victim were contained within his belongings that she collected after his death. Wymott argued that it was not for them to decide which items should be given to the mother as they had all belonged to the man. Prisons need to be mindful, however, that particular items of property may cause offence to bereaved families. The care taken to present a loved one's belongings to the family is a fitting reflection of the feelings the establishment shows towards that family. Whilst I in no way suggest that Wymott's actions were deliberate, it would have been good practice to warn the mother of the items she might find distressing, thus giving her the option of whether to accept them.

141. The man's father was concerned that, having driven to Wymott, he was unable to see where his son had died. He expected a governor to contact him once the cell was free. Wymott thought that the father would contact them to arrange another visit. In circumstances where the father was still dazed and shocked by his son's death, it would have been better if the prison had tactfully followed up with him to see what he wanted to do. Although Wymott was dealing principally with the mother, as the man had named her as his next of kin, I do not think that was a reason for the prison not to make sure that the father's needs were met.

Recommendation: I recommend that the Governor contacts the man's father and arranges a time for him and other members of the family to visit Wymott if they wish and see where the man lived and died.

142. I note that the clinical reviewer mentions that a defibrillator was not taken to the cell when health care staff were alerted by radio that there had been a "code blue" incident. It is clear from the accounts of staff who found the man and attempted to resuscitate him that he was already dead despite their efforts. I have no criticism to make of staff in this respect. They reached the man within one minute of the radio alert. I have found their response to have been prompt and professional. The reviewer has commended the staff nurse and the HCO for their actions in caring for the man. I endorse her sentiments.

Recommendation: I recommend that the Governor considers whether the colour code system for identifying the type of incident is sufficiently detailed for staff to respond effectively.

Recommendation: I endorse the recommendations of the Clinical Review that the healthcare department at Wymott change their Inmate Medical Record to the new Clinical Record so that documents are more appropriately filed and therefore easier to follow. The Clinical Review makes a number of other recommendations which the Governor and Primary Care Trust will want to consider.

The Prison Service's response to my draft report

In addition to the quotes in paragraph 139 of my report, the Prison Service commented:

"The preface to the report (5th paragraph) refers to the man wanting a transfer to a prison in the South of England to be closer to his father: it should be noted that there are difficulties in placing prisoners in a prison of their choice, particularly to the South East of England which generates more prisoners than there are available spaces.

This does not, of course, mean that the issues regarding the administration of the transfer system as noted in the report are not relevant but operationally it can be difficult to accommodate prisoner's wishes to be located at establishments of their choice."

The Prison Service has not commented on my recommendations.

Summary of Recommendations

1. I recommend that the Governor takes steps to ensure that the profile of the Anti-Bullying Strategy is raised at Wymott with fresh impetus towards intelligence gathering and firm management of those prisoners who are suspected of bullying others.

2. I recommend that the Governor reviews the availability of counselling services for prisoners to ensure that adequate provision is available to meet the needs of prisoners who have been bereaved.

3. I recommend that the Governor reviews the administrative system for transfers from Wymott to ensure that:

   -There are regular updates to prisoners on the progress of their application. The onus should be on Wymott to provide information rather than depending on prisoners to ask.

   - Replies to prisoners about transfers are addressed to the prisoners themselves. A separate copy should be provided to the personal officer or designated officer whose responsibility it should be to update the prisoner's Record of Events.

   - Reasons for an unsuccessful transfer application are given to prisoners and that the standard reply proforma is redesigned to make the information it contains clearer to prisoners.

   - The transfer clerk is given more support in her role from the daily designated Senior Officer. This should include forging links with residential wings, so that staff and prisoners have a clear understanding of the entire process of dealing with a transfer application.

4. I recommend that the Governor and the Area Manager conduct a comprehensive review of the operation of transfers from Wymott with a view to enabling prisoners held in the Segregation Unit for reasons other than punishment to return to normal location.

5. I recommend that the Governor reviews procedures for the reporting of incidents in the light of the events of 2 February and the man's subsequent death.

6. I recommend that the Governor explore the possibility of asking a governor or chaplain of the nearest Prison Service establishment to break the news of a death to a family where they are some distance from the prison. I am aware of several cases where this has worked successfully. However, it is a practice that needs to be handled with sensitivity, having regard to the particular circumstances and the need to ensure the other establishment is fully briefed beforehand.

7. I recommend that the Governor contacts the man's father and arranges a time for him and other members of the family to visit Wymott if they wish and see where the man lived and died.

8. I recommend that the Governor considers whether the colour code system for identifying the type of incident is sufficiently detailed for staff to respond effectively.

9. I endorse the recommendations of the clinical review that the healthcare department at Wymott change their Inmate Medical Record to the new Clinical Record so that documents are more appropriately filed and therefore easier to follow. The Clinical Review makes a number of other recommendations which the Governor and the Primary Care Trust will want to consider.