Circumstances surrounding the death of a man at HMP Rye Hill in March 2005

Report by the Prisons and Probation Ombudsman for England and Wales

July 2007

I have now opened investigations into approaching 300 self-inflicted deaths in prisons, hostels and immigration detention. The circumstances surrounding the man's death are among the most disturbing I have come across. This is an account of individual and systemic failures of disturbing proportions.

The man died at his own hand in the segregation unit at HMP Rye Hill in March 2005. However, this investigation was on hold for many months before the police would allow me to proceed. They conducted a lengthy and detailed investigation of their own into the man's death, and this resulted in three members of staff being charged with manslaughter by gross neglect. One of those accused, together with a fourth member of staff, was also charged with attempting to pervert the course of justice. In the event, the judge directed that there was no case to answer on grounds of lack of causality in respect of the first charge and lack of intent in the second.

Given the thoroughness of the police investigation and the amount of time that has now passed, my own investigation has relied heavily on the vast amount of evidence which the police have shared with me. I record here my very grateful thanks for their willingness to facilitate my investigation and to furnish my staff with information and documentation.

One consequence of the delay in conducting my investigation is that some of the family's many questions about how the man came to take his own life remained unanswered for far too long. I hope that this report now gives them the answers they seek. However, I am all too conscious that neither they, nor any other reader, will derive any comfort from what I have discovered.

In some of my investigations into self-inflicted deaths, I have found a failure by the authorities to adhere to proper systems and safeguards. In others, I have found that procedures were adhered to but there was a lack of compassion or imagination in the way an at-risk prisoner was managed. In the case of the man who is the subject of this report, I have uncovered both an appalling breakdown in procedures and a lack of sensitivity and kindness (or worse) in the treatment of a vulnerable and broken man. I have taken the very unusual step of recommending that this report should be sent both to the Minister and to the Chief Executive of the National Offender Management Service for their consideration.

I should conclude here by saying I very much regret the delay in completing this investigation, and hope that the man's family will accept my sincere, if belated, sympathies for their loss.

STEPHEN SHAW CBE
PRISONS AND PROBATION OMBUDSMAN **July 2007**

CONTENTS

SUMMARY

The man was serving a sentence of four years for two offences of possessing class A drugs with intent to supply. He had spent time on remand at Birmingham, Nottingham and Blakenhurst prisons, before transferring to HMP Rye Hill on 9 December 2004. Whilst at Rye Hill he was suspected of involvement with the drug culture at the prison, but otherwise the first few months of his time there were unremarkable. On 8 March 2005, however, an officer alleged that the man was pressuring him into bringing in drugs. At the same time (or perhaps in response) the man alleged that a member of staff was bringing items into the prison for prisoners. He was placed in segregation whilst the matter was investigated. He had no problems with segregation and was returned to normal location (albeit a different unit) on 14 March.

On 18 March, the man had an altercation with a member of staff about a fan which she said he had taken from the wing office. He overturned a pool table in temper and was subsequently removed once again to the segregation unit to await adjudication. Whilst there, his demeanour changed completely. He had a violent outburst the following day when he tried to force his way out of his cell past the Director and assaulted an officer in the process. He subsequently became tearful and said he wanted to be baptised as he was ready to die. The man was placed on a F2052SH (suicide and self harm management form). The following day he wrote a note on the back of a menu sheet addressed to his mother saying that he wished, “the Almighty would take him away with his mighty hands as he sat in his cell”. The note amounted to a suicide note. The man had episodes of uncontrolled crying and was clearly confused. During exercise on 20 March, he took off all his clothes and continued to walk around in the cold outside reciting the Lord’s Prayer and saying he was ready to die. On the Monday (21 March), he agreed to go for a shower but stopped on the stairs and refused to go backwards or forwards. Eventually, he was removed by staff using Control and Restraint techniques. He had no memory of the incident the following day and continued to be very confused.

On the afternoon of 22 March, the man had a visit during which his appearance and manner caused his family great concern. They also saw marks on his hand, neck and throat where, he told them, he had deliberately hurt himself.

On 23 March, the man’s segregation was reviewed. During the review, he sat with his hands on his temples and appeared not to be taking anything in. He was unkempt and his personal hygiene was not good. He did not understand why he was segregated and said he wanted to go back to his unit. He was apparently upset when he was told he would remain in segregation. He was told he would see the psychiatrist the next day and that his uncle would also visit.

On 24 March, the man was offered a shower and a change of clothes. He started to come out of his cell, but then picked up his stereo and some papers

saying that he wanted to take them with him. He was told he could not and went to sit on his bed. He then refused to come out. At 11.00 am, he asked to have his shower, but this could not happen because adjudications were being carried out.

At 11:55 pm, a manager from one of the residential units went to see the man as she had promised a couple of days previously. He was slumped against the cell door and not responding when spoken to. As he was on a four-man unlock, they waited for another member of staff to attend before opening the door. When they did so, they found that the man had hanged himself with a shoelace attached to a small hole in the metal plate on the back of the door. Staff tried to resuscitate him and an ambulance attended, but he was pronounced dead at 12:38 pm.

The man's mother has raised a number of serious concerns. Amongst these were that, following her visit on 22 March, she had phoned the prison and told them about the marks on her son's hand, neck and throat. She said no action was taken as a result and that her son had remained in the segregation unit rather than being transferred to the healthcare centre. The man's mother has suggested that staff neglected her son because of the allegation he had made about one of their colleagues and because they were racist.[1]

I have considered these matters - and others - as part of my investigation. I found no evidence to suggest that staff had deliberately neglected the man, and could reach no finding on whether staff had failed to act on information from his mother about marks on his body. However, I did find that staff failed to carry out and document proper checks on him and to communicate effectively and forcefully enough with healthcare staff. I also found evidence that documents had been tampered with to cover up the failure to carry out proper checks. I discovered that routine security checks of cells in the segregation unit had not been carried out for some time (or not been recorded), and that two residential managers had been appalled at the condition of the cells just two days before the man's death. (They cleaned them out personally.)

Although I uncovered no evidence that staff had neglected the man because of the allegations he had made or for racist reasons, I formed the strong suspicion that staff did not engage effectively with the man because they were scared of him following his outburst on 19 March.[2] Despite assurances by the

[1] The Group Managing Director, Care and Justice Services, GSL wrote to me on 18 June 2007, commenting on a draft of this report. He said, "We feel we are justified in questioning why in the brief summary you include this allegation by the man's mother which is based on hearsay when you found no substantiation for it." The fact that an allegation has not been substantiated should never mean the allegation and the finding should not be reported – especially when it concerns racism.

[2] GSL went on to say, "it was recorded that on 19 March the man had carried out a serious assault on members of staff injuring one seriously and force was used to return him to his cell. On 21 March he had again been subjected to C&R techniques during the incident when he refused to go to the shower or return to his cell despite staff attempts to reason with him. He was on a four-man unlock because of the risk he presented to staff." I would suggest that this tends to substantiate my comment rather than otherwise.

Home Office Controller that the segregation unit was the best in the prison and a beacon of good practice, I was concerned by the picture that emerged of a segregation unit struggling to discharge its basic daily functions, let alone offer any real care for the prisoners accommodated within it.

I made some 28 recommendations in my draft report. I am pleased to report that, having read the draft, GSL accepted all of them. They told me that they had either been implemented or an action plan was being prepared "for their swift implementation".

I have amended or expanded some of these recommendations and added eight new ones following representations from solicitors acting for the man's mother and a conversation between a former residential manager at Rye Hill and the Assistant Ombudsman, who conducted this investigation on my behalf.

PART I - BACKGROUND

Investigation

This investigation was opened on my behalf by an Assistant Ombudsman, assisted by a Family Liaison Officer. They met the man's mother and her legal representatives and liaised closely with the police while the criminal investigation was ongoing. My Family Liaison Officer has been in touch with the man's mother periodically since.

Another Assistant Ombudsman took over the investigation after the original investigator went on maternity leave.

The Assistant Ombudsman reviewed the vast number of documents helpfully supplied by the police. These included contemporaneous records from the prison, as well as statements and transcripts resulting from detailed interviews with staff, prisoners and others.[3] The Assistant Ombudsman visited the prison, obtained additional documents and information and interviewed the Home Office Controller.[4]

A clinical review was conducted for the police investigation. (The reviewer is also regularly engaged by my office for the same purpose.) I am grateful to her for allowing me to incorporate her findings in this report.

The report was shared at draft stage with the police, the man's family, the Prison Service, Global Solutions Ltd (GSL) and the Regional Offender Manager. Some amendments have been made as a result.

Following representations by a former residential manager at Rye Hill, in relation to the draft report, the Assistant Ombudsman interviewed her informally. Her comments are also reflected in this final report, as are those of two officers who provided feedback by phone.

HMP Rye Hill

Rye Hill opened in January 2001 and has been run since that time by GSL. It is a category B prison and holds up to 660 prisoners accommodated in eight living units. All cells, including those in the segregation unit, are built to Prison Service safer cell specifications.

The prison is contracted to act in accordance with all Prison Service Orders (PSOs).[5]

---

[3] In their letter, GSL suggested that it was important to bear in mind that the evidence was gathered in the pursuit of a criminal investigation. They also said that the statements of those officers who were charged should be placed in the context "that they were made either to the police when under investigation or in their defence or mitigation against serious criminal charges and internal disciplinary measures. As such they cannot be considered unbiased."

[4] Controllers are engaged by the Home Office to monitor and enforce contract compliance by Contractors in privately run prisons. They operate from within the establishment itself.

[5] PSOs provide guidance and instructions to all Prison Service establishments on operational and policy matters. They typically have some advisory and some mandatory elements.

The segregation unit, which is separated from the main prison, holds a maximum of 16 prisoners on two levels. It does not have in-cell television or CCTV coverage. The healthcare centre has eight beds and a ward that can be used as a crisis suite for suicidal prisoners.

In April 2005, three weeks after the man's death, an unannounced inspection of the prison was undertaken by Her Majesty's Inspectorate of Prisons. (The previous full inspection was in 2003.) The unannounced inspection looked at key concerns raised by the earlier one. The HM Chief Inspector of Prisons commented positively on efforts made by staff to provide a good environment for prisoners from a basis of mutual respect and reported that race relations were reasonably good and that prisoners with mental health problems were managed on normal location wherever possible. However, she also commented:

> "The prison undertook to put in place more effective management and support systems. However, this full unannounced follow up inspection found that those key concerns had not been dealt with. Indeed, the prison had deteriorated to the extent that we considered that it was at that time an unsafe and unstable environment, both for prisoners and staff."

And:

> "We had very serious concerns about the safety at Rye Hill. Staff lacked experience and confidence in managing an experienced prisoner population; this was exacerbated by the absence of visible management support, very low staffing levels and high staff turnover. As a consequence, it was by no means clear that staff were in control of prisoners on some wings … Induction and the management of safer custody had improved, but the implementation of anti-bullying and suicide prevention at wing level was inadequate. There was no Listeners scheme. The regime for vulnerable prisoners had improved, but agreed staff training had not been provided. The prison was performing poorly against this healthy prison test."

HM Chief Inspector was very concerned about issues relating to staffing and recommended that the Office for Contracted Prisons should review the position at Rye Hill, taking into account recruitment, retention, deployment and management. She said the review should include a risk assessment of safe staffing levels and mechanisms to ensure a visible and experienced management presence on all residential units. The Chief Inspector noted that 30 per cent of Prison Custody Officers (PCOs) had less than 6 months experience in the job and there was a 40 per cent turnover of staff in 2004 – 2005.

In relation to suicide and self-harm prevention, HM Chief Inspector noted that reviews were carried out on time and that there was a consistent and broad membership of the suicide prevention group. At least one counsellor was

available every day. In addition, the Safer Custody Manager had recently produced a safer custody bulletin which provided staff with information about trends and initiatives. However, the Chief Inspector also commented that the frequency and standard of entry on SASH [Suicide and Self Harm] forms was often poor and that staff had little time to engage with the prisoners.[6] She also noted that there was no prisoner-Listener scheme in operation because of a breakdown in relations with the Samaritans.[7]

Of the segregation unit, HM Chief Inspector noted that her earlier recommendation for the installation of CCTV coverage had not yet been implemented. She also commented that staff did not have sufficient confidence to challenge prisoners, hence there was a "poor level of cleanliness and untidy state of many of the cells". In addition, entries in wing history files provided "little evidence of engagement with the individual concerned". On the positive side, someone from education attended the segregation unit daily to enable prisoners to partake in education.

Finally, and with reference to the healthcare centre, HM Chief Inspector noted that the beds were rarely used and there were no strategies in place for dealing with the mentally ill. As a result, they spent long periods in their cells.

[6] F2052SH is a documented process until recently used throughout the Prison Service for caring for and monitoring those identified as being at risk of suicide or self-harm. At Rye Hill, this is known as 'SASH'.

[7] Listeners are prisoners trained by the Samaritans to listen to other prisoners who are contemplating self-harm or suicide.

PART II - EVENTS AT RYE HILL

9 December 2004 – 23 March 2005

The man transferred from Blakenhurst to Rye Hill on 9 December 2004, following sentencing in November. He was assessed on reception. His behaviour and attitude gave no cause for concern and he was not considered to be a suicide risk. He acknowledged having used cocaine in the past. He completed a form on which he recorded that he did not suffer from any physical disabilities and had no mental health problems.

He was placed on Hastings Unit, but moved to Edwards Unit on 23 December. On 21 December, the man received an initial assessment from the CARATs (Counselling Assessment Referral Advice Throughcare) team. He apparently claimed he had been 'clean' for the whole of his sentence but had not done a lot of work regarding CARATs. He was listed as urgent for the drugs awareness course. The man was recorded as saying that he had no concerns regarding drugs and wanted to focus on his parole and re-categorisation (having recently been upgraded to B) so that he could gain qualifications in higher education. Three objectives were set:-

- To maintain contact with the CARATs team;
- Raise awareness of drugs [shown as completed in February 2005]; and
- Remain drug free.

His wing history sheets note on 9 January 2005 that the man was very vocal on racial issues, claiming that the unit was racist as there were no black men on the servery. The entry said he could be quite verbally abusive and aggressive at times. It warned staff to be aware that his mood swings were unpredictable.

On 11 January, a Prison Custody Officer (PCO) submitted a Security Information Report (SIR) saying that the man told him, "I have spoken to my people and you will be getting a call soon." The PCO reported that the man and another prisoner dished out veiled threats to staff at every opportunity.

Five subsequent wing history entries recorded "No concerns", and on 5 February a Remission of Additional Days form was completed. It said the man had settled on the wing, associated with only a few others, complied with the prison regime and caused no major concerns. It said he was polite when speaking to staff. A governor noted that he was making good progress at Rye Hill and granted the application, remitting to the man five added days previously imposed as a disciplinary punishment.

On 21 February, the man applied to become a Listener. (He was turned down on 16 March for security reasons.)

On 5 March, however, the wing history sheet reported that he was "rapidly becoming a major control problem. He is rude, demanding and very

disrespectful to staff. He seems to believe that if he shouts the loudest then he is right."

Intelligence suggested the man might have been involved in criminality within the prison. On 8 March, he allegedly tried to corrupt a PCO by passing him a note asking him to obtain cannabis, heroin and a mobile phone. The man was removed to the segregation unit while the matter was investigated.[8]

It seems that a decision was initially made to transfer the man to Norwich prison on 8 March, as there is a note in his Inmate Medical Record (IMR) that he was fit for travel and transfer and an escort form had been prepared. In the event, he did not go. No reasons are recorded.

The man's segregation was reviewed on 11 March. It was noted that his general attitude and behaviour had been of a very good standard. He was to remain segregated until 16 March, "Pending investigation into allegations you attempted to compromise a member of staff."

Staff reported that he had no problems while he was in segregation and that they had established a good rapport with him. He was returned to normal location, but to a different unit (Davies unit), on 16 March.

On 17 March, a CARATs team worker reported in the man's CARATs file that he was:

> "… very angry about incidents which have occurred on Edwards Unit … He is in no state to talk about drug issues. He states that he has no dealings with the drug culture within the prison. Another inmate who works with the team joined us to try and calm the man down and we both got him to focus on some positive issues such as parole and getting home to his partner/family."

The Davies handover book noted that the man appeared agitated on the morning of 18 March.

On 19 March, the handover book reported, "the man has left the unit!!" It said First Response had been called after he up-ended a pool table. It said he was very irate, shouting and swearing, and that he was going to be 'lifted' (that is, moved under Control and Restraint), but decided eventually to walk.

[8] An SIR submitted on 20 May 2005 (sic) recorded a conversation between an officer and a prisoner. It said the prisoner told him that an officer had been bringing in drugs for a group of prisoners and that the man had asked the officer to bring in drugs for him also. When the officer refused, the man said he would report him. The officer then went to security and said the man was pressuring him to bring in drugs. (GSL commented that the fact that one officer was prepared to report on an allegation against a colleague ran contrary to conspiracy theories relating to staff corruption.) Another SIR relating to the same conversation reported that the prisoner said that, after the man came back from segregation, an officer deliberately wound him up by taking his fan.

The segregation unit log book showed that the man was received in the unit on 18 March, "on 53.4 pending adjudication from Davies Unit".[9]

A prisoner told the police that he heard the man crying at about 6:00 am on 19 March. It went on for about an hour. After a member of staff spoke to him, he was quiet until around 9:00 am.

A PCO recorded that, "The man's behaviour is varied, ranging from hostility towards staff right through to sobbing and crying. I believe that he took something on the wing and at present is coming down from it."

An entry in the chaplaincy log book (possibly dated 19 March, although it is unclear) said:

> "Spent a long time with the man. He is very stressful and has a lot family related problems on the outside. We prayed together. I encouraged him to be strong. He would like the support of the chaplains on a daily basis until he gets through this period. The staff gave him a bible while I was there."

The Duty Director's log and Control and Restraint report forms show that on 19 March at about 2:00 pm, the Director was doing his segregation rounds. The man initially declined to speak to him, but an officer subsequently called the Director back saying that the man had changed his mind. However, when the cell door was opened, the man threw his bible at the officers and the Director before then trying to barge his way out of the cell. In the process, he apparently struck one officer repeatedly in the face. Staff reported that the man showed incredible strength and it took a number of officers to bring him under control sufficiently to force him back into the cell. They put him face down on the floor and then exited the cell in the prescribed manner. However, he managed to get up and jam his foot in the door. They then had to restrain him once again before finally managing to secure the cell door. The PCO recorded in the segregation unit log that three officers had been injured during the incident.

The Duty Director noted in the Duty Director log that the man had fought with "unnatural strength" and it took very many staff on an 'all staff' call eventually to deal with him. He added, "He is clearly mentally unbalanced and paranoid. I don't think he really knew what he was doing."

A Report of Injury to Inmate form dated 19 March recorded that, following an incident at 3:10 pm when the man had tried to get out of his cell, First Response had been called and force was used to put him back into his cell. The form noted that he was complaining of a sore arm and face, but commented, "Unable to assess because the inmate is still very volatile." (A prisoner who witnessed the incident said he saw an officer strike the man in the face. Others said they saw no such thing.) The Medical Officer noted that

[9] 53.4 is the Prison Rule allowing a prisoner charged with a disciplinary offence to be segregated pending the governor's first inquiry.

the man was complaining of a sore right arm and swollen face and neck – "Very aggressive behaviour at present, not happy to open him up at present. Will check him when calmed down."

An officer opened a F2052SH form at 4:30 pm. She said she was concerned because the man had stated that he wanted to be baptised as he was ready to die. She advised that staff should offer support and counselling if required. She noted on the Daily Supervision and Support Record that:

> "The man is in a highly agitated state. He is constantly saying he wants to see a chaplain as he wants to be baptised, as he is ready to die. He is also standing by his door reading passages from the bible incoherently."

The Duty Security Manager noted on the form at 6.00 pm that the man wanted to die and was reading the bible. He advised that the man should be offered "full support as per Rye Hill policies" and that he should have counsellor support. Perhaps surprisingly, given that the man had said he was ready to die, he did not refer the case immediately to healthcare. Instead, he ticked the box to advise that he should be managed on normal location.

The healthcare assessment section was completed at 6:15 pm. Under "Give your assessment", the Nurse has written, "Sitting in cell reading bible, states that he is 'sound'." She advised that the man should remain in a single cell in segregation and be subject to six times hourly watches. She made no other interim instructions.

An entry in the chaplaincy log recorded that the man and another prisoner had been very abusive towards staff that evening. It said they were asking to see a chaplain in order to be baptised that day. The chaplain noted that he had gone to the segregation unit as the incident with the man was coming to an end. The chaplain said he did not see either prisoner and that, although the healthcare counsellor was present, she had not seen them either.

A Crisis Intervention Record sheet dated 19 March and timed at 6.00 pm recorded that the Counselling Service had been called that morning by the chaplaincy. It recorded, "Chaplaincy v. concerned about this man. Seems unstable – assault to officers in seg, then crying – reading bible – has found God this morning. By the afternoon (after the assault) he wished to be baptised before killing himself tonight. Spoke to him thro' door. Said he was 'safe'." Action/Outcome was recorded as, "Officers and nurses believe he is coming down off drugs.[10] GP feels symptoms point to cannabis psychosis. Possibly needs psychiatric assessment?" The time spent with the man was about five minutes.

A form entitled "F2052SH Opened/Counsellor Support Visit" and dated 19 March recorded under Inmate's Response/Mood/Feelings, "Assaults to staff, talking about suicide, very erratic and unstable." Counsellor Comments were

[10] As I report later, the post mortem toxicology report found no illicit drugs in the man's body.

"Unsuitable to be seen by counsellor. Referred to the RMN [Registered Mental Nurse])." The form was unsigned. The counsellor told the police that the reason why she judged the man unsuitable for counselling was that he refused to engage with her.

At 9:00 pm that evening, the man was issued with three notices of report:

- one for using threatening, abusive or insulting words or behaviour on Davies unit the previous day, when he was alleged to have said to a female officer, "What you fucking looking at?" (this apparently followed the incident when he overturned the pool table (for which he was not charged));
- one for having in his possession two mobile phone SIM cards (he had apparently handed these over on being searched on arrival in segregation the previous day); and
- one for assaulting an officer during the incident when he tried to barge his way out of his cell.

(The former residential manager said there was a further outstanding adjudication for possession of cannabis. Whilst I understand that a substance believed to be cannabis was found on the man when he went to the segregation unit, I have not found any corresponding adjudication paperwork.)

An entry in the segregation unit log book on 20 March recorded that, "Whilst out on exercise the man stripped naked and walked in continuous circles reciting the Lord's Prayer. After two and a half hours he voluntarily came in having no recollection of how or why he was naked." In interviews with the police, staff said it was a cold day and they tried to encourage him to get dressed and to come back in but he just ignored him. They therefore left him to it, observing him through the window. No segregation manager was on duty that day so staff informed the Duty Security Manager (DSM) (who happened on that occasion to be the Safer Custody Manager). She discussed the incident with the Duty Director. They agreed to leave the man in the exercise yard, but to have a counsellor on stand-by for when he came in. This decision was not documented anywhere. (I have to say that, notwithstanding that staff were anxious about how he might react if challenged, I am baffled why more rigorous steps were not taken to bring him inside much earlier.[11]) Although the Safer Custody Manager was present when he came back in, she decided not to refer him to healthcare because he said he did not want to see or talk to anyone. (Surprisingly, given her primary role in the prison, she did not record any of this in his F2052SH.)

[11] GSL commented that there was no reason for staff to be anxious as they could call for back-up and restrain the man if necessary. This had happened on a previous occasion. They said the Safer Custody Officer and Duty Director agreed not to use C&R but instead "to keep the man under observation to see if he would return voluntarily (which he did) and to have a counsellor on stand-by. This was an operational decision that, like any other, may be questioned with hindsight. However, under the circumstances it is difficult to conclude the decision to be a wrong one." My point was a different one. I criticise not the decision not to use C&R, but the fact that a vulnerable, naked man was outside for two and a half hours without being offered a blanket and with no engagement by the chaplain or senior staff.

The Unit Occurrence Log for 20 March recorded that, “On exercise has stripped naked is ignoring staff. He is reciting passages from the bible. His state of mind seems somewhat out of sync.” There is no corresponding entry in the man’s Inmate Medical Record to show that this incident was reported to healthcare staff.

The Safer Custody Manager recorded that she spoke to the man after he got dressed and that he seemed very confused and did not know why he had taken off his clothes. She said she had offered him a counsellor but he said he did not want to talk to anyone.

A Chaplain noted in the chaplaincy log that when he saw him, the man referred to several bible passages, “but on the whole seemed quite subdued and calm”. He told the police that he nevertheless voiced his concerns to an officer, suggesting that his behaviour might have been due to a breakdown rather than to drug use. He advised her to contact healthcare which she did. A member of healthcare staff arrived while the Chaplain was still on the unit.

The Duty Director recorded later that the man had a pain in his stomach and that he (the Duty Director) had agreed to contact healthcare. (There is no corresponding record of this in the man’s IMR.)

During the evening of 20 March, the man wrote a letter to his mother on the back of his menu choice sheet and pushed it under his cell door. In it, he said he wished the Almighty would take him away:

> “… with his mighty hands as I sit in my cell for judgement to be passed on me. All I ask for me to be remembered in your heart and tell gran to keep on trying as my heart grows weak but stronger every day as you pray.”

To “[My brother] and Son” he wrote, “I miss you so much and forever for your touch when you are older promise me you will follow the bible in great detail and pray for everlasting peace.”

A doctor completed his section of the F2052SH at 7:20 pm on 20 March (that is, more than the prescribed “to be completed by Doctor as soon as possible following all referrals to the Health Care Centre *(and in any event within 24 hours)*”). He noted, “Wanted 2 paracetamol – otherwise he claims he is O.K.” A further entry dated 21 March said, “Appears to be in a mental confusional state. Refer to RMN to psych. See tomorrow. Stay in segregation.”

At 7:15 am on 21 March, the night officer reported on the Daily Supervision and Support Record that, “The man seems to be very upset and disturbed – keep reading bible and asking WHY? Think he needs to speak to Chaplaincy – not a good night at all.” On the Unit Special Watch Record he made a number of entries between 3:00 and 5:15am stating that the man was crying. At the end of his shift he wrote, “Very upset and disturbed. Keep a close eye on.”

On 21 March at about 9:30 am, the man was let out of his cell for a shower. He stopped half way down the stairs when he saw one of the exercise yards being hosed down by an orderly. He asked if he could be hosed down too. He was told he could not. The man then refused to move either on to the shower or back to his cell. Staff tried to talk him round, but eventually it was decided to return him to his cell using Control and Restraint procedures. A Use of Force form noted that handcuffs were applied "due to the violent nature of the inmate". He was charged later that evening with assaulting an officer by spitting on him.

A note in the man's Inmate Medical Record reported that he had not sustained any injuries during the return to his cell, but that he "appeared very distressed he was rambling about 'the demons talking to him' and that he wanted to die as he had nothing to live for. Appeared agitated and unable to sit or stand still and very difficult to engage in conversation." The nurse who made the entry noted that she had discussed the man with the Healthcare Manager (also a Registered Mental Nurse) and that a Doctor had been asked to see him.

The following entry reported on a conversation between the Healthcare Manager and a Forensic Consultant Psychiatrist. The Healthcare Manager recorded that she informed the Forensic Consultant Psychiatrist of the man's details since Friday, and that he said the man was suffering from a psychosis. He did not know the reason but advised he required medication. He prescribed olanzapine and diazepam. The Healthcare Manager noted that the man was to be reviewed the following Thursday by another Doctor (a psychiatrist).

(In the event, a doctor instructed that the medication proposed by the Forensic Consultant Psychiatrist should not be administered. The clinical reviewer considers this decision in her report)

The Duty Director visited the man at 11:45 am on 21 March. He noted in the Daily Supervision and Support Record that he appeared low – "very different to when I spoke to him 2 weeks ago". In the segregation unit log, he wrote, "Acting very strange – stating 'I went about it the wrong way'. Asked if he had pressure put on him to which he replied 'No'."

The Chaplain visited subsequently and wrote in the segregation log, "Quiet and uncommunicative. NTR [nothing to report]."

At 10.00 pm that evening, the Daily Supervision and Support Record reads, "Seems low and upset. Not happy."

The man was seen by a Registered Mental Nurse at 10:15 am on 22 March. Speaking to him from the cell doorway, he found the man to be calm and rational and showing no psychotic symptoms. The man apparently told him he felt well and had no problems. The RMN told the police that the man's

condition did not give him any reason whatsoever to suggest he should be removed from the segregation unit to the healthcare centre.

On 22 March, the man was due to appear before the Home Office Controller for adjudication. (The Controller told the Assistant Ombudsman that the hearings had been opened the previous day but adjourned for medical assessments without any plea being heard.) The Controller noted that he had opened and adjourned the hearing because the man was on a visit. He advised that the man should be fitted for adjudication by the medical officer. For some reason, the medical officer who saw him at 10:15 am had not apparently been asked to consider fitness for adjudication, even though it was known that he was to appear before the Controller. (I understand in any case that it is the Controller's normal practice to adjourn adjudications where the prisoner is on an open F2052SH.)

On 22 March, the only entry in the Daily Supervision and Support Record said that the man was lying on his bed talking (to the prisoner next door - they communicated through the pipes) at night manager's visit. The segregation unit log shows that both the Duty Director and the Chaplain visited. The former recorded, "No reported problems" and the latter "Sitting quietly. NTR." The chaplain told the police that on this occasion, although he was teary, he was more lucid and clear. His speech was clearer, he maintained better eye contact and he appeared more positive. The Chaplain thought the man was significantly improved as compared with the previous Sunday.

The man went for a visit during the afternoon. His F2052SH did not go with him and staff on visits were unaware that he was considered to be a suicide risk.

The man's mother told my colleagues that the family noticed some marks on her son's skin for the first time during the visit. There was a large mark to the right side of his neck. When asked, the man said he had tried to hurt himself as he had been told his family were dead. He had also hurt himself with a pen, hurt the palm of his right hand with his radio, and had marks on his wrist – possibly from handcuffs. He told them he had not been sleeping in the segregation unit, and believed the food he was being given was poisoned or that something was given to the prisoners in their food to control them. As a result, he was not eating (except the sausages) and was constipated. His mother said that, when the visit ended, her son became very agitated saying, "Please, please, I can't go back to the seg."

The man's return was substantially delayed due to difficulties on the unit and, when he did come back, he was placed in a different cell because his own had no power. Managers who arranged the cell moves said the cells were in a disgusting state. In particular, they said of the man's cell that there were plates in his cell and old bits of food. One said it smelled appallingly bad. They cleaned the cells themselves before they were re-occupied. Both managers told the Assistant Ombudsman that the man seemed fine when he returned, notwithstanding that he had had to wait so long in visits.

During 22 March, a member of staff reported to the Safer Custody Manager that there were gaps in the F2052SH supervision sheets for the segregation unit. She spoke to the Segregation Unit Manager about this the next morning. He said at first that staff were all fully occupied with a hostage taking situation. When it was pointed out to him that the incident referred to lasted for a much shorter period than that for which there were no entries in the forms, he said that staff had been very busy.

At 10:30 am on 23 March, the man rang his call bell and asked to use a phone. I have not been able to establish what response he was given. The last call he made using the PINphone system was at 6:45 pm on 21 March when he tried to phone his brother..

On 23 March, the man's continued segregation was reviewed. The then Duty Director recorded in the segregation unit log that the man:

> "… seems confused and requesting to return to normal location. Advised he is to remain segregated pending further assessment by HCC [healthcare centre]. Nurse present on review to arrange visit by counsellor today. [There is no evidence that this happened.] Told I had spoken with his mother today and he is to receive visits Thursday and Friday. Requested he take a shower and allow us to launder his clothes. The response was vague."

The then Duty Director told the police that, before making his decision, he asked the nursing assistant if there was any medical reason why the man should not remain in the segregation unit and that she had said there was not. He said he explained to the man that, even though he was authorising continued segregation for a further seven days, he was not necessarily going to stay there for the entire period, but that he wanted him to be assessed by healthcare.

An Independent Monitoring Board (IMB) member,[12] told the police:

> "When the man did enter the adjudication room he was being escorted by two PCO's. He appeared a lot scruffier than most prisoners that have entered review hearings in the past at which I have been present. He looked dejected to an extent that I have not seen this before in a prisoner. He entered shuffling rather than walking; he was stooping, looking at the floor rather than at persons present in the room. He made no engagement with any person as he entered the room ...
>
> I didn't think he was at all with us; I didn't think that he had the ability to think. In my view a psychologist was required for him ...
>
> Once the man had left the room the then Duty Director spoke to the representative from healthcare saying that she needs to ensure that the

[12] IMB members are appointed by the Home Secretary to monitor conditions in each establishment. They also have a formal role in monitoring the continued segregation of prisoners (beyond the first three days).

man gets an examination that afternoon. The healthcare representative replied that she will make sure he is examined."[13]

The nursing assistant gave a different account. She said:

> "I do not recall any specific questions being put to me with regard to his suitability to remain within the unit however I would have had no issues to the contrary.
>
> From my brief contact with the man I did not consider him being moved to healthcare as his condition did not warrant this ...
>
> He did not display anything to me in the manner that he spoke or his behaviour that would necessitate me bringing it to the attention of either the Healthcare Manager or indeed the doctor. Furthermore segregation staff addressed no concerns with regard to his behaviour or mental state to me."

The Segregation Unit Manager told the police that he did not consider it was appropriate for the man to remain in the segregation unit in light of his mental state. He said that there was a discussion during the review about whether he would be better located in healthcare. He said healthcare were reluctant because of the man's violent behaviour. (The reluctance to treat potentially difficult or violent prisoners in the Healthcare Centre is confirmed by what both a member of healthcare staff and the Healthcare Manager said in their police statements.)

The Segregation Unit Manager completed an F2052SH case review entry following the review of the man's continued segregation. It listed the then Duty Director, the Segregation Unit Manager and the member of healthcare as being present. It was recorded that it was believed that the man had taken illicit drugs and that he had confirmed he smoked something prior to 'losing it' the previous Friday. The support plan was for him to be offered full support (segregation staff to be responsible) and to speak to a counsellor (healthcare responsible). It was noted that his mother was to visit the following day.

The then Duty Director was shown the form by the police. He said he had not seen the man's SASH form before and had not taken part in any review. (He was aware, however, that the man was on SASH.) He noted that what was written reflected what was said at the Rule 45 review and that, although it was right that the findings of the review should be recorded on the SASH form, the case review was not the appropriate place to do so.[14]

---

[13] The IMB member who attended the Rule 45 review told the police that the Segregation Unit Manager did not leave the room during five reviews. However, he filled in the observation sheet for the man for this period.

[14] Rule 45 is the Prison Rule that allows Governors to remove prisoners from association with other prisoners (that is, to segregate them) in order to maintain good order or discipline within the establishment.

A PCO recorded in the Unit Special Watch Record for 23 March that at 3:45 pm the man called her to his cell. He was very upset and seeing writing on the walls which he said was talking to him. She advised him to lie down and try to calm down. He called her back at 4:00 pm. He was sobbing and saying that he wanted to see his mummy. The PCO noted that she had informed segregation unit staff again and that the psychiatrist was coming to see him the next day. She advised the man once again to lie down and calm down. The PCO told the police that she phoned healthcare to arrange for a counsellor to see the man. She was told that none was available.

On 23 March a second chaplain recorded in the segregation unit log book that the man was in tears requesting to be baptised. He told the chaplain he was feeling scared and was sorry and that he had made a complete mess of his life. She noted that she was sending him some literature. She recorded in the Daily Supervision and Support Record that she had spoken and prayed with him and that he was "very tearful".

A large number of both prisoners and staff spoke during interview with the police about the man sobbing uncontrollably in his cell on many occasions during his time in segregation. They said he was not just crying but bawling. He could be heard throughout the unit. Several prisoners said that staff attended the cell when this happened and spoke to him until he calmed down.

On 24 March, the Safer Custody Manager sent a warning letter to a member of staff who had typewritten entries in the segregation unit F2052SHs. She also tried once again to speak to the Unit Manager about shortcomings in completing the forms.

24 March 2005

Three PCOs and the Unit Manager were detailed to run the segregation unit on 24 March. One of the PCOs regularly worked in the segregation unit. Another had only worked there for a couple of hours about two years previously and the third had been a PCO for only a few weeks in total and never worked in segregation before that week.

From 9:00 am, the Segregation Unit Manager and the experienced PCO were both involved with the adjudications. This left just two officers to carry out the routine tasks of the unit. Both officers said they were given no briefing on starting work and muddled through what needed to be done. One was aware that the man was on special watch; the other was not (even though this was his third day on the unit). (Extraordinarily, although the Unit Manager knew the man was on SASH, he was unaware that another prisoner on his unit also was.)

In addition to the 'bespoke' segregation unit staff, a number of other staff were present for a time because of the planned movement of a difficult prisoner. Others came and went in connection with the adjudications being carried out that morning. (The Home Officer Controller was also present for part of the morning, as he was conducting adjudications.) At about 10:30 am, however,

it transpired that the planned movement would not be taking place after all, and the staff deployed for the task gradually left the unit and were all gone by 11:00 am. One of the officers designated to work in the segregation unit that day was given permission to attend a meeting elsewhere in the prison, and he too disappeared at about 11:00 am. The Segregation Unit Manager was occupied full time first with the Home Office Controller's adjudications (which lasted from about 9:30 am to 10:10 am) and then with preparing for and assisting with the independent adjudicator's arrival and the subsequent adjudications (independent adjudicators are district judges who conduct the most serious adjudications). Between about 11:05 am and 11:25 am, the experienced segregation unit officer was away from the unit whilst he fetched an orderly, leaving just the manager and one officer from the original team of four. Both were wholly consumed with the adjudications – as was the second officer once he returned to the unit. (It was suggested that this position was not unusual and that it was usually dealt with by asking for another member of staff to come to cover the SASH watches or by asking staff who attended for adjudications to hang around to help out. Neither apparently happened on this occasion.)

The man was the first to be served his breakfast on 24 March. This was at about 8:15 am. No-one could recall if he actually ate it. Staff who were present described him variously as upset and much more in control of himself than he had been. One described him as 'humbled'. He apparently said repeatedly that he did not understand what was wrong with him. Dirty, 'stinking' plates from the previous couple of days were at this time removed from his cell. (Apparently no-one had removed them previously because the man was considered unpredictable and possibly violent.[15])

The man summoned staff via his cell bell on six occasions between 9:00 am and 10:17 am. He complained of having a headache and hearing voices. He was also concerned and confused about an envelope that had been handed to him earlier that morning. (It is not known what this was.) The electronic print out shows that he did not use his cell bell after that time.

The man apparently asked two or three times for a shower and this was reported to the Unit Manager. At some time between 10:00 am and 11:00 am (frustratingly, but understandably, staff were unable to give specific times of events), the Segregation Unit Manager offered the man a shower and a change of clothing. The man picked up his stereo and some papers and said he wanted to take them with him to the shower. The Segregation Unit

[15] This chimes with HM Chief Inspector's finding that staff avoided challenging difficult prisoners, resulting in their cells being unclean. GSL have commented that the situation was more complex than this. They said the man was not merely difficult but violent. He was agitated and disturbed and staff were unable to engage with and persuade him. GSL continued, "staff removed plates from the man's cell when they considered they were able to do so safely without risk of confrontation and possible violence and that staff also cleaned his cell. Importantly, had the decision been taken to intervene with the use of force for the purposes of cleaning cells and removing dirty plates, I am sure we would now be facing justified criticism for doing so." They said the same considerations applied to ensuring the man showered and changed his clothes.

Manager explained that this was not appropriate and the man refused to come out. The Segregation Unit Manager said he would try him again later.

The Unit Special Watch Record shows that the man was checked frequently during the morning. The entries are as follows:

7:39 Appears asleep
7:40 Woken up, breakfast
8:00 Appears disturbed
8:09 Talking with PCO (the experienced officer)
8:21 Still disturbed
8:30 In cell
8:39 In cell
8:48 In cell still disturbed
9:00 In cell
9:09 In cell under duvet
9:21 Under duvet
9:30 Under duvet appears to be crying
9:39 Under duvet showed face
9:48 Under duvet
10:04 Under duvet
10:09 Under duvet
10:13 Request shower
10:30 Need shower
10:38 In cell
10:49 In cell
11:00 In cell
11:09 In cell
11:17 In cell
11:30 In cell
11:43 In cell

During one check, timed at 9:30 am, it was noted that the man was crying and rocking on his bed. He had pulled the duvet right up and just his head was showing.

The PCO that had only been in Seg for a couple of hours made all the entries up until 11:00 am. At that time, he was put on other duties. No-one was specifically detailed to carry out the checks and the police established that the entries on the record after 11:00 am were made only after staff became concerned about the man, after 12:00 pm.

Despite the recorded checks and one officer stating that he spoke to the man about four times during the morning and looked on him eight to ten times, several prisoners told the police that no checks were carried out on him in the period leading to 12:00 pm. (Some suggested that the period was over two hours, but the evidence of the electronic cell bell record refutes this.) Another prisoner who was on an open F2052SH told the police that neither the man nor he was checked regularly. He said whether checks were carried out depended which staff were on. Some would simply endorse the form without

carrying out the checks. He added that many of the checks that were done on him did not involve any conversation between him and the officer who was doing it. The prisoner said that staff at Rye Hill were “very relaxed” about the F2052SH checks as compared with staff in other prisons.

A Unit Manager, was in the segregation unit because she was required as a witness in an adjudication. Once she had discharged this duty, she went to the man’s cell at about 11:55 am because she had previously promised to go to see him. When she looked through the hatch of his cell door, she could see the back of his head partially covering the hatch. His feet were pointing towards the back of the cell. She told the police that she formed the opinion that he was slouched against the cell door and was ‘playing up’. She said the orderly told her that the man had not been checked for two hours. The Unit Manager told the police she then ran to the office and told the experienced PCO that she could not get any response from the man and that he was slumped against the door. She said she then returned to the cell with the experienced PCO following behind. As they went, he told her the observation book was not up to date. The experienced PCO then returned to the office and phoned the communications office and asked for the then Duty Security Manager to attend. As he left the office, a PCO arrived with a prisoner. The experienced PCO locked the prisoner away (he was the only one with segregation unit keys at that time) and returned to the man’s cell. The then Duty Security Manager arrived and the experienced PCO explained the position. They both ran up the stairs calling for the Manager to join them. The experienced PCO explained to the police that the man was on a four-man unlock due to his unpredictable behaviour. He said he and the Unit Manager had discussed at the door whether they should open it, but they were not sure how the man would be. He said they feared that he would come rushing out and attack them. The then Duty Security Manager unlocked the door and a PCO was sent to the office for a ligature knife.

The PCO who had been in the Seg unit for a couple of hours told the Deputy Ombudsman, after seeing a draft of this report, that he was “third on scene”. He said he was on his way back to the segregation unit and passed the Segregation Unit Manager escorting the judge in the opposite direction. He said he offered to escort the judge, but the Segregation Manager declined, saying he was needed in the segregation unit. The PCO who had been in the Seg unit for a couple of hours said he was not aware of anything going on, as he had turned down his radio whilst he was assisting with adjudications. He said that, when he arrived, the Unit Manager and the experienced PCO were at the cell. The Duty Security Manager arrived subsequently.

The then Duty Security Manager recorded in an Incident Report that at about 12:10 pm, he was called to the segregation unit by the experienced PCO who told him that the man was sitting behind his cell door. (the Deputy Ombudsman established that the then Duty Security Manager was no more than a couple of minutes away from the segregation unit at the time.) The then Duty Security Manager said he went to the cell and lifted the viewing panel cover. He could see the man who appeared to be pushing the back of the cell door. He realised the man was too high up to be doing this and

pushed the door open. On looking behind the door, he found that the man had tied a shoe-lace to a hole in the viewing panel edge and placed the other end round his neck. He said he lifted the man up and, with the assistance of the Unit Manager, removed the ligature. A PCO administered CPR [cardio pulmonary resuscitation] while the Unit Manager gave mouth to mouth. The then Security Manager said he then called a Code 1 [the code indicating the nature of the emergency] and asked for the air ambulance. Healthcare nurses arrived and took over treatment.

The Senior Nurse said in an Incident Report that at about 12:10 pm a call went over the radio for Hotel 2 [the code for healthcare response] to attend the segregation unit. She said she phoned to ascertain what was happening and was told only that the man appeared to be in a collapsed state. She and three colleagues started to make their way there. At about 12:15 pm, they received a radio message to take resuscitation equipment with them. She therefore returned to healthcare to collect the defibrillator and suction. At about 12:17 pm, a Code 1 call was put out. She said when she arrived at the man's cell she found him lying on his back, and that CPR had been started by a PCO and the Unit Manager. She said she requested a blue light ambulance at 12:19 pm (in fact the Duty Director had already done this). The air ambulance arrived at about 12:29 pm. A doctor took over management of the situation and the man was intubated and intravenous access gained. Full CPR continued throughout, but the man was pronounced dead at approximately 12:39 pm.

The man left a note. In it, he said he had led a troubled life ruled or led by money and material things "that are of a sinful nature". He said he had left it to the last of his days to seek God. He asked for forgiveness and said he was a sinner and a heartless person who only cared about himself and what pleased him. He asked why he was like this.

PART III - CLINICAL REVIEW

(What follows is taken from the clinical review conducted for the police.)

Until he went to the segregation unit, the man was virtually unknown to the doctors and nurses at Rye Hill. On reception on 9 December 2004, he stated he was fit and well apart from a hernia. The assessing nurse recorded specifically 'No mental health problems'.

Apart from an entry about his hernia, the next healthcare intervention was when the Senior Nurse attended the man's move from Edwards Unit to the segregation unit on 8 March without the application of restraint. The Senior Nurse completed the segregation safety algorithm advising that segregation would not be detrimental to the man's mental health. Thereafter a nurse saw him daily in the segregation unit, as required by Prison Service Order (PSO) 1700, with the visits being recorded in the medical record. (However, the clinical reviewer noted that the integrity of the medical record entries was undermined by entries on 15 and 17 March suggesting the man was still in the segregation unit when in fact he had been relocated to Davies Unit.)

On 18 March, the Senior Nurse again attended a move of the man to the segregation unit after he overturned a pool table. The clinical reviewer noted that, in the event, the man once again walked without application of restraint and the Senior Nurse completed the algorithm as before.[16]

There was a nurse in attendance on 19 March when the man had to be forcibly restrained after throwing a bible at the Director and resisting being put back in his cell. Two PCOs were injured during the struggle. The Nurse was unable to examine the man for injuries immediately after the incident because he was too aggressive. The healthcare assessment Nurse visited the unit later to see him and spoke to him at his door. He reported that he was 'sound'.

However, the man's behaviour had concerned the officers in the segregation unit. He was distressed, speaking of wanting baptism and wanting to die. They duly opened a F2052SH. The healthcare assessment Nurse carried out the required nursing assessment at 6:15 pm. She recorded that the man was "sitting in his cell, reading bible, states he's sound". She found no reason he should not stay in the segregation unit in a single cell and endorsed the proposal for six times per hour observations.

When interviewed and shown the medical record, the healthcare assessment Nurse recalled seeing the man in the segregation unit on 19 March and that he was "being very noisy". The relevant entry is not timed but was made before the incident in which Control and Restraint was used. She also recalled seeing him later that day, "because he had earlier refused to return to his cell and Control and Restraint techniques had to be used". The healthcare assessment Nurse had visited because the nurse attending the use of force

[16] The Deputy Ombudsman was unable to locate a copy of the algorithm.

incident had not been able to carry out the required health check due to the man's aggression. The entries in the medical record regarding these encounters are not timed. It appears that all the healthcare assessment Nurse's exchanges with the man were conducted at or through the door without physical examination.

The medical assessment of the man was completed by a doctor at 7:20 pm on Sunday 20 March. The clinical reviewer noted that the medical assessment should have been completed within 24 hours of the referral to healthcare, which, she suggested, could be timed from the healthcare assessment Nurse's entry in the F2052SH at 6:15 pm the previous day. There is no evidence that the doctor examined the man. His entry reads, "wanted 2 paracetamol – otherwise he claims he's OK".

Notwithstanding the entry in the F2052SH, the clinical reviewer has noted that there was no record of a healthcare visit to the man in the medical record on 20 March. This is a breach of PSO 1700 (Prison Service rules covering segregation).

The clinical reviewer commented that there was no evidence that the nurses or the doctor knew about an episode earlier in the day when the man stripped naked in the exercise yard and paced round reciting prayers. The experienced PCO managed the incident and recorded it in the man's history sheet and the unit log. However, the clinical reviewer suggested that he did not appear to have recognised its significance, and did not consult healthcare about this deterioration as required by national policy on suicide prevention (PSO 2700). The clinical reviewer also noted that, although the man received support from the Safer Custody Manager (also Duty Security Manager on the day), and her offer of a counsellor was refused, there is no evidence that she suggested involving a doctor or nurse.

On 21 March, the Senior Nurse made a comprehensive entry in the medical record describing Use of Force to relocate the man after he refused to go back in his cell. She described him as very distressed, rambling about demons talking to him and wanting to die. She reported her concern to Healthcare Manager and asked the regular prison doctor to see the man. The Healthcare Manager discussed the Senior Nurse's report with the Consultant Forensic Psychiatrist, by telephone. He recommended olanzapine (an antipsychotic drug) and diazepam (an anxiolytic drug) and agreed a plan for his colleague to assess the man on 24 March. This was duly noted in the medical record.

The regular prison doctor, endorsed the doctor's entry in the F2052SH on Monday 21 March writing, "appears to be in acute confusional state. Refer RMN → psych. See tomorrow. Stay in segregation."

The same day, he wrote in the medical record:

> "Assessed briefly in seg. Appears confused and can't explain how he feels. Made appropriate eye contact. Speech rate/content normal but

> just ‘can’t explain how he feels’. For psychiatrist this week. I will review later today or tomorrow. Strongly suspicious of drug induced psychosis.”

(The clinical reviewer noted that there was no record that the regular prison doctor saw the man again. At interview with the police, he claimed that he had done so but was unclear if it was on 22 or 23 March.)

The regular prison doctor wrote a prescription along the lines suggested by the Forensic Consultant Psychiatrist (the clinical reviewer has noted that the prescriptions are signed but undated.) He told the police that he wrote it in case it should be needed at a later date if the man’s condition deteriorated. (the clinical reviewer commented that the nurses who were interviewed had limited knowledge that these prescriptions were available.) The olanzapine was prescribed to be given once a day in the evening. The diazepam was prescribed eight hourly prn (if required) although administration times of am, noon and pm were circled on the chart. Neither medication had been dispensed. The clinical reviewer commented that the Healthcare Manager described the suggested medication as forming part of the man’s ‘management plan’, but that there was no evidence of such a ‘management plan’ in the medical record or the F2052SH.

On 22 March, the man was seen by psychiatric nurse, probably in response to a request from the regular prison doctor or possibly from the counsellor . He found no signs of psychosis. He offered to see the man again if requested.

(It was widely thought by both discipline and healthcare staff that the man was ‘coming down’ from some sort of illicit drug. The clinical reviewer has commented that the suggestion that he was suffering from a psychosis induced by illicit drugs was never tested by any drug test.)

The clinical reviewer noted that a healthcare assistant, and not a registered nurse, represented healthcare at the man’s Rule 45 review board. The clinical reviewer reported that the healthcare assistant had not familiarised herself with the man’s medical record or any other history before attending the review. She had, in her words:

> “… picked up through general conversation with staff members that he had displayed violence towards prison staff. Furthermore, I was made aware, however I am not sure from whom, that [the regular prison doctor] and [the RMN] had seen him owing to his bizarre behaviour. I was also of the belief that a psychiatrist had seen him.”

The healthcare assistant saw no reason for the man to be moved from the segregation unit to healthcare. The healthcare manager corroborated this and emphasised that the healthcare centre was not considered as a suitable location for the man. The clinical reviewer recorded that at no time did the healthcare manager visit the man to assess him for her own information.

The IMB member wrote up the Rule 45 review as follows:

> "23-03-05 SRB. The man not at all well. His condition appears to be induced by taking of drugs. Was signed up for 7 days but an assessment by healthcare was considered very necessary. This will take place today. Signed up for 7 days."

The healthcare assistant recorded in the medical record:

> "23.3.05 Inmate seen in seg for Rule 45 Review board. Inmate appeared confused and not fully aware of his surroundings. Didn't appear to remember events of past few days and his actions. To remain in seg 7 days and be seen by healthcare."

The Duty Director wrote in the history sheet:

> "Seems confused and requesting to return to normal location. Advised he is to remain segregated pending further assessment by HCC. Nurse present on review to arrange counsellor. Told him I had spoken to his mother and he will be having visits."

The clinical reviewer noted that these accounts were significantly contradictory with both the IMB member's and the Duty Director recording actions to be taken by healthcare of which the healthcare assistant had made no record.

On the morning of 24 March, the healthcare assessment Nurse did the segregation round and recorded that the man had been "seen in seg, talking to officer, waiting to see psychiatrist this pm". She did not appear to have actually spoken to him or considered his clinical state.

The clinical reviewer reported that the remaining healthcare entries referred to the attempt to resuscitate the man following the discovery of him hanging in his cell at around 12:10 pm.

PART IV – THE MAN'S MOTHER'S CONCERNS[17]

My colleagues met the man's mother with her legal representatives on 27 April 2005.

She said that, at around the end of February, an officer had approached her son offering to get him a mobile phone. He had discussed this with his girlfriend who told him not to as his parole was coming up soon. The officer kept on at her son, however, until he eventually agreed to get a mobile and some 'weed' from him. Someone else wanted heroin so this was also 'ordered'. The officer asked the man to write down his request. When he did so, however, this was then taken straight to the Director. The officer apparently told the Director that the man had been threatening him to make him bring in the items.

The family believed that the man saw the Director on Thursday 17 March as "something had gone wrong". The man's mother had received a call from her son during which he was very distressed and crying. He told her that "they had had him in the office again about the same thing". This was the third time he had been taken into the office. This time the police were involved and he had given them the names of five officers who, he said, were bringing in drugs and mobile phones, as he did not want the full blame. He was told they had been suspended. The man was concerned about the safety of his family and the "Coventry lot" had been mentioned to him. The man's mother thought her son sounded as if he had been smoking weed in this phone call and he told her he had been passed a smoke, not rolled it himself. The man's mother wanted to know what had happened to the officers her son had named.

She said that her son was fine on Friday 18 March. His girlfriend had spoken to him and he sounded much better. He was still talking about safety concerns, however, and about threats being made against his family.

On the Saturday, a prisoner called the family to tell them that something had happened and that fourteen officers had taken the man to the segregation unit.

The man's mother said she called the prison several times to express serious concerns, and spoke to different people including the Duty Director and the former residential manager. She had even spoken to the Director's secretary on the Monday morning. She said it had been extremely difficult to get to speak to the same person each time. She was only told that her son was being watched. She said the former residential manager had also told her on

[17] In his letter of 18 June, the Group Managing Director noted that the man's mother's evidence included "speculation, hearsay and inconsistencies together with allegations that cannot be substantiated and are at odds with other evidence and witness statements. In the interests of accuracy and balance, I believe this evidence should not be included without some notes of qualification." However, the purpose of this section of my report is to give full voice to her many concerns. I have therefore simply reflected without comment or other footnote what she told my investigators. The principal matters she raises are either explicitly or implicitly considered in the section entitled "Examination of the issues". GSL's comments on her evidence are therefore incorporated in that section.

the phone that staff thought the man had been given something [that is, some sort of drug], and that if he had a positive urine test they would not hold it against him.

The man's mother visited him on Tuesday 22 March. She said that, when he was brought into the visiting room, she did not recognise him as he was so different from his usual self. He used to dress especially for visits, but had not done so on this occasion and was drawing attention from other visitors as he appeared odd. She said he was clearly distressed. When they eventually got him to sit down, he had said "they told me you were dead". She said that her son had started to cry on several occasions so they had had to refrain from talking about certain things.

The man's mother said conversation had been difficult, as her son thought the prison officers were watching him. This was because he had been positioned to face them whereas in other visits he had had his back to them. He seemed desperate to talk to his family but found it difficult as he felt he was being watched. Nevertheless, he was able to hold a conversation and was not confused at all. The family remembered talking about his brother's birthday. The man had written two cards for him but been told he could not post them and they were never sent.

The man's mother also said it was clear that her son did not know why he had been put in the segregation unit. He had been there on previous occasions in Rye Hill and again had said he was unclear why. She had called his solicitor about this as she was concerned. The man had also written to his solicitor about being taken to the segregation unit, and said he was being victimised as the prison was racist. The man's mother said her son had given examples of this racism in the letter. She was not sure if he made a formal complaint about it, but was sure other prisoners had and had received no reply. She was also aware that her son had complained to the Commission for Racial Equality, but had received a reply saying there was nothing they could do.

During the visit, the man's mother had noticed injuries on her son's hands and neck. Given that he was on a self-harm/suicide watch (F2052SH), she was especially concerned that staff had apparently not noticed these, even though the former residential manager had made a comment that without his moisturiser his skin was breaking out again (that is, she had been close enough to notice). The man's mother said she had specifically mentioned the marks to the former residential manager when they spoke on the phone.

The man's mother said that, when the visit ended, her son became very agitated saying, "Please, please, I can't go back to the seg." She had told her son to write things down. He told her his pen did not work and he had tried without success to get a new one. He showed them his dirty teeth and said he had not been able to brush them or wash since Friday when he was taken to the segregation unit at 7:30 pm. (No toothbrush was found in his cell, and no moisturiser. The man's mother was concerned that he was allowed his shoelaces in his cell but not a toothbrush.)

This visit was the last time anyone in the family spoke to the man. After the visit, they were so concerned they asked to speak to the Director straightaway. No-one came to speak to them, and they were told that there had been a problem on the segregation unit so all the managers were there to deal with that. The man's mother was given a number for the then Duty Director. She said she tried three times to call him when she got back to the car, but was eventually told by reception that he would not be available until the next day. She was then given details of another person to whom to convey her concerns, but they too had not been available.

The man's family were certain that he had not tried to harm himself before. He had seen other prisoners carried out [dead] in the past and his girlfriend had asked him if he had ever thought of doing this. He had become angry at this suggestion and was adamant that he would not. The family had trouble understanding that he took his life, as he only had six months left to serve and everything to live for. He was going to go to university and had worked as a fitness instructor. They described him as someone who loved life. He had been in prisons in the past and been segregated, but never got into the state he was in Rye Hill. He had never been on an F2052SH before and the family were concerned that he was on this occasion. They believed the difference this time was that he knew something about the officers.

The man's mother was angry that several prison officers knew her son, and knew what he was normally like, and should therefore have noticed the changes in him and realised something was wrong. She also said that a police officer had told the family that he had a statement from another prisoner to say he had heard her son crying. The man's mother believed that if another prisoner heard her son crying, then so must staff have done. She wanted to know why nothing was done to help him. She understood that the chaplain had voiced concerns about her son's state of mind. She questioned why, in that case, he was still in the segregation unit rather than moved to healthcare. She was also aware of an incident when her son was on exercise in the yard with another prisoner when he had taken all of his clothes off to draw attention to himself. She thought this might have been a cry for help. There was also a series of other incidents in the segregation unit that were managed as (mainly disciplinary) incidents at the time, and no follow up care was ever given.

The man's mother believed her son had been put into a dirty cell, as dirty dishes were found after his death which exceeded what he would have accrued in the timeframe. She said this cell had a badly repaired door offering a ligature point, and was concerned that someone on an open self-harm/suicide form was placed there with such an obvious risk.

The man's mother was concerned that she had received some unopened mail back, which suggested her son was not getting his post, and that he was

being denied essential contact with his family and loved ones at a time when he was obviously having problems coping.[18]

She also had concerns about the suicide note. She said that, although it was her son's writing, it might have been written under duress as it said "he was" as if this was being dictated, then "he" had been crossed out and replaced with "I". It also did not mention his aunt's and uncle's names even though they were due to visit him that day.

Finally, she referred to the age and experience of the officers at Rye Hill and asked what the minimum age for a prison officer there was. She said prisoners said staff did not know what they were doing.

Contact with the prison

The man's mother was angry that the prison had contacted her sister-in-law about her son's death, rather than her. She said the prison would have had her details as the man's next of kin and because she had called so many times to relay her concerns. When the man's mother then called them back, she had to go through the switchboard as no direct number or contact name to call had been given to her sister-in-law. She was told staff had tried to call her, but she did not believe this as she had her mobile phone on her and her other son was at home near the land line number.

The man's mother said that when she spoke to the Director, he would not let her come to the prison until the police had been. The family had had very limited contact with the prison since the death and no letter of condolence was sent. [19]

Unfortunately, the man's mother had been unable to see her son's body until the weekend due to the police investigation, and due to being told (wrongly, by a police officer) there were no viewing facilities at the Infirmary.

She said the police facilitated a visit to the prison, but this was made more upsetting by their being searched and having their phones taken away. She also heard a prisoner on the wing shouting "murderers" to the prison staff. The man's mother said she was prevented from talking to another prisoner on the segregation unit who appeared to want to talk to her. During this visit, she

[18] Given the passage of time, I have not investigated why the man's mail was returned unopened. My guess is that the correspondence office forwarded it to the man's residential wing (rather than the segregation unit), thus causing a delay in it reaching him. I agree with the man's mother that her son would almost certainly have benefited from the contact with his family.

[19] On 14 December 2006, my office received a letter from solicitors acting for the man's mother. They said that, despite the Director's agreement (on 14 August 2006) to pay £3,000 towards the funeral expenses, this had not as yet been paid and the man's mother had received a letter from the funeral directors about the outstanding amount. They asked for the assistance of my Family Liaison Officer in ensuring the prison fulfilled its 'obligation'. My Family Liaison Officer duly contacted the prison and discovered the delay was due to their not having received an invoice. She advised the man's mother accordingly.

saw trainers outside a cell in the segregation unit and wondered why her son’s were left with him.

PART V - EXAMINATION OF THE ISSUES

Location in the segregation unit

The man was taken to the segregation unit on 18 March to await adjudication. When his adjudications were remanded the following Monday, a decision was taken to retain him in the segregation unit on grounds of good order or discipline. This was because of the incident when he tried to force his way out of his cell and assaulted an officer.[20]

Safety algorithm

Since I became responsible for the investigation of fatal incidents on 1 April 2004, I have been very concerned at the number of deaths occurring in segregation units. Segregation is stressful and demanding. It is recognised that it can have a deleterious effect on emotional and mental health, and PSO 2700 emphasises that statistically the risk of suicide is elevated when prisoners are in the segregation unit. For this reason, it is important that a risk assessment is carried out before a prisoner is placed in segregation and that this is reviewed in light of significant events. However, I can find little evidence on the man's care plan or elsewhere that the dangers of holding him in the segregation unit were actively considered. A safety algorithm was completed when he was segregated on 8 March, but I have been unable to find a corresponding form for the second period of segregation (although one of the police statements refers to one having been completed). There is therefore no evidence that the safety of segregating the man for the period 18 – 24 March was ever formally assessed. This is a matter of significant concern.

Even if the need to complete the algorithm was overlooked on 18 March (or one was completed and has gone astray), there were several incidents during the man's time in the segregation unit that should have resulted in a new assessment of his fitness to be there. The first of these was the opening of the F2052SH form. (National guidelines and local policy both refer to prisoners on F2052SH not being routinely located in the segregation unit.) The second was the finding of the suicide note, and the third the episode where he stripped off in the exercise yard. Of course, I cannot say that staff would have concluded that the man should not have been segregated or that he should be segregated somewhere other than the segregation unit (in principle, a prisoner may be segregated anywhere in a prison), but manifestly the question should have been specifically and explicitly considered.[21]

---

[20] I have found no paperwork recording any of this. The Controller assured the Deputy Ombudsman that the necessary paperwork would have been completed, but its unavailability is a matter for concern nonetheless. Referring to the man's mother's suggestion that her son did not know why he was in segregation, GSL commented that he was "fully informed of the reasons for his removal to segregation." In light of the lack of any relevant paperwork, I simply do not know which account is correct.

[21] GSL commented that "it is apparent from other evidence that the man's retention in segregation was considered and reconsidered with healthcare staff and so he was not 'routinely' confined. Whether healthcare staff took the correct decision may be open to question but it is apparent that the matter was specifically considered. It was also discussed

Support available

The Home Office Controller told the Deputy Ombudsman that he, the Deputy Controller, and the Duty Director, discussed the man on the morning of 21 March. He said they concluded that he should be segregated in light of his behaviour. The Controller said he was aware of the events of the weekend and that the man was on an F2052SH. (He said he was not aware of the suicide note found the previous evening, but that it would have made no difference if he had been.) The Controller said authorising segregation did not necessarily mean the man had to remain in the segregation unit, but that both he and his Deputy had understood that this would in fact be the case. He said he was comfortable with this because the man would be closely supervised there. The Controller explained that the segregation unit had an excellent record of caring for volatile, unpredictable individuals and that segregation unit staff at Rye Hill had done some of the best work he had seen. In addition, the segregation unit was smaller and the staff/prisoners ratio was better than elsewhere – on normal location, there were one or two staff per 80 prisoners, whereas the segregation unit had a manager and two PCOs to a maximum of 16 prisoners. The Controller said the segregation unit was also quieter and there was more conversation between prisoners. Finally, it was staffed by good, caring officers. In particular, the Segregation Unit Manager approached his role from a perspective of care.

I take note of what the Controller has said, but have serious reservations about the decision. PSO 2700 says:

> "Prisoners who are at risk of suicide or self-harm must not be routinely held in the Segregation Unit under Rule 45 GOOD (good order and discipline). Such prisoners must only be placed in a Segregation Unit in exceptional circumstances, or where all other options have been tried, but considered inappropriate and only where it is possible to provide the degree of continual care identified as necessary in the prisoner's care plan. A case review must be held as soon as possible to take account of events leading up to the decision to segregate. If the decision is taken to locate prisoners at risk of self-harm within the Segregation Unit this must be for as short a period of time as possible, and the temporary nature of this must be reflected in the care plan."

GSL argued that the man was not "routinely" held in the segregation unit. They said,

> "There were exceptional circumstances in that he was placed in segregation not because he was a suicide risk but because of his violent outburst and his subsequent assault on officers the following day and history of violence. As previously stated, on admission to segregation he was found to be in possession of a substance thought

---

with the Home Office Controller." With the exception of the last point, I do not know to what evidence GSL refer. I found no other evidence that the matter was critically considered.

> to have been cannabis and mobile phone SIM cards. Notwithstanding his violent behaviour, this in itself might also have been reason for him to have been removed to segregation. The medical staff considered that it was possible to provide appropriate care with the segregation unit."

There are a two points I should make. The first is that I believe this comment is based on a misunderstanding of the PSO. The PSO does not say that prisoners should not be placed in segregation because they are at risk of suicide (although manifestly this is true). What it says is that those at risk of suicide should not routinely be placed in the segregation unit for reasons of good order and discipline. I accept that the man did not become a risk until after he was moved, but his location should have been considered as soon as he was so identified. In addition, GSL's comments disregard the fact that segregation can be effected anywhere in the prison – including healthcare.

Section 4 of PSO 2700 says that the "crucial considerations" when deciding on the type of accommodation in which to place at-risk prisoners are "the degree of risk and the level of support (not just supervision) which is available." The distinction in the PSO between support and mere supervision is an important one.

However, the evidence that has emerged suggests that, even if segregation unit staff were able to offer an enhanced level of supervision – and this is by no means certain – they had little time to offer support. (This was an observation also made by HM Chief Inspector of Prisons.) Although the superior staff to prisoner ratio in the segregation unit theoretically provided the opportunity for greater individual contact, the reality that emerged from evidence given to the police was of a busy unit with staff hard pressed to complete the minimum necessary tasks, let alone offer meaningful support to distressed prisoners.[22]

Regime

In any case, the potential for enhanced individual contact must be offset against the more austere regime. There is little ongoing contact between prisoners other than what can be achieved through talking through a wall, and

[22] In their letter of 18 June, GSL took exception to my reference in the foreword to a "lack of sensitivity and kindness (or worse), in the treatment of a vulnerable and broken man". They noted that it was "evident from the tragic outcome that the care provision for the man was inadequate. More should have been done with regard to his deteriorating mental health and it should have been done with a greater sense of urgency." However, GSL said my comment was emotive and sweeping and implicated all staff. They said it did "not give recognition to the compelling weight of evidence from other sources of the caring and conscientious approach of the overwhelming majority of our staff or the specific evidence that numerous members of staff involved with the man demonstrated compassion and concern for him and acted upon it." They went on to list the various people who came into contact with him during his time in the segregation unit – the Director, the duty director, healthcare staff, the chaplaincy, custody officers. However, I do not suggest that there was no contact. My point is that there was no meaningful contact with him. There was too little actual support. Various people fulfilled their statutory duties, but very few actively engaged with him during that contact.

time out of cell is limited to the completion of a few specific tasks (e.g. phone calls, exercise, showers). There are no televisions in the cells and, whilst in theory prisoners should be able to take with them their belongings, it seems that the man had very few of his. His sole means of occupying his mind were apparently his stereo and his bible. I understand that education staff visit the segregation unit daily, but can find no evidence that there was any attempt to engage him in some sort of educational activity. He had little therefore to distract him from his thoughts of dying other than the occasional – and brief – visits of various staff who spoke to him only from his cell door. The man's F2052SH care plan should properly have recognised and addressed the dangers of the more restricted regime.

I recommend that the Director reminds staff that care plans should take account of and address the specific conditions of the prisoner's location.

PSO 1700 says that:

> "The regime for segregated prisoners … should be as full as possible … In-cell education or work that could be done in cell (e.g. packing) should be encouraged. Access to activities … should be comparable to those for a prisoner held on normal location."

I recommend that those authorising segregation be reminded of the need to draw up detailed, constructive action plans to safeguard the mental health of those located in the segregation unit. This should apply even to relatively short term stays where the prisoner is identified as being at risk of suicide.

Single cell

A further disadvantage of locating the man in the segregation unit was that it only has single cells – the national suicide prevention guidelines state that shared accommodation should be the norm unless the prisoner poses a risk to others or is too disturbed to share. PSO 2700 says:

> **"**4.1.2.3 Special consideration should be given to prisoners on an open F2052SH who are segregated either under Rule 45 or who are subject to an adjudication or have been located in the Segregation Unit as a result of their adjudication hearing. The risk of locating the prisoner in a single cell in these circumstances should be considered."

The man was seen by a nurse within the prescribed time after a F2052SH had been opened for him. However, the nurse does not appear to have considered or consulted with others as to whether he should be in a single cell. [23] It is quite likely that, had the matter actually been considered, the man

[23] GSL commented, "This criticism does not appear to take into account the context of the man's removal to segregation." They said he was segregated as a response to violent behaviour and that, given that he was not considered to be a suicide risk at the time, the question of single or shared accommodation would not have arisen. The next day, he

would have been judged a risk to others or too disturbed to share. However, the reason for the prisoner to be in a single cell should be documented in the F2052SH. It was not. I cannot be certain therefore that the matter was addressed.

Bearing in mind that segregation need not be effected in the segregation unit, I recommend that, even where a prisoner on an open F2052SH is segregated, the Director should remind staff that consideration must be given to accommodating him in a shared cell.

Given the man's need for greater individual contact, staff might reasonably have considered placing him in a cell near to the wing office where it would have been easy for them both to keep an eye on and engage with him. I accept that it might have been quieter for him upstairs, but I am not persuaded the question was even considered. Certainly, when he was moved on 22 March, he was simply put in an available cell.

72 hour review of segregation

The man's segregation was reviewed on 23 March. An IMB Rule 45 – Review Sheet (the only relevant documentation I have discovered) says:

> "The man was not at all well! His condition appears to be induced by taking drugs. Was signed up for 7 days, but an assessment by healthcare was considered very necessary. This will take place today."

The man's F2052A Record of Events/Segregation History shows that the Duty Director was concerned about the man's state of mind and wanted to hold him in segregation until he was checked over by healthcare. Even though the Duty Director told the police that he made it clear to the man that, although he was signing him up for a further seven days, this did not necessarily mean he would remain segregated for the duration, I still question the decision. If the Duty Director had concerns about the man's mental health – and he clearly did – the appropriate course of action would have been to seek his urgent admission to healthcare.[24]

The Duty Director said he referred to the Healthcare Assistant in reaching his decision, and that she had said there was no reason why the man should not remain where he was. The Healthcare Assistant said she did not recall being asked for her view on continued segregation, but added that she would have been content for the man to remain where he was if she had been. However,

---

assaulted officers causing serious injury to one. The deterioration in his mental condition became apparent only after that time and when he was already judged to be a serious risk to others.

[24] Worryingly, the Duty Director did not refer at all to risk of self-harm as such when explaining his decision – only to general concerns about the man's mental health. In fact, I can find no evidence that the question of self-harm was actively and specifically considered in reviewing his continued segregation. Equally, no mention of the Rule 45 review board was made on the F2052SH.

she noted at the time that the man appeared confused, not aware of his surroundings and not appearing to remember events of past few days and his actions. I am not a healthcare professional, but a lay person might well judge that how the man presented would be sufficient to warrant referral for an urgent, full healthcare assessment *before* agreeing to continued segregation.

In her report the clinical reviewer criticised, "The failure of healthcare to be represented at the segregation review board by a qualified nurse who had made herself knowledgeable about the prisoner or prisoners to be reviewed." She viewed this as "a very significant missed opportunity", adding, "It is not acceptable practice in my view for this to be allowed to happen". I agree.

I recommend that a qualified, informed healthcare professional should attend all Rule 45 review boards. Where there are concerns about a prisoner's mental health, this professional should be a mental health specialist.

There also appears to have been a failure of communication. Both the Duty Director and the IMB member recalled that the Duty Director had asked the Healthcare Assistant to ensure the man was seen by healthcare staff that afternoon. (It is recorded in the F2052A that she was to arrange a visit by a counsellor.) The Healthcare Assistant on the other hand said she saw nothing about the man that warranted her referring him to healthcare colleagues and that no segregation unit staff raised any concerns about him with her. In the absence of a contemporaneous record, I cannot be certain whether or not the Healthcare Assistant was asked to refer the man to healthcare colleagues (although the balance of evidence suggests she was). Suffice to say that he was not so referred, so the question of his continued segregation was not urgently considered by those best qualified to make a judgement. I accept that the man was to be seen the following day by a visiting psychiatrist. By normal standards this is a swift response by visiting mental health specialists. However, his case was urgent. He was dead before the visit took place.

Segregation unit

In February 2005, the then Director at Rye Hill issued a notice entitled Principles of the Management of the Segregation Unit and its Related Services. This described the unit as "a compact special purpose residential unit with a dedicated staff team led by a Segregation Unit Manager." It said staff working in the segregation unit would be "selected for their particular competence in dealing with difficult situations and difficult people. Their appointment as segregation officers will be confirmed personally by the Director. All staff will be especially aware of the contents of PSOs 1700 and 1701." The first stated purpose of the unit was to: "Hold all prisoners segregated from normal location safely and securely and to treat them fairly and with dignity." The notice said that, "The regime of the Segregation Unit will be ordered and disciplined at all time through the meticulous application of decency and respect." The manager should therefore: "Ensure that the standard of cleanliness throughout the unit is an example to the rest of the

prison." The manager should also, "Whenever feasible, seek and provide prisoners with constructive activity in their cell. Materials for reading, for certain hobbies and for educational purpose are examples." The notice concludes with:

> "For the purposes of good management, safety and control in these circumstances, it is of utmost importance that staff adhere strictly to all security procedures and routines at all times. This is another area in which the Segregation Unit will set an example to the rest of the prison."

Rye Hill's policy at the time was that only staff with more than one year's custodial experience and who had demonstrated enhanced skills in dealing with (difficult) prisoners should be detailed to work on the segregation unit. They were required to be certificated for the role by the Director and on appointment were given a letter which says:

> "You are a certified PCO with a minimum of twelve months general experience; you've demonstrated competence in dealing with difficult situations; you've shown particular aptitude for managing difficult prisoners; you've demonstrated sound knowledge of PSO 1700 and other instructions and procedures relevant to the work of the Segregation Unit ..."

It adds:

> "You'll be supported in this special work on a daily basis by the appointed Segregation Manager and by visiting operational duty managers. Further line support will be provided by Head of Custody and a member of senior management."

The sentiments, aspirations and underlying ethos of the Principles and the letters to Segregation Unit staff are impressive and laudable. Unfortunately, they were not matched by the reality.[25]

On the day the man died, the segregation unit was a busy place:

- A total of 32 adjudications were to be heard by the Controller and a visiting district judge. The Controller dealt with his cases between 9:00 am and 10:10 am. The judge then dealt with the others.
- The escort of a troublesome prisoner (who had been involved in a hostage taking incident earlier in the week) was also planned for that day, and a number of extra staff had been deployed to deal with it. They were present in the unit, kitted up ready to carry out control and restraint. As a result, some senior managers were also present.

[25] It is worrying that both the Segregation Unit Manager and a regular segregation unit officer told the police they had not read PSO 1700 which governs segregation. The Segregation Unit Manager also said he was unfamiliar with PSO 2700 on suicide and self-harm.

- Two prisoners (the man and another) were on SASH observations and had to be seen six times during each hour.

In addition, the routine business of the unit - fabric checks, meals, cleaning and the like - had to be carried out. This hectic schedule underlines the need for effective and visible leadership.

The picture of the segregation unit that emerged from the police evidence was of a unit with barely sufficient staff (notwithstanding the presence of the additional staff for moving the hostage taker), and with little experience of segregation between them (one had been a PCO for only a matter of weeks). There appears to have been little management or organisation.[26]

The police evidence shows that four personnel were detailed to the segregation unit (as opposed to being present for other reasons). Three arrived on duty at about 7:00 am. The Unit Manager was not scheduled to be on duty until 8:00am but then spent the first hour or so in the administration block (where the LIDS[27] terminal was) preparing for the day's adjudications. Thereafter he was fully occupied with the adjudications themselves. This left the officers to get on with things. There appears to have been little by way of formal handover (and certainly none by the Unit Manager) and no allocation of duties. Staff simply got on with the job as they saw it. (Worryingly, and in contravention of policy, no prisoners in the segregation unit had a SASH watch indicated in the Occurrence Log on 24 March.) One of the officers was a new PCO. He described being made to feel very unwelcome by his more experienced colleagues and not knowing what he should be doing. He said he simply took up a position at the bottom of the stairs and responded to cell bells, lighting prisoners' cigarettes etc.

I recommend that GSL introduces on every unit a system of formal handovers between each shift attended by all unit staff. The purpose would be to inform them about any particular issues and to ensure priorities are clear.

Segregation of prisoners is a very serious matter. The additional deprivation of rights and freedoms entailed in segregation means that it is an area of the prison that must be particularly carefully regulated and monitored. It is critical

[26] GSL commented that those who provided this evidence could not be considered to be unbiased because of the circumstances in which they were giving evidence. They added, "staffing on the units is determined in consultation with experienced prison managers having backgrounds in both the private and public sectors. The staffing levels are in line with our operating proposals which were evaluated by the Home Office prior to contract award and the staffing patterns are similar to other very successful prisons that we operate. The prison management team have discretion to put additional officers on duty in the segregation unit as required." Whilst I accept these points, it is worth noting that HM Chief Inspector of Prisons had concerns about staffing levels at the prison and recommended they be reviewed. It is also relevant to note that the prisoner profile at Rye Hill is a particularly challenging one. Comparison with other GSL run prisons is therefore not necessarily appropriate. GSL also said that, in the interests of balance, they referred me again to the positive account of the segregation unit given by the Home Office Controller.

[27] LIDS is a computerised prisoner information system and, amongst other things, provides personal information relevant to the conduct of adjudications.

that procedures are followed to the letter and properly documented. This needs effective hands-on management and appropriate direction of staff. I would have expected a segregation manager in a category B prison to be on duty in the unit first thing, and to remain there long enough to be certain that everything was running smoothly.

I recommend that GSL develops training modules specifically for Segregation Unit Managers and staff. This should include dealing with particularly challenging prisoners and the possible effects of segregation and how they can be ameliorated. The training should incorporate enhanced suicide prevention training with emphasis on the drawing up and implementation of detailed, effective support plans.

I recommend that the Segregation Unit Manager is given specific responsibility for ensuring he has sufficient numbers of trained staff on the unit at any one time.

I recommend that a LIDS terminal be placed in the segregation unit.

I recommend that responsibility for preparing for and co-ordinating adjudications be given to a member of staff other than the Unit Manager.

I also understand from the Segregation Unit Manager's evidence to the police that the Unit Manager could be taken away from the segregation unit by the requirement to act on a regular basis as Duty Security Manager, and sometimes to take part in escort duties.

I recommend that the Segregation Unit Manager is not required to undertake other duties and that, where this is unavoidable, an experienced and certified manager is allocated to run the segregation unit in his absence (this should apply seven days per week).

Cleanliness and hygiene

The man's mother expressed concern that more dishes than were sufficient for the two days her son was in the cell were found there after his death. They suggested that he had been put into an unclean (as well as an unsafe) cell. The evidence of two officers who moved the man on 22 March is that they swept out all the cells themselves. I have no reason to doubt what they say, especially given the level of disgust they expressed at what they found. It was apparent that many cells had not been tidied or cleaned for some considerable time. Some of them - including the man's - smelled bad.[28]

It is evident from both the man's mother's evidence and that of staff to the police that the man had also neglected his own hygiene.[29] He claimed that he

[28] I understand that the man would have been offered the opportunity to clean his cell, but this is not the same thing as staff ensuring that the cell was clean.
[29] This in itself should have been identified as a cause for concern (it is one of the warning signs listed in Rye Hill's policy on suicide prevention) - especially given that he had previously been careful about his hygiene and appearance.

did not have a toothbrush (and none was found in his cell after his death). We know he declined a shower on 21 March, and on 22 March he was unable to take one (there was a problem with the power). An attempt to take him for a shower on 24 March was aborted. Staff cannot of course force a prisoner to wash, but they should have tried all measures open to them to ensure that the man did so. One of the things certain to exacerbate depression is low self-esteem. How must he have felt about himself in a cell that smelled and was strewn with dirty dishes, and when he had not showered or brushed his teeth for several days? Common decency dictates that prisoners should keep themselves and their cells clean, but this assumes much greater importance in relation to someone who has stated their readiness to die. It should have been incorporated into his care plan as soon as staff became aware it was an issue.[30]

I recommend that arrangements for ensuring the cleanliness of both the prisoner and his environment should form part of any support plan where there are indications that the prisoner is neglecting either or both.

There is evidence of poor management by the Segregation Unit Manager which might in part explain the state of the cells.[31] But responsibility does not sit wholly with him. It is clear from his evidence to the police and following the trial that the he felt unprepared and unsupported in his role. Segregation units are rightly robustly regulated. Certain members of staff – including a governor, a doctor and the chaplain – are required to attend on a daily basis to ensure that all is well. The unit log shows that the requisite staff visited – but I have to ask what use their visits were if they failed to identify basic problems of hygiene or, having identified the problems, failed to act on them.

I recommend that GSL provides managers with additional training with regard to their responsibilities in relation to the segregation unit.

SASH checks

No entries at all were made on the man's SASH record whilst he was on the visit on 22 March. Potentially key information could have been gleaned during this time, as his mother has said that her son was distressed throughout the visit. She also relayed her concerns to visits staff. The officer who went to

[30] GSL said it was "too simplistic to say more should have been done to persuade the man to co-operate, given the evidence of numerous failed attempts to engage with him." However, I have found no evidence to suggest that segregation staff had noticed either the state of his cell before the two residential managers did on the evening of 22 March or the man's own unkempt appearance before the Duty Director did so on 23 March. Certainly, I am not persuaded that they even tried to engage with him in these respects. GSL have said there is clear evidence that he was offered and encouraged to have a shower and accept clean clothes, but this did not happen until 24 March following the Duty Directors direction the previous day.
Referring to the man's mother's allegation that her son did not have a toothbrush, GSL commented, "We are not able to say if the man had or did not have a toothbrush. However, what we can say is that a toothbrush would have been provided on request. It was clearly not the case that he had not been able to brush his teeth or to wash. He had declined to do so."
[31] As noted at footnote 14 above, HM Chief Inspector of Prisons found that staff were unwilling to challenge difficult prisoners.

collect the man for his visit told the police that segregation staff did not inform the escorting officers that he was subject to SASH observations. Nor did they give them the F2052SH on which to continue to record observations. This too shows a lack of a co-ordinated approach to the management of those at risk of self-harm.

I also recommend that he reminds staff that the F2052SH (now ACCT form) must accompany the prisoner to whatever part of the prison he goes.

(I note that visits staff responded to the man's mother's concerns by trying to find a manager with whom she could speak. In light of what she told them and the fact that they were not aware that the man was already on an F2052SH, it is arguable they should have raised one themselves.)

On the day of the man's death, no-one was specifically detailed to carry out the SASH observations on either the man or another prisoner on an open F2052SH. (The Segregation Unit Manager maintained that he had asked a PCO to keep an eye on the man; The PCO said the Segregation Unit Manager told him to keep an eye on the paperwork.) Nevertheless, it seems that checks were carried out as they have been entered on the monitoring sheet. (In saying this, I am conscious of statements from several prisoners that no such checks were carried out and of evidence that records were falsified in the man's case as well as others.) In the period to 11:00 am, the sheet was filled in by the PCO.

However, it is not clear whether the sheet was completed contemporaneously. A PCO told the police that she had looked at the SASH records in segregation on 24 March and found that there was about an hour's worth of entries that had not been completed for the man. (Since she said the man's cell buzzer was being used constantly whilst she was there, she must have noticed this before 10:19 am.) However, she said she did witness a PCO answer the man's buzzer several times while she was there.

A PCO made his last check at 11:00 am. (This was corroborated not just by the record but also by the Segregation Unit Manager who said the PCO reported to him at this time that the man was once again asking for a shower.) However, at 11:00 am, the PCO was asked to help out with adjudications. No-one appears to have considered who would complete the SASH checks thereafter, and the PCO did not mention them even though he had been carrying them out alone for the previous hour. As a result, they were not done. (The Duty Director denied that he had told the Segregation Unit Manager that he would take care of the segregation unit regime whilst he (the Segregation Unit Manager) was occupied with adjudications.)

During the police investigation, a PCO admitted that he wrote the four final entries for the period between 11:00 am and 11:43am on the instructions of the experienced PCO. This was after the Unit Manager had failed to get a response from the man at 12:10 pm.

Unfortunately, the failure to carry out and record SASH checks was not confined to the day of the man's death. The Safer Custody Manager told the police she had complained in writing over a long period that these were being neglected regularly, and she had brought this to the attention of managers, including the Segregation Unit Manager. In fact, she told the police she had spoken to him about gaps in the SASH records. On 23 March, she had spoken about the period the day before when no entries were made on any SASH records between 1:15 pm and 5:45 pm.

A PCO also told the police that, about two or three days before the man's death, a new PCO had brought to her attention a SASH record where his own entries had been changed to cover up a gap in the recordings earlier in the shift. The PCO said she warned all the PCOs whom she saw in the segregation unit about the importance of completing and documenting SASH checks. She said she told the Segregation Unit Manager about two days before the man's death that he needed to get his officers to fill in the SASH and keep it up to date. She said it was not the first time she had mentioned this to him, but little improvement in the records had resulted.

I recommend that Unit Managers be required daily to sign the Unit Special Watch Records to show they have checked them and also to note any action taken to rectify identified problems.

I also recommend that Rye Hill considers placing the Unit Special Watch Records outside the respective prisoner's cell so that it can be completed on the spot by the member of staff carrying out the check.

In view of the doubt over whether the checks were actually carried out and indeed the need for the actions of segregation unit staff to be open to proper scrutiny,

I endorse HM Chief Inspector of Prisons' recommendation that CCTV should be installed in the segregation unit.

The clinical reviewer pointed out that Rye Hill requires a six times an hour watch on all prisoners identified at risk of suicide and self harm unless the level is raised or lowered on the instructions of the weekly SASH meeting. She suggested that this local procedure is not part of any national guidelines and its application is indiscriminate. It is also in excess of the requirements set out in PSO 2700 and places enormous demands on staff, especially where more than one prisoner is subject to the arrangements. In this respect, the policy may well have been set up to fail. Faced with an overly burdensome task, staff are unlikely to carry out the checks, or be unable to do so, or to record that they have done so.

It is also possible to envisage circumstances where any sort of watch would not be appropriate. It is commendable that Rye Hill wishes to ensure the physical safety of those identified as at risk from self harm, but this is both labour intensive and may distract from the implementation of other measures to support the prisoner and help him through the crisis. Such intensive

supervision may also be intrusive for the prisoner and tend to exacerbate his state of mind rather than otherwise.

I recommend that Rye Hill reviews its policy with regard to observations of prisoners identified as being at risk of self-harm.

Falsification of suicide watch record

One of the most troubling aspects of this case is that staff allegedly falsified records in order to make it look as though the man had been properly monitored. The Segregation Unit Manager admitted that, despite warnings from the Safer Custody Manager about record keeping in the segregation unit in relation to F2052SH, he had made four false entries in the man's special watch record on 23 March. In fact, he was involved in the man's Rule 45 review during the period for which he signed the sheets. He admitted that no-one else had made the checks.

The experienced PCO also admitted to the police that he had falsified entries (although not in the man's F2052SH) because he was too busy. He claimed that he often checked prisoners without actually noting the fact at the time. He also admitted telling a PCO to falsify the record for an hour during the morning of 24 March (the hour during which the man probably died).

I also note that in several instances on the man's F2052SH the checks have been recorded on a computer, with the same entry being made repeatedly. This of itself makes one question whether the checks were actually carried out or if the form was simply filled in at some time during the shift.

I shall not say much more about this, as it has been the subject of a criminal prosecution. What I can say is that it suggests that at least some staff knew that they were supposed to carry out checks on prisoners at risk of self harm, but did not truly appreciate the significance of the role. They appear to have believed that it was important only to go through the motions and if that did not happen, to make it look as though they had. Until the man's death, there appears to have been little appreciation that the measures they were required to take were aimed at saving a man's life. I hope the message has got through and that details of this report are used in GSL's training on suicide and self harm.

The other key point to make is that, to paraphrase the title of a hugely influential report issued by the then Chief Inspector of Prisons, suicide is indeed everybody's concern. It is not sufficient to say that there was not enough time or that no instructions were given. Everybody has a duty to be proactive and assume responsibility where self-harm and suicide is concerned. This struck me most forcibly in reading the police interviews with those who were charged with manslaughter. They make salutary reading.

I recommend that, subject to the views of the police, the transcripts of interviews of staff by the police be used in some form during staff training.

Self Harm and Suicide Prevention Policy and Procedures

Completion of F2052SH

In completing his section of the F2052SH, the Duty Security Manager advised that the man should be offered "full support as per Rye Hill policies" and that he should have counsellor support. This is a lazy way of formulating a care plan and could be said to demonstrate a lack of care.[32] It shows no recognition that each prisoner at risk of suicide has individual needs that may not fall into a 'norm'. It shows no consideration of the man's particular circumstances and I have found no evidence that the 'plan' was ever considered subsequently. Nor did it identify who was responsible for ensuring the care plan (such as it was) was implemented.

Given that the man had apparently expressed his readiness to die, and in light of his unwonted behaviour earlier in the day, I am surprised that the Duty Security Manager did not make an immediate referral to healthcare. I am led to wonder whether he actually saw the man for himself before making the entry.

The doctor who saw the man at 7:20 pm on 20 March also does not appear to have examined him, and there is nothing to suggest that he was aware of the incident earlier in the day when the man stripped naked in the exercise yard.

All in all, I am struck by a lack of rigour and application in completing the main body of the form.

Daily Supervision and Support Record

Rye Hill's suicide prevention policy (paragraph 9.5.2) requires an entry in the prisoner's F2052SH at the end of each shift commenting on his behaviour and demeanour. It states, "It is important to make valued and informative entries." PSO 2700 requires entries to "demonstrate meaningful interaction". However, the clinical reviewer has commented that in many instances the man's F2052SH contained just two entries a day – both by the night staff and not at all meaningful – for example, "in bed reading" or "no problems".

The clinical Reviewer judged that staff had failed to use the Daily Supervision and Support Record in the F2052SH in any meaningful way. The clinical reviewer has pointed out that the record should tell a story about the prisoner's behaviour and mood, and track the success or otherwise of the support plan. Staff have completed the special watch to the detriment of the support record. Very few staff other than shift managers wrote in the body of the record and it was rarely meaningful. She has said that she expects

[32] The Duty Security Manager's instruction also pre-supposes that all staff would be familiar with Rye Hill's policies. Evidence given to the police suggests that they were not. Even the Segregation Unit Manager, who might be considered to be in the lead with the man's care, told the police that he was not familiar with the suicide prevention policy document.

healthcare staff to write in the document each time they see a prisoner on a F2052SH who is not an in-patient. At Rye Hill they did not do this. The only people who wrote in the record other than unit staff were a Duty Director and a chaplain.

The former residential manager spoke on two occasions to his mother. Accounts differ as to the degree of detail given by his mother. She said she mentioned her son's injuries to the former residential manager, but this was denied.[33] However, the fact is that by the time of their second conversation in particular, the man's mother was extremely concerned. This should have prompted the former residential manager to instigate an urgent review. Certainly, she should have recorded the conversations in the F2052SH as required by PSO 2700.

The Duty Director also spoke to the man's mother when she apparently expressed her concern about her son's behaviour during visits and the effect segregation was having on him. He did not make any entry about this on the F2052SH.

I recommend that the Director reminds staff of the need to recall all salient events in the Daily Supervision and Support Record and of the need to make meaningful and informative entries at the end of each shift.

In light of the man's mother's reported difficulties in speaking to someone to relay her concerns and the doubt around what exactly was said,

I recommend that GSL establish a dedicated phone line for people to contact in order to report concerns about prisoners. The line should be manned 24 hours a day and calls recorded.

Unit Special Watch Record

PSO 2700, at paragraph 4.2.3, instructs that "supervision of the suicidal should be active, involving supportive contact rather than mere observation." Of course, during the night when the prisoner is asleep only simple observation would be appropriate. However, the entries generally at Rye Hill show a lack of engagement with the man during the checks (this is not to say of course that others did not engage with him at other opportunities) and provide little, if any, insight into his present state of mind. It is worth noting here that the form itself does little to encourage staff to provide any useful information – there is space only for a very few words for each entry.

[33] The former residential manager told the Deputy Ombudsman that she had told the man's mother when she would be available. She acknowledged that she made a comment that the man looked better than he did previously, but a bit spotty (she said there was no mention of moisturiser). As far as the man's mother specifically mentioning marks to her, she said that this was not the case. She said their conversation covered a range of topics, including arranging for the man's mother to visit, his brother's birthday, property and staff corruption. She added that, during the trial, the man's mother said she could not be sure what she had told the former residential manager.

I recommend that Rye Hill reserves its Unit Special Watch Record for night time entries and requires staff to record daytime checks in the Daily Supervision and Support Record.

Management oversight

The minutes for the Suicide Prevention Team meeting on 21 December 2004 record that part of the role of the newly appointed Safer Custody Manager was to ensure all the F2052SH paperwork was correct. A marked improvement in quality was noted. The minutes say that the Safer Custody Manager was writing to individuals who had failed to carry out their duties correctly by not filling in SASH paperwork. The minutes indicate that disciplinary action would be taken against persistent offenders.

I welcome the close oversight of standards of form completion. The clinical reviewer has commented that, in her experience, performance and record keeping only improve if staff have evidence that managers are regularly checking the F2052SHs and putting a note in each record. I was concerned therefore to discover that Rye Hill's pro forma for monitoring F2052SH records includes columns for ticking where things have happened, but does not have any section inviting comments on qualitative issues. This is a significant oversight, since the actual carrying out of various functions is largely irrelevant if the quality of the work is sub-standard.

I recommend that Rye Hill revises its management audit form for F2052SHs to incorporate a space for qualitative comments.

However, the detail of the form is unimportant if it is not actually used. The clinical reviewer noted that managers at Rye Hill Unit are required to do a quality check of entries at least twice a week. She said there was no evidence of this.

Not surprisingly, therefore, the minutes for the Suicide Prevention Team meeting for 17 March 2005 record that, "The audit sheets are showing that the main areas of concern for incomplete booklets is Unit Managers and the general observations."

Case reviews

PSO 2700 requires there to be a formal review of any prisoner on an open F2052SH within 72 hours of the form being opened. Such a review was therefore required before 4:30 pm on 22 March. It did not take place until 23 March (and it is a moot point that one took place in any meaningful sense then). However, I believe an urgent review should have been convened much earlier. The clinical reviewer noted that the local policy for Rye Hill lists a number of warning signs for staff to look for to identify prisoners at risk of suicide or self-harm. These include crying, mood swings, poor personal hygiene, suicide notes. She commented that all of these applied to the man but no action was taken.

This point is worth repeating. All of the potential warning signs were present in the man, but no action was taken.

There were also a number of specific incidents that should have prompted an urgent case review. The incident where the man stripped naked in the freezing cold during exercise was one, as was the note he pushed under his door saying he wished the Almighty would take him away. In light of his general demeanour at the time, it is arguable that his asking to be hosed down and refusing to move either backwards or forwards (though ultimately not putting up any resistance when he was moved) might have properly triggered a review.

I get no sense of staff truly engaging with the man's situation and responding appropriately. Some - notably members of the chaplaincy and perhaps a PCO - made efforts to support him, but there appears to have been a collective failure really to get to grips with his needs.[34] It may be that they were more preoccupied with the possibility of violence, or it might have been that they set too much store on the assumption that he was coming down off drugs and thought things would simply resolve themselves over time.[35]

72 hour case review

In the event, there was no F2052SH review until 23 March, when one was apparently conducted following the man's segregation review. The entry on his SASH page 3 records that the Duty Director, the Segregation Unit Manager and the Healthcare Assistant reviewed his case, but it is inadequate, unsigned and undated. It advises that the man should receive full support and that a counsellor should be made available. The form identifies that segregation unit staff were to be responsible for the full support, but it does not identify a single individual for making sure this happened. Nor does it describe what form that support should take. There is also no mention of referring him once again to healthcare, despite the conclusion of the segregation review (conducted immediately beforehand) that he should remain in the unit pending assessment by healthcare staff.

The Duty Director told the police he had never seen the form and it seems likely that the Segregation Unit Manager completed it by himself after the Rule 45 review. This was plainly inappropriate. Whilst there might properly have been cross-reference between the two reviews, they had quite different purposes. A proper 72 hour review should also have been attended by a

[34] The man was of course due to be seen by the visiting consultant psychiatrist on the Thursday. This was a speedy referral, but staff should have been actively managing him in the interim.

[35] GSL commented, "We do not consider this to be a fair representation of the situation. First, because it implies the members of the chaplaincy made the only noteworthy efforts to support and engage with him, which is certainly not the case as we have detailed elsewhere … Second, because when staff rightly consider the risk of violence it should not be assumed they are incapable of making a professional judgement. Third because it is not correct that the man had previously been involved in only one incident of violence. He had a poor behaviour record in custody at Rye Hill and prior to his arrival here."

chaplain (with whom the man had had significant contact) and a Registered Mental Nurse.

Audit

Even following the man's death and the various issues raised in relation to SASH observations and form filling, an internal suicide and self-harm prevention audit conducted in May 2005 noted a need for training for staff to be followed through. The following weaknesses were identified:

- F2052SH log not up to date
- Entries on 2052SH lacked depth
- Some entries looked repetitive and entered all at the same time
- Support plans sketchy
- Photos missing from F2052SH
- Manager's initial assessment not always filled out
- The 72 hour reviews not done on time
- Initiating officers' comment not entered in 100 per cent of cases
- Segregation use of special accommodation paperwork not in place, log not up to date
- Listener scheme not in operation [still]
- Multi-disciplinary teams but did not include the prisoner himself or any external agencies.

I recommend that GSL bolsters its suicide prevention training to cover all the shortcomings identified in the investigation into this case and the audit and that refresher training is provided for all operational staff on a frequent and regular basis.

Shoelaces

PSO 2700, at paragraph 4.4, instructs that, "Personal items including shoelaces and belts must not be removed from at-risk prisoners as a matter of course. The reasons for the decision to remove or return items must be recorded in the prisoner's F2052SH."[36] Removing belts and laces, even when done with the best of intentions, can be counter-productive since it may lower the prisoner's sense of self-worth and make him feel even worse about himself. Staff should only resort to removing articles of clothing when nothing they are doing seems likely to prevent the prisoner from trying to kill himself. However, the premise on which the instructions and guidance in the PSO is based is that staff will take very good care of prisoners at risk of suicide and self-harm. I cannot say that this was the case with the man. Worryingly, I can find no record of the question of his retaining his shoelaces ever being considered.

Ligature point

The cells at Rye Hill are designed to be safer cells. This does not mean that they are 'suicide proof'. It means that the opportunities for spontaneous acts of self-harm are much reduced. The man hanged himself from a shoelace

[36] It is worth mentioning here that, had the man been located in the healthcare centre, his shoelaces would have been removed as a matter of course.

that he had threaded through a small hole on the door plate. The hole should not have been there.

The plates securing the observation panels should be entirely smooth. They should therefore be held in place by means of welding from the other (outward facing) side of the door. However, in this instance, it seems likely that, when the panel was replaced following some repair, it had been attached by means of a rivet – or at least that this was the intention. Either a rivet had been inserted at some time and then fallen out, or the rivet had never been put in. As a result, a small hole was left in the plate and the corner of the plate was capable of being eased away from the surface of the door. This provided an easy and obvious ligature point.

I understand that cell doors should be separately examined (that is, quite apart from the daily locks, bars and bolts checks[37]) every 13 weeks. The hole had clearly been there for much longer than this as it had been painted over. It is difficult to see how an examination could have failed to reveal the hole in the door plate. This calls into question whether these important checks were actually carried out, or if they were, to what standard?

I have considered whether the officers who re-located the man were negligent in placing a man on an open F2052SH in a cell with a ligature point. Although I would expect them to check that the cell was serviceable, I would not ordinarily expect them to carry out a full fabric check. The hole was on the back of the door and would not have been visible to someone standing in the cell with the door still open. I cannot criticise them for not having noticed it. Certainly, in their evidence to the police, the staff concerned suggested that they were relying on the locks, bolts and bars checks having been carried out properly.

I infer from the police evidence that staff were reluctant to enter the cells in the segregation unit while the occupant was inside them. It could be that, aside from poor management, this accounts for the lack of fabric checks. I need hardly add that, if this is the case, it is extremely worrying.

I recommend that the Director impresses on managers the imperative that all cells should be inspected daily, regardless of the occupant. (It is particularly important that the cells of those considered to be at risk should be examined closely to ensure no action has been taken to facilitate self-harm.)

It is to be hoped that such inspections would also ensure there is no build up of old food, plates and eating utensils.

[37] There was no record of any locks, bolts and bars checks having been carried out in the two weeks before the man's death.

Response after the man was found behind his door

The Unit Manager said that, when she first saw the back of the man's head against the hatch, her first reaction was that he was playing up. Unable to get any response from him, she apparently went back down the stairs (remembering that his cell was located the furthest away from the office) and spoke to the experienced PCO before returning to the cell. The experienced PCO asked for the Duty Security Manager to attend, but no-one entered the cell until he arrived. The officers involved said that this took a matter of seconds, but in reality it must have been a matter of minutes. All in all, several minutes must have passed between the time the Unit Manager first went to the man's cell and when the door was unlocked. (Worryingly, although timings on statements cannot be taken as absolutely accurate, the Unit Manager said she went to the man's cell at 11:55 am and the Duty Security Manager said he received the call at 12:10 am.) Such time loss can be crucial in determining whether someone lives or dies.

I entirely understand staff's concerns about unlocking potentially violent and unpredictable prisoners without proper back-up (one of the officers concerned said he had in mind a previous incident where a prisoner pretended to be ill and then attacked staff who entered his cell to help him). I also appreciate that the man had shown extreme strength in trying to exit his cell the previous Saturday. Inevitably, staff would have heard about that incident and would have feared a repetition. The police have suggested that, given that the man was behind the door, staff could easily have closed it quickly had he reacted when they opened it. However, this does not allow for the circumstance that the prisoner remains still until the door is fully open and staff are inside the cell.

Nevertheless, there were three officers present, with another one in the unit office and the man was known to be a high suicide risk. My own view is that an attempt should have been made to open the cell as soon as the three officers were there. (I also believe that the threat posed by the man had been over-stated, notwithstanding the incident on 19 March.)

However, it was a judgement call on the day and taken in the heat of the moment. I do not think staff were wrong to be concerned about the potential risk they felt they were facing.

Healthcare

I set out below the clinical reviewer's examination of the issues and her conclusions in relation to the healthcare afforded to the man. However, I first have a couple of observations of my own.

Rye Hill's Healthcare Policy states (paragraph 4, Policy and Procedures PD10), "Only in exceptional circumstances will [mentally ill prisoners] be located in the Health Care Centre." I dislike this formulation. I accept that it will not always be appropriate to locate mentally ill prisoners in healthcare (just as it is not appropriate for every mentally ill person to be treated in

hospital outside prison). But the phrase "only in exceptional circumstances" is too great an inhibitor. The clinical reviewer commented that it was probable, bearing in mind statements by healthcare staff about the man's unsuitability for admission, that this guideline had resulted in a 'closed door' policy where mentally ill prisoners were concerned at Rye Hill.

I recommend that the Healthcare Policy is amended to read that, "Mentally ill prisoners should be located in the healthcare centre strictly according to clinical need."

The Healthcare Manager told the police that they tended not to accommodate unpredictable or violent patients in the healthcare centre, as there were only nursing staff there and they had no control over prisoners. In addition, such prisoners might disrupt other patients. She said that if such a prisoner were to be located in healthcare, then discipline officers would have to be brought from the main prison to unlock the patient. Instead, healthcare staff treated them on the wings.

I do not consider that this is acceptable. I am concerned that it also reflects a more general reluctance to engage with prisoners who might be violent or unpredictable. This is evidenced in part by the practice of interviewing and/or assessing prisoners from their doorways – both the regular prison doctor and the RMN assessed the man from his cell door. Of course the safety of nursing staff is important. But the prison has a duty to look after prisoners and their (mental or physical) health should override any other considerations. This means that they should be located in an appropriate therapeutic environment where their condition can be monitored round the clock,[38] and where it is possible for staff to engage meaningfully with them throughout the day – not merely to check on physical safety during the SASH observations.[39] If concerns about the man's mental health on 23 March were such that it was not considered appropriate to locate him on one of the wings, he should have been transferred to the healthcare centre and appropriate additional staff should have been detailed there as necessary.

The clinical reviewer commented that the healthcare centre at Rye Hill has a policy for such circumstances. If the nursing staff had wanted to assess the man in the healthcare centre but were concerned about the risk to themselves, the Duty Director could have authorised custody officer support. She added that, from the evidence in both policy and interviews, she did not think Rye Hill had any experience of making such as decision.

[38] The man appears to have suffered episodically, so that it was something of a lottery as to what condition healthcare staff found him during their visits to the segregation unit. They appear to have generally turned up during his calmer periods.

[39] This is not to undermine the efforts of staff in the segregation unit. Several prisoners told the police about staff spending time talking to the man when he was crying until he finally calmed down. However, this is not the same as being able to focus attention on him rather than finding time for him amongst the many other pressing tasks with which they were charged.

Rye Hill's inaugural Safer Custody Bulletin (March 2005) alerted staff to the existence of a crisis suite in healthcare. It said the room was "for prisoners who display a high risk of serious self-harm or committing suicide to spend some time in an atmosphere that is calming." Two Listeners would remain with the prisoner in crisis. The man was clearly such a prisoner. It is difficult to see why, given the note he had written, his express readiness to die, and his bizarre behaviour, he was not moved into the suite. I can only conclude that this did not happen because he was viewed as being too volatile. I am not impressed by a suicide strategy that caters only for well behaved and placid prisoners.

I recommend that GSL discusses with Primecare what needs to be done by both parties to ensure all prisoners get the healthcare to which they are entitled.[40]

I also recommend that GSL impresses on Primecare the need fully to record all developments, assessments and treatments in the IMR and, where the prisoner is at risk of self harm, the ACCT form (bearing in mind the need for medical confidentiality).

(I have in mind here particularly, although by no means exclusively, the fact that treatment was available for the man should his condition deteriorate, but no-one - residential or healthcare staff - was aware of this.)

Assessment of the man's mental health

The clinical reviewer commented that, quite apart from the symptoms of mental illness manifested by the man following his segregation, PSO 2700 says:

> "4.1.2.2 A mental health assessment must be undertaken by health care staff of all prisoners at risk of suicide or self–harm who are placed in a Segregation Unit, and the reviewed care plan implemented."

She said the adjudication procedure provided an opportunity to medically examine him. Records show that the Controller adjourned his outstanding adjudications for medical reports. The clinical reviewer said it would have been the responsibility of the Unit Manager to ensure this happened, thus enabling the man to be presented for his adjudications in a timely manner. However, despite the hearings twice being adjourned for the purpose, the medical examination did not take place.

The clinical reviewer said that the Senior Nurse correctly reported her concerns about the man on 21 March to her manager and to the regular prison doctor. The clinical reviewer was struck that, notwithstanding the fact that the Healthcare Manager, a psychiatric nurse, sought advice from the visiting forensic psychiatrist following the Senior Nurse's 'referral', she did not actually go to see or assess the man herself. Similarly, the doctor (not himself

[40] Healthcare provision at Rye Hill is sub-contracted by GSL to Primecare.

a mental health specialist) did not himself confer with the consultant psychiatrist. (The clinical reviewer said she found this entire third party consultation unsatisfactory. I agree.) The regular prison doctor visited the man on 21 March and said he would review him later that day or tomorrow, but there is no evidence that he actually did so.

An RMN visited the man in his cell at 10:15 am on 22 March. He found him to be calm and rational and showing no psychotic symptoms. The man apparently told him he felt well and had no problems. The RMN told the police that his condition did not give him any reason whatsoever to suggest that he should be removed from the segregation unit to healthcare.[41] I note that this interview was conducted from the man's doorway.[42] I do not consider that this meets the requirement in the PSO for a mental health assessment. The RMN told the police that, where he considered it warranted, he would ensure that patients were taken somewhere private for assessment but he did not consider this was appropriate here. I suggest this should happen in every case.

I recommend that arrangements are made for all mental health assessments to take place in privacy whilst ensuring the safety of the interviewer. It is generally unacceptable for healthcare assessments to be carried out in the doorway of the prisoner's cell.

The man was due to see a psychiatrist on the day he died. But this was four days after his behaviour first gave real cause for concern. In the interim, whilst there was contact with mental health services, I am not persuaded that he was properly assessed as required by the PSO.

The clinical reviewer noted that experienced psychiatric assessment might have uncovered the level of risk the man's distress presented. She also said he might have been calmed by the administration of the prescribed diazepam until the psychiatrist appointment. She was not critical that the olanzapine was not given. To recommend such a drug on the strength of a telephone conversation was surprising. The clinical reviewer commented that it would have been preferable for the regular prison doctor not to have prescribed it without speaking to the Forensic Consultant Psychiatrist himself. She added that it would have been a benefit to the man if the psychiatric appointment could have been arranged in less than four days (Monday to Thursday interval). She surmised that there was no urgency attached to the request for

[41] It was on the afternoon of 22 March that the man had his visit with his mother at which he was very distressed and said he had been told his family was dead. This suggests two things. It emphasises the episodic nature of his condition (and therefore the importance of keeping him in healthcare where his state of mind could be constantly monitored by trained professionals). It also calls into question the appropriateness and effectiveness of carrying out a mental health assessment in his cell with numerous people around.

[42] All the medical and nursing interventions appear to have been at the cell door or through the observation flap. At no time was the man observed closely enough for his injuries to be observed, yet his mother saw them straight away in visits on 22 March. No other staff saw them either, despite him being unclothed from time to time in their presence.

an opinion because of the assumption that the man's state was drug induced and would resolve itself.

(I should say that I am surprised this suspicion was not formally tested at the outset.

I recommend that where a prisoner's unwonted behaviour is suspected to be drug-induced, a 'dip test' be carried out immediately.)

GSL commented that,

> "With the benefit of hindsight one may be critical of the quality and timeliness of healthcare/ mental health provisions delivered to the man. We accept there is justification for concluding that the very rapid deterioration in hiss mental health was not properly diagnosed soon enough or appropriately treated … However, we believe that in engaging a specialist healthcare contractor the prison management and custodial staff should be entitled to rely on the expertise of the qualified professional healthcare staff. At this stage we have our healthcare provision under review."

I assume a copy of this report will form part of that review. However, to ensure that the lessons of this investigation are not overlooked,

I recommend that a copy of this report is provided to the Chief Executive of Primecare.

Throughout her report the clinical reviewer is critical of the failure by healthcare really to get to grips with the man. I wholly endorse her comments. There was a lack of thoroughness, engagement and effective follow-up in their dealings with him. However, the fault does not lie entirely with healthcare staff. Despite clear and recorded concerns about his condition, and repeated references to his crying and 'bawling', no-one ensured that healthcare staff took the situation seriously and gave more than a cursory check. I can find no evidence that healthcare staff were kept fully in the picture about his condition – that they were not informed, for example, about the episode in the exercise yard, about his strange behaviour when taken for a shower or about the extent of his evident distress. Above all, there is no evidence that segregation unit staff (or others) pressed healthcare to become more involved. As time went by, staff should have repeatedly asked healthcare to assess the man and ensured that this happened. Despite their own real concerns, they seem to have been too easily satisfied with healthcare having visited and with the received wisdom that the man's condition was drug induced. (This should in any case have made no difference to their response to him.) It is almost as though they considered that their responsibility was discharged by the very fact that healthcare had seen him. This was not the case, of course, and they should have impressed on healthcare the need for thorough, in-depth checks. Medical expertise was not necessary to know that there was something clearly (and medically) wrong with the man – whether or not this was induced by drug taking. (The

post mortem toxicology report found no evidence of alcohol or drugs of any description other than atropine, which the toxicologist suggested was probably administered during the resuscitation attempt.) [43]

The responsibility to ensure that the man received appropriate clinical care was shared by all staff who came into contact with him. However, PSO 2700 places specific responsibility on the Unit Manager to consult healthcare staff again if the prisoner's condition deteriorates and requires further medical assessment. The Segregation Unit Manager has left GSL's employment, but there is a lesson here for all Unit Managers.

I recommend that the Director at Rye Hill reminds all Unit Managers of their specific responsibilities with regard to engaging healthcare staff meaningfully in the care of prisoners at risk of self-harm and of sharing with them current information about the individual.

Corruption allegations

The man's mother suggested that her son might not have been properly looked after because of the allegations he had made about staff at Rye Hill.

On 17 March 2005, the man alleged that four (named) officers were bringing drugs and/or mobile phones into the prison. This allegation and its possible ramifications formed part of the police investigation into his death.[44]

One of the PCOs named by the man was charged for being concerned in the supply of drugs. He was found in possession of small amounts of amphetamine and cannabis and was dismissed by the prison for the drugs offence. He currently awaits trial for conspiracy to supply drugs. A second officer was arrested but not charged. A third officer named by the man was not arrested, although the police inquiry team spoke to him. The man's allegation gave no details and no intelligence supported the officer's involvement in these matters. The fourth 'officer' was identified as probably being an orderly (that is, a prisoner), and could not therefore be charged as a corrupt officer.

The police concluded that there was no direct evidence that staff mistreated the man as a result of the allegations. However, the senior investigating officer commented that:

> "I can find no evidence that would indicate these failings and the acts/omissions of individuals resulted from any motive associated with

[43] GSL commented that, "it is apparent that certain officers failed to carry out their SASH watch duties properly and to maintain records appropriately. There is justification to assert that more should have been done and sooner about the man's deteriorating mental health; there were errors of professional judgement. That is very different from suggesting that the majority of staff involved with him didn't care."

[44] GSL said they had no evidence to support the man's mother's allegation that her son had named five officers to police as being corrupt. They said, "We do know the context of police involvement is that the prison management called in the police when the man allegedly tried to corrupt an officer by handing him the note asking him to obtain drugs and a mobile phone."

> the man's corruption allegations against staff. This is naturally at the forefront of some family members' views. Whilst I cannot substantiate mistreatment as a result of his corruption allegations I find it equally as challenging to rebut such a suggestion."

I am similarly unable to make a finding either way. I should add that, despite my concerns about the decision to keep the man in the segregation unit, I can find no evidence that this decision was taken other than in good faith and with his best interests at heart. Significantly, the IMB member who was present at the review reported on the Duty Director's genuine concern for the man and the sensitive way in which he had treated him.

Racism

The man's mother also questioned whether her son was treated differently as a result of racism by staff.

She said that her son had complained to his solicitor and to the Commission for Racial Equality about racism at Rye Hill. In addition, the police took possession of two letters the man sent his girlfriend in which he alleged the same thing. However, these letters did not apparently provide any detail of why he considered the prison was racist.

A comment on the man's wing history sheet shows that he complained that there was no-one black to serve him meals, and claimed that this was racist. Apart from this, there is no record of his having made a formal complaint of racism within the prison.

The man's behaviour at Rye Hill was challenging. Some 29 SIRs were submitted in which he was named. Amongst other things, these contained allegations that he threatened or abused staff and was involved with drugs. There appears to have been no attempt by either wing managers or other senior staff to investigate and regulate his behaviour through advice or counselling, or by use of the formal discipline reporting system. Certainly staff do not appear to have dealt with him heavy-handedly – quite the reverse. (Indeed, in light of the number of SIRs, there seems to have been a failure to challenge him. One possibility is that staff felt intimidated and not in control.)

The police inquiry asked all those giving statements for any evidence of attitudes, behaviour or comments made to or about the man of a derogatory nature. None alleged any impropriety. The police concluded that the evidence to hand did not justify suggestions of racism in respect of his treatment, but they would remain open-minded. I can only endorse that conclusion.

Contact with the family

The man's mother complained that it was her sister-in-law rather than she who was contacted following her son's death. I understand that the prison chose to phone the man's aunt because she and her husband were due to

visit the man that afternoon. However, any parent would wish to know immediately and at first hand that their child had died and not rely on a message conveyed through a third party. I can only imagine how this must have added to his mother's distress. I appreciate that the prison wished to prevent the man's aunt and uncle arriving for the visit only to be told that their nephew was dead. But surely it would have been possible to tell both parties simultaneously or within a short time of each other. If, as the man's mother suggested, the prison told her that they could not find her number for her, I agree that this was totally unacceptable. All the more so, given the number of calls between her and the prison during the period 19 – 24 March.

I recommend that Rye Hill's contingency plans include an instruction that the next of kin be informed first hand and immediately of a death.

I am also saddened that the visit she made to Rye Hill actually added to her distress. It would not have been appropriate for a category B prison simply to have suspended all its security measures for the visit. But it is self-evident that the visit by next of kin following a death in custody must be arranged and conducted in as sensitive a way as possible. In particular, it can reduce the shock if families are warned beforehand exactly what will happen on their arrival (as suggested in PSO 2710, Family Liaison Officer guidance).

I recommend the Director at Rye Hill reviews arrangements for ensuring visits from bereaved relatives are handled as sensitively as possible.

Finally, I note that the man's mother said she had not received a letter of condolence from Rye Hill. This is a shoddy, not to say heartless omission. It is hard not to see it as symptomatic of every other failing revealed in this report.

I recommend that, even at this late stage, the Director should write to the man's mother to offer her an apology for the omission and his condolences over her son's death.

I recommend that a requirement to send a letter of condolence to the next of kin is incorporated into Rye Hill's contingency plans.[45]

[45] GSL said: "The evidence presented by the man's is very distressing and she has my sincere sympathy for the loss of her son in such tragic circumstances. The omission by the prison management to write a letter of condolence to the family is a serious failure and is contrary to our practice and operating procedures in our prisons when there is any death in custody whatever the circumstances. It was either a serious oversight or a wrong judgement at the time that such a letter would have been considered inappropriate in the circumstances of the investigation into the death and the allegations made by the man's mother. The director has now written to her as you recommend and we will take steps to ensure our procedures in this regard are followed." I am very grateful to the Group Managing Director for his frank acknowledgement and prompt action.

PART VI - CONCLUSION

Very few people who came into contact with the man during his last days emerge from this investigation with any credit. They include the Duty Director (who described the man as being 'unbalanced and paranoid', yet took no action) and the most junior PCOs and Healthcare Assistants. Few reacted with any urgency to the distress the man was showing. Many appear simply to have gone through the motions of observing the suicide prevention policy. Some did not even do that.

The impression is that the man was treated primarily as a violent, unpredictable prisoner coming down off an illicit drug, rather than as someone desperately in need of support. Staff did not engage with him in the way they should with all at-risk and vulnerable prisoners – that is, face to face, in privacy and without time constraints. More often than not, they spoke to him from the 'safety' of his doorway. Ultimately, the perception that he was a danger to staff rather than to himself also led to a delay in opening his cell door when he was found slumped behind it. (I have no reason to suppose the delay was material in the particular circumstances, however.)

The so-called care plan on the man's F2052SH was simply hopeless. The interface between discipline and healthcare staff appears to have been fragile and remote. And there was a failure by all concerned to take personal responsibility for looking after him and really getting to grips with his care.

I have not sought to hide the shortcomings of individuals where they have been revealed in this investigation. However, many of the individuals of whom I am most critical are no longer employed by GSL and it would be wrong to scapegoat those responsible for lesser failings and omissions. In addition to providing the man's family with an authoritative account of what happened, the purpose of my investigation has been to ensure that the company and the prison learn the lessons from this tragedy. Systemic failings – the operation of the suicide prevention policy and the interface between healthcare and operational staff, for example – and weaknesses in training and management must be robustly addressed.

Solicitors acting for the man's mother commented on a draft of this report that she was "somewhat surprised and disappointed at [my] reluctance to recommend that GSL or Primecare bring any of their employees to account". They said:

> "Given the depth of your investigation and the level of disapproval you express regarding specific individuals, (relying in addition on the findings of the clinical reviewer in her report) common sense and our client's legitimate expectations dictate that such individuals should be held accountable in some way, including through disciplinary action. In your own words, the majority of the officers appeared to have 'simply gone through the motions' when dealing with her son and several did so when they clearly should have done more and should be held accountable for their serious lack of professionalism and care."

The solicitors go on to list those individuals whom they suggest should be subject to disciplinary action.

I have considered this matter further, but on balance am not minded to change my original view. Those who manifestly did not do their job have already been disciplined and no longer work for the company. In addition, I understand that the healthcare team has been replaced with a new one, albeit still under the auspices of Primecare. As for the others listed by the solicitors, they do not emerge very well from my investigation but I do not consider their actions are such as to warrant disciplinary action. Their conduct left much to be desired, but the fact they did not go beyond the minimum expected of them does not constitute a disciplinary offence. In addition, the death itself, the ensuing criminal proceedings and my report will all have a salutary effect.

GSL acknowledged in their letter to me of 18 June, "that there were failures in systems and safeguards and that on occasions procedures were not adhered to. As a consequence some members of staff faced the unsuccessful prosecution and internal disciplinary measures; our procedures and the management systems to ensure compliance have been reviewed and strengthened and we are implementing further changes some of which are in line with your draft recommendations". I welcome this response. Nevertheless,

In light of the individual and systemic failings revealed in this report, copies should be sent to the Minister, to the Chief Executive of the National Offender Management Service and the Chief Executive of GSL for their consideration.

LIST OF RECOMMENDATIONS

1. I recommend that the Director reminds staff that care plans should take account of and address the specific conditions of the prisoner's location.

2. I recommend that those authorising segregation be reminded of the need to draw up detailed, constructive action plans to safeguard the mental health of those located in the segregation unit. This should apply even to relatively short term stays where the prisoner is identified as being at risk of suicide.

3. Bearing in mind that segregation need not be effected in the segregation unit, I recommend that, even where a prisoner on an open F2052SH is segregated, the Director should remind staff that consideration must be given to accommodating him in a shared cell.

4. I recommend that a qualified, informed healthcare professional should attend all Rule 45 review boards. Where there are concerns about a prisoner's mental health, this professional should be a mental health specialist.

5. I recommend that GSL introduces on every unit a system of formal handovers between each shift attended by all unit staff. The purpose would be to inform them about any particular issues and to ensure priorities are clear.

6. I recommend that GSL develops training modules specifically for Segregation Unit Managers and staff. This should include dealing with particularly challenging prisoners and the possible effects of segregation and how they can be ameliorated. The training should incorporate enhanced suicide prevention training with emphasis on the drawing up and implementation of detailed, effective support plans.

7. I recommend that the Segregation Unit Manager is given specific responsibility for ensuring he has sufficient numbers of trained staff on the unit at any one time.

8. I recommend that a LIDS terminal be placed in the segregation unit.

9. I recommend that responsibility for preparing for and co-ordinating adjudications be given to a member of staff other than the Unit Manager.

10. I recommend that the Segregation Unit Manager is not required to undertake other duties and that, where this is unavoidable, an experienced and certified manager is allocated to run the segregation in his absence (this should apply seven days per week).

11. I recommend that arrangements for ensuring the cleanliness of both the prisoner and his environment should from part of any support plan where there are indications that the prisoner is neglecting either or both.

12. I recommend that GSL provides managers with additional training with regard to their responsibilities in relation to the Segregation Unit.

13. I also recommend that he reminds staff that the F2052SH (now ACCT form) must accompany the prisoner to whatever part of the prison he goes.

14. I recommend that Unit Managers be required daily to sign the Unit Special Watch Records to show they have checked them and also to note any action taken to rectify identified problems.

15. I also recommend that Rye Hill considers placing the Unit Special Watch Records outside the respective prisoner's cell so that it can be completed on the spot by the member of staff carrying out the check.

16. I recommend that Rye Hill reviews its policy with regard to observations of prisoners identified as being at risk of self-harm.

17. I recommend that, subject to the views of the police, the transcripts of interviews of staff by the police be used in some form during staff training.

18. I recommend that the Director reminds staff of the need to recall all salient events in the Daily Supervision and Support Record and of the need to make meaningful and informative entries at the end of each shift.

19. I recommend that GSL establish a dedicated phone line for people to contact in order to report concerns about prisoners. The line should be manned 24 hours a day and calls recorded.

20. I recommend that Rye Hill reserves its Unit Special Watch Record for night time entries and requires staff to record daytime checks in the Daily Supervision and Support Record.

21. I endorse HM Chief Inspector of Prisons' recommendation that CCTV should be installed in the segregation unit.

22. I recommend that Rye Hill revises its management audit form for F2052SHs to incorporate a space for qualitative comments.

23. I recommend that GSL bolsters its suicide prevention training to cover all the shortcomings identified in the investigation into this case and the audit and that refresher training is provided for all operational staff on a frequent and regular basis.

24. I recommend that the Director impresses on managers the imperative that all cells should be inspected daily, regardless of the occupant. (It is particularly important that the cells of those considered to be at risk should be examined closely to ensure no action has been taken to facilitate self-harm.)

25. I recommend that the Healthcare Policy is amended to read that, "Mentally ill prisoners should be located in the Health Care Centre strictly according to clinical need."

26. I recommend that GSL discusses with Primecare what needs to be done by both parties to ensure all prisoners get the healthcare to which they are entitled.

27. I also recommend that GSL impresses on Primecare the need fully to record all developments, assessments and treatments in the IMR and, where the prisoner is at risk of self harm, the ACCT form (bearing in mind the need for medical confidentiality).

28. I recommend that arrangements are made for all mental health assessments to take place in privacy whilst ensuring the safety of the interviewer. It is generally unacceptable for healthcare assessments to be carried out in the doorway of the prisoner's cell.

29. I recommend that where a prisoner's unwonted behaviour is suspected to be drug-induced, a 'dip test' be carried out immediately.

30. I recommend that a copy of this report is provided to the Chief Executive of Primecare.

31. I recommend that the Director at Rye Hill reminds all Unit Managers of their specific responsibilities with regard to engaging healthcare staff meaningfully in the care of prisoners at risk of self-harm and of sharing with them current information about the individual.

32. I recommend that Rye Hill's contingency plans include an instruction that the next of kin be informed first hand and immediately of a death.

33. I recommend the Director at Rye Hill reviews arrangements for ensuring visits from bereaved relatives are handled as sensitively as possible.

34. I recommend that, even at this late stage, the Director should write to the man's mother to offer her an apology for the omission and his condolences over her son's death.

35. I recommend that a requirement to send a letter of condolence to the next of kin is incorporated into Rye Hill's contingency plans.

36. In light of the individual and systemic failings revealed in this report, copies should be sent to the Minister and to the Chief Executive of the National Offender Management Service for their consideration.