Investigation into the circumstances surrounding the death of a man at HMP Dovegate in February 2006

Report by the Prisons and Probation Ombudsman for England and Wales

March 2007

This is the report of an investigation into the circumstances of the death of a man at HMP Dovegate in February 2006. The man was found hanging in his cell in the segregation unit at 4.15pm and was pronounced dead shortly after. He was 28 years old.

I extend my sincere condolences to the man's family and friends for their loss.

The investigation was carried out by two of my investigators. A review of the man's clinical care and treatment was carried out by a qualified nurse who also works for my office. I would like to thank the Director of Dovegate and his staff for their help.

The man's records show that he was someone whose behaviour often led to problems with other prisoners. It was for this reason that he came to be located in the segregation unit for his own safety.

All of the segregation unit staff at Dovegate were surprised that the man took his life. However, there was a day just over two weeks before the man's death when he was transferred to healthcare as staff were concerned about his mental health. He remained under observation in healthcare for several days, during which time he was assessed by a visiting community mental health nurse (CMHN). In that assessment, the man had spoken about self-harm. The CMHN noted this in the man's records and also recorded that she had informed the senior nurse on duty in healthcare. Despite this, the man was not made subject to the specific monitoring arrangements for prisoners deemed at risk of self-harm.

I have made six recommendations. One is about making cells safer and another is about anti-ligature knives. The remaining four recommendations are about healthcare provision.

Stephen Shaw CBE
Prisons and Probation Ombudsman **March 2007**

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SUMMARY

The man, who was 28 years old when he died, had spent a good proportion of his brief life in custody – both in young offender institutions and in adult prisons. His final period in prison custody had commenced in June 2002 following a conviction for armed robbery.

While serving this sentence, the man moved between several different prisons including HMP Dovegate, where he served some time on two separate occasions. His records both at Dovegate and elsewhere show that he tended to get himself involved in arguments and disputes with other prisoners. On occasions these disputes resulted in an assault – sometimes the man was the perpetrator, sometimes he was the victim. In addition, there were at least six recorded occasions when he threatened or abused staff, and one instance when he assaulted a prison officer. There were other occasions when he damaged his cell. As a result of these incidents, the man was moved to different wings within Dovegate to see if he could settle in a new location. He was also located in Dovegate's segregation unit a number of times – both as punishment for infringing prison rules and sometimes for his own safety. It was for the latter reason that the man found himself in Dovegate's segregation unit for the final time. The man had been transferred back to Dovegate from HMP Lowdham Grange on 10 January 2006, after he assaulted a member of staff. On the very day of his arrival in Dovegate, the man made a racist comment and he then asked staff to move him to the segregation unit as he feared reprisals from black prisoners. He moved to the segregation unit on 12 January.

The evidence of the officers in the segregation unit indicates that the man settled quite well. He continued to be prone to outbursts, such as making abusive comments and kicking his cell door, but the staff seemed very forgiving of such behaviour. Their view was that the man simply could not stop himself from behaving in this way from time to time. In fact, staff talked quite warmly about the man, mentioning that he was someone who laughed and joked most of the time. He was a forgetful person, and it seemed to be a standing joke between staff and the man that he would usually forget to collect cutlery when taking his meals.

Nothing occurred of any particular note until 29 January when the man was transferred to Dovegate's healthcare unit for 48 hours' observation. He was moved to healthcare after talking to an officer about having suicidal thoughts. The officer asked the man whether he was thinking about harming himself. After spending about 20 minutes talking with the man, the officer asked a mental health nurse to come to the segregation unit to review him. While in healthcare, the man was noted to have spoken about self-harm as a way of coping. An F2052SH[1] was not opened however.

The man returned from healthcare to segregation on 2 February. He seems to have settled back into the unit routine and his usual ways.

[1] An F2052SH is a form used by the Prison Service for monitoring prisoners adjudged to be at risk of self-harm. The F2052SH procedure has since been replaced by a different process – ACCT (Assessment, Care in Custody and Teamwork). Dovegate converted to ACCT on 17 July 2006.

On the morning of 16 February, the man caught the attention of a solicitor who was visiting one of her clients. He told her that he had been assaulted by staff two weeks earlier. He also spoke to the solicitor about his parole. He said that he thought he was due parole in 2007.

The man took his lunch as usual. When his dinner plate was being collected an officer detected a phosphoric burning smell, as though matches were being burned. The officer did not enter the man's cell, but from the doorway he looked inside to see if there was any smoke or anything burning. Satisfied that everything was in order, the officer locked the door. This was the last time the man was seen alive.

At about 4.15pm, the man was found hanging from a ligature that he had tied onto the cell light fitting. Staff entered the cell and attempted resuscitation. However, their attempts were not successful and the man was pronounced dead just after 4.30pm.

This report makes six recommendations.

THE INVESTIGATION PROCESS

The investigation was opened on 21 February 2006 when two of my colleagues visited HMP Dovegate. They met the Director of Dovegate as well as the Assistant Director of Security and Operations (who had been the Duty Director on the day of the man's death). They also met the Head of Residence (who acted as the prison Family Liaison Officer). They also met a member of the Independent Monitoring Board (IMB) and a trade union representative. My investigators informed them of the nature and scope of the investigation. Notices were also issued for staff and prisoners notifying them of the investigation. My investigators subsequently interviewed a number of the staff who had dealings with the man as well as a number of prisoners.

Another of my staff, a trained nurse, was appointed to carry out a clinical review of the man's care and treatment.

One of my Family Liaison Officers contacted the man's mother to inform her of the investigation. He subsequently met the man's father and aunt. The man's aunt said that he had seen a solicitor on the morning of his death and they understood from her that he had been in a light hearted mood. She said that this was also reflected in the tone of letters that he wrote to his family in the days before his death. This evidence made it seem unlikely that he was thinking of taking his life and the family thought these circumstances were very suspicious. The aunt added that a family member who is also in Dovegate said that her nephew had regularly been the victim of bullying and assaults by staff.

Following issue of the Ombudsman's draft report, the man's mother asked to know Dovegate's mission statement. At the time the man was at Dovegate, its mission statement was: 'To Improve Peoples' Lives.'

HMP DOVEGATE

HMP Dovegate is a category B male training prison in Staffordshire. It was opened in July 2001 and is a private prison managed by Premier Prison Services.

The prison consists of two houseblocks each with five wings. As of January 2006, Dovegate's operational capacity was 860. Training opportunities at Dovegate include horticulture, painting and decorating, information and communications technology and hairdressing.

The last two inspections of Dovegate by Her Majesty's Chief Inspector of Prisons (HMCIP) were announced inspections that took place in March and April of 2003 and in August 2006. The latest report has not yet been published, but I understand that among other things it will reflect that the organisation of the segregation unit had improved since the previous inspection and that records were well maintained. The inspection team found that staff in segregation engaged with and knew the prisoners well, but also concluded that the regime in the unit was poor.

KEY EVENTS

In June 2002, the man was arrested in connection with an offence of armed robbery and was remanded into prison. He remained a remand prisoner while awaiting trial. In due course, the man was convicted and on 7 January 2003 was sentenced to nine years' imprisonment.

Over the course of the next few years, the man spent time in a number of different prisons, including Liverpool, Rye Hill and Lowdham Grange. On 10 January 2006, the man was transferred back to Dovegate, a prison where he had been on a previous occasion while serving this sentence. Upon his arrival back in Dovegate, the man was placed in D wing. However, within half an hour of arriving there, he was noted to have made some racist comments leading to him being threatened by other prisoners. As a result, the man was moved to C wing later that same day. On 11 January, the man's wing file records that he told staff that some black prisoners had told him that he would be beaten up in retaliation for the remarks he had made the previous day. Staff discussed with the man the options for a further move and it was decided that the best option was to move him to the segregation unit for his own safety[2]. This move took place on 12 January.

On 29 January, various staff in the segregation unit made a number of entries in the man's records to show that he was having a difficult time that day. Entries included that he said that he had psychological problems and was suffering from paranoia. The man thought that staff were going to attack him and also thought the shadows on his cell wall were going to get him. In another entry, the man was noted to have said he was feeling suicidal. As a result of that last entry, the man was examined by a mental health nurse and admitted into healthcare for 48 hours observation.

On 30 January, the man was seen by a CNHN from the prison mental health in-reach team (which is managed by the local NHS Trust). Her record of the consultation included her view that it was difficult to rule out the possibility that the man was at risk of self-harm as he seemed to speak of it as a way of coping.

An entry in the man's medical record for 31 January stated that he had had an unsettled night, claiming to have seen a ghost. He was then noted to have had a settled night on 1 February with no health concerns noted. A similar entry was made for 2 February and the man was transferred back to the segregation unit that day.

The records kept by discipline staff in the segregation unit contain no significant entries for the man from 2 February until his death in mid February. Throughout this period, nurses saw him on a daily basis as part of the standard review of prisoners held in segregation. On all but one occasion, the man was noted to have no health related problems. The only exception was 10 February when he refused a painkiller and was given an alternative, which he said worked well for him.

[2] Prison Service Rule 45 provides authority for the segregation of a prisoner who might be at risk of assault by other prisoners.

ISSUES

Evidence from staff and others

Dovegate's Head of Residence told my investigators that it was through this role that he came into fairly regular contact with the man during 2005. The Head of Residence said that the man tended to get involved in altercations, arguments and fights with other prisoners. Some of the altercations arose as a result of the man making racist remarks to black prisoners. Sometimes these incidents would lead to friction between the man and other prisoners and, when that occurred, the Head of Residence would arrange for the man to be moved to other wings in the prison. Occasionally, the man was placed in the segregation unit. Sometimes that was because he had broken prison rules; sometimes the move to segregation was to allow matters to settle while the Head of Residence decided where he should next locate the man. Although the Head of Residence used the segregation unit in this way with the man, he said that he prefers not to locate people in segregation if he can avoid doing so.

The Head of Residence said that in November 2005 he decided to try giving the man a fresh start by transferring him to HMP Lowdham Grange. Unfortunately, the man caused some trouble at that prison and so they asked Dovegate to take him back[3]. He returned to Dovegate on 10 January 2006.

The segregation Unit Manager said that he had worked for Premier Prison Services since 1997 and been a unit manager at Dovegate since July 2001. He said that training delivered to the segregation unit staff included suicide awareness training and mental health training. The Unit Manager explained that there are a variety of reasons why prisoners are located in the segregation unit. These include punishment for breaching prison rules, or for the prisoner's own protection and safety, which is most usually related to the nature of their offence.

The Unit Manager said that he had known the man for a couple of years. While at Dovegate, the man had spent time in most, if not all of the prison wings and he had not been able to settle in any of them. It was for this reason that the man was transferred to Lowdham Grange. The Unit Manager understood that the man was involved in an incident at that prison and so was transferred back to Dovegate. Within a day or two of his return, he was allocated to the segregation unit as this seemed to be the best location for him.

The Unit Manager said that there had been a number of incidents where the man had been prone to volatile behaviour, such as causing damage to his cell, but as time went on that pattern became less and less regular and the man grew less volatile. He remained liable to the odd outburst, but that would pass. The Unit Manager said that the man was the sort of person one could joke with. Staff got on well with him. In terms of friendship with other prisoners, the man generally kept himself to himself. The Unit Manager said that, in any case, the segregation unit is organised in such a way that the man would not have had much opportunity for

[3] A 'report of injury to prisoner' form notes that on 1 January the man punched a member of staff in the mouth. He was forcibly restrained and himself incurred some minor injuries to his head and neck.

interacting closely with other prisoners in the unit.

The Unit Manager said that he was shocked when the man took his life. At the time this happened, he seemed to be making the best of the situation he was in. There was nothing to indicate that he was not coping, in particular given that the unit and its regime was nothing new to him.

The first Prison Custody Officer (PCO) told the investigators that he had worked in the segregation unit since June 2005 and he knew the man from the occasions he had been in the unit. The first PCO said that the man was not very patient. He would ring his cell call bell for assistance, but if the officers were dealing with other matters and were not able to attend to him straight away, he would begin to shout and kick his cell door. However, apart from situations like that, the man was not a difficult person to work with. The first PCO described him as usually quite a cheerful person. He was also a forgetful person – he would go to the servery to collect a meal, but would forget his cutlery. He would then have to go back to get some cutlery and the man and staff would laugh together about this. The first PCO said that he had not known the man to harm himself and he had not expected that he would take his own life.

The second PCO said that he had worked in the segregation unit for around 18 months up to the middle of 2004. He then spent three or four months in another of the wings at the prison, before returning to the segregation unit at the end of 2004. The second PCO said that he, along with two other officers, had been asked by management to return to the segregation unit. The reason for this was that discipline problems had been occurring in the unit with some of the cells being smashed by the prisoners. The prison needed to re-instil discipline.

The second PCO said that he had known the man for a couple of years. He said that nine times out of ten the man would be polite and reasonably respectful. However, from time to time he would start kicking his door and scream and shout. The reason for this was often because he was asked to wait if he had requested something such as a towel or a roll of toilet paper. The second PCO said that he had several conversations with the man about his use of the cell bell system for trivial reasons. He would tell the man that the system was only to be used for emergencies, but within 10 minutes he would have forgotten and he would again ring his cell bell for a petty reason. The second PCO said that he recalled the man being subject to special observation about 18 months earlier, when he had deliberately cut himself. He thought that his actions that time had been due more to frustration rather than a desire to harm himself. The second PCO did not think that the man was a person who would take his own life.

The third PCO said that he had been employed at Dovegate since it opened in 2001 and had worked in the segregation unit since January 2004. The third PCO said that he got on very well with the man. He said that they had a good understanding and he described the man as ‘a likeable rogue’. As with all the other staff who had dealings with him, the third PCO was aware that the man had a tendency to cause problems whenever he was located in other wings in the prison. However, when in the segregation unit, the third PCO found the man to be generally polite and respectful to staff. Having said that, the third PCO accepted that the man would

sometimes have a shout and moan about things. One such occasion was on 28 January 2006 when the man was kicking his door and trying to smash his window. Adjudication hearings[4] were being held that morning so the third PCO asked the man to be quiet. The man swore at him and threatened to kill him. The third PCO said that such remarks would not have upset him as that was how the man responded in that sort of situation. Half an hour later, the man would apologise for what he had said.

On 29 January, the third PCO recorded that the man told a nurse that he had psychological problems, that he was feeling paranoid and that he thought that staff were going to attack him. The third PCO did not know of any reason for the man to fear being attacked by staff. The third PCO said that he did not speak to either the man or the nurse about the references to psychological problems and paranoia. He said that he did not have the medical background to get involved in such matters. The third PCO was not on duty when the man died, but a colleague had telephoned to tell him what had happened. The third PCO told the investigators that he was devastated to hear the news and it still upset him to think about it.

The fourth PCO told the investigators that he had worked in the segregation unit at Dovegate since April 2005 (having joined the prison about six months earlier). He said that he had been asked by one of the operations managers to apply for the segregation unit job and had then been successful at interview. The fourth PCO described himself as being a good, strong, reliable officer who is good with prisoners. He believed it was for those reasons that he was asked to apply to join the segregation unit.

The fourth PCO said that he knew the man from the times he had been in the segregation unit. He said that, when the man was located in standard prison wings, he was a danger to himself as he had a tendency to get involved in disputes or fights with other prisoners. However, it is a tighter regime in the segregation unit with prisoners remaining in their cells for most of the day. The fourth PCO said that the man tended to have mood swings, but nine times out of ten one could have a laugh and a joke with him.

The fourth PCO was unaware of the man having any close friends among the other prisoners. He said that prisoners in the segregation unit often shout remarks at each other and there were occasions when other prisoners would have ‘a dig’ at the man. However, he would usually shout comments back and nothing occurred to indicate that he was upset by any of these incidents.

The fourth PCO was asked at interview about the incident on 29 January when the man said he was feeling suicidal. The fourth PCO said that he went to the man’s cell in response to him pressing his cell call button and asked him what was wrong. The man said that he was sorry for banging his door but his ‘head had gone west’ and that he felt suicidal. The fourth PCO asked him to explain why he was feeling suicidal, but the man was not able to explain any further. He asked the man if he had any thoughts of harming himself, which the man denied, while repeating that his ‘head had gone west’. At the same time, the man was laughing and joking. The

[4] Adjudications are disciplinary hearings, presided over by a governor or a visiting District Judge.

fourth PCO told the investigators that he spent around 20 minutes talking with the man, before contacting a registered mental health nurse (RMN).

The RMN spent some time with the man and noted that there was evidence of deterioration in his mental state, including inappropriate laughter at several points during the assessment. The RMN noted that the man agreed that he was behaving erratically so he admitted him into healthcare for a period of observation.

A community mental health nurse CMHN working for the local NHS Trust told my investigator that Dovegate is one of several prisons at which she sees patients. The man was not one of her patients, but when she visited Dovegate on 30 January 2006 she was asked to see him. Her record of the consultation included:

> *'Reviewed in healthcare at the request of the Senior Nurse.*
>
> *'The man … appeared anxious and distracted and didn't cope with questions very well …*
>
> *'Difficult to rule out risk of self-harm as he appears to speak of this as a way of coping, he made reference to feeling like cutting himself …*
>
> *'Handed over to the Senior Nurse …*
>
> *'… There is no further intended follow-up … at present from our team.'*

The CMHN told my investigator that she would not ordinarily open an F2052SH form to facilitate enhanced support. She said that would usually be something for the prison's primary care team to decide after she had handed the prisoner back to their care.

The man's medical records contain no entry from the Senior Nurse. He told my investigator that he could not entirely recall the events of 30 January. He did say, though, that he would normally expect an F2052SH to be opened only in the case of a prisoner being at definite risk of self-harm, and not when the prisoner has only made a vague allusion to it. He added that the man did not have a history of being a regular self-harmer.

While I take the Senior Nurse's point that the man was not a regular self-harmer, his records from this sentence contain two reports of him committing acts of self-harm while at Dovegate. The first was in August 2004, when the man inflicted cuts to his arms and chest. An F2052SH monitoring form was opened and remained open for eight days. The man was in the segregation unit at this time and the F2052SH was opened by the second PCO. The second occasion was in April 2005, when the man inflicted cuts to both wrists. Again, an F2052SH monitoring form was opened and remained open for 21 days. The man was in the segregation unit once more and the F2052SH was opened by the third PCO.

The fourth PCO said that the man was his normal self on his return from healthcare. He resumed collecting his meals and he continued to go for exercise. The fourth

PCO said that it was a shock when the man took his life. He said that he never saw any signs in the man that he might harm himself or take his life.

Prison Service Order (PSO) 1700 requires that a chaplain should visit the segregation unit on a daily basis and should speak to all prisoners in the unit. A chaplain who knew the man from her visits to the segregation unit told my investigators that the man's mood did not differ very much on a day-to-day basis. He often smiled, but she found him to be quiet and introverted. He never gave her any indication that he might be suicidal. The chaplain said that, when she visited the segregation unit on 12 February, the man asked her for her cross. He said that he needed it to get rid of the demons. The chaplain said that the man seemed under stress that day, but he was also laughing. The chaplain told the man that he could not have her own cross, but she would get him another one as the chaplaincy were having some made. When the chaplain saw the man on 13 February, he seemed more rational than he had been the day before and less stressed. But he again asked her for her cross.

In the case of prisoners segregated under Prison Service Rule 45, authority for their continued segregation must be reviewed at least every 14 days. The Head of Residence is usually on such review panels and he was the chair of a panel that considered the man's segregation on 15 February. The Head of Residence told the investigators that he had reminded the man that he did not like to keep people in segregation. He asked the man where he would like to be relocated within the prison. The man said that he would like to take a little time to think about that. This was the last time that the Head of Residence saw him alive.

The same Independent Monitoring Board[5] member (IMB) met the man at the segregation reviews of 25 January and 15 February. In a written statement, the IMB member reported that on 15 February the man had appeared reasonably cheerful and was co-operative with staff. The IMB member added that he had no cause for concern for the man's physical or mental well-being.

On the morning of 16 February, a solicitor visited the segregation unit to see one of her clients. She also spoke to the man. The solicitor agreed to speak to one of my investigators. The solicitor said that when she went to see her client, the man asked to speak to her. He told her that a couple of weeks earlier, he had been physically assaulted in his cell by several of the officers[6]. He told her that he had suffered a cut inside his mouth, bumps on his head and bruising to his ribs. He said he had received treatment for these injuries. The man told her that the segregation unit was appalling and he wanted a move to another prison. The solicitor told my investigator that she did not notice any obvious signs that the man had suffered any recent injury. She also said that as they spoke, the man kept losing focus as though he were 'engaging' with another person. However, he had not seemed suicidal. Instead, he spoke about his future. He said that he thought he would be eligible for parole in 2007 and that an officer was helping him with the parole process.

[5] The Independent Monitoring Board (IMB) is independent of the Prison Service. Its function is to monitor day-to-day activities in prisons to ensure that proper standards of care are maintained. IMB members are unpaid volunteers.

[6] This matter is dealt with in a separate section of this report.

The day of the man's death

The third PCO told the investigators that he was working an early shift on 16 February. The last time that he saw the man was around 12.45pm when he was escorting the segregation orderly who was collecting prisoners' dinner plates. When the third PCO opened the man's door, he detected a smell of phosphorous as though matches were being burned and asked the man what he was burning. The man was laughing and joking and said something along the lines of him being a gangster. The third PCO did not enter the cell, but while standing at the cell doorway looked around the cell for any signs of smoke or burning. His check included looking at the light shade. The third PCO did not note anything amiss. As he closed and locked the door, the third PCO said 'see you later lad' and the man replied 'see you later'. The third PCO finished his shift at about 1pm.

The second PCO said that the man declined breakfast on the morning of 16 February, but it was not unusual for him to refuse that meal. The second PCO could not recall if the man went to exercise that day, but at lunchtime he collected his meal and was laughing and joking as usual. At about 4.15pm, the first and second PCOs went to move the man to another cell so that his own cell could be repainted. When they got to the cell, the second PCO opened the observation flap. When he looked through he saw the man hanging. The second PCO shouted for assistance and with the first PCO went into the cell. The second PCO said that he and the first PCO supported the man's body while the Unit Manager collected a knife to cut the ligature. The second PCO said that from the condition of the man's body it seemed that he was probably already dead. Once the man's body was laid onto the floor, the Unit Manager and the first PCO attempted cardio pulmonary resuscitation (CPR) while the second PCO went to summon further assistance.
I recommend that the Director ensure timely implementation of the recently issued Prison Service Instruction on anti-ligature knives being carried as a standard item of equipment by relevant staff.

The first PCO gave similar evidence as the second PCO about finding the man hanging, and about how they supported his body until the Unit Manager cut the ligature. The first PCO added that both he and the second PCO had pressed their personal alarm buttons, but neither had registered with the prison's communications unit. He said that the segregation unit is known to have poor signal reception. The first PCO said that he and the Unit Manager attempted to resuscitate the man, and they continued until relieved by clinical staff. He estimated that it took between two to five minutes for the clinical staff to arrive. The first PCO's description of the man's body was similar to that given by the second PCO. He also said that it seemed obvious to him when he first looked at the man that no amount of first aid or CPR would be of any use.

The Unit Manager told the investigators that he was in the unit office when he heard his name being shouted repeatedly. The Unit Manager ran to the man's cell and saw two PCOs supporting his body. He also saw a ligature around the man's neck and tied to the light fitting. As staff at Dovegate do not carry anti-ligature knives as part of their standard equipment, the Unit Manager returned to the office where the

anti-ligature knife is kept. He then went back to the man to cut the ligature. With the first PCO, the Unit Manager carried out CPR until the arrival of the nursing staff. The Unit Manager said that the man's body was stiff.

A Reception Nurse was called on her radio and told to go to the segregation unit. As she entered the man's cell another nurse (the Senior Nurse) arrived with the emergency bag. She and the Senior Nurse took over from the Prison Custody Officers the attempts at CPR. They continued with CPR until around 4.30pm when the hospital doctor pronounced death.

The means by which the man secured the ligature

The man used bedding material to make the ligature. To secure the ligature, he threaded the material through holes he had burned through the plastic light fitting on the ceiling. The man was believed to have lit a tightly rolled wad of toilet paper to make a taper and it was with this that he melted the holes.

The man created a total of four holes. Two of these were facing the window at the back of the cell. The other two were facing the cell door. As noted above, the third PCO who noticed a phosphoric burning smell at about 12.45pm, said that he looked into the man's cell to see if anything was burning. His check included looking at the light fitting and the part facing the door was undamaged.

The man weighed around 10½ stones (67kg). The Unit Manager agreed with the investigators that it was surprising that the light fitting was able to hold so much weight. He added that, since the man's death, the retaining screws had been removed from all of the light fittings in the cells in the segregation unit (the light fittings are now held in place by mastic).
I recommend that the Director consider whether all of the cell light fittings in the prison should be secured in place without the use of their retaining screws.

The Unit Manager also explained that, although the man did not smoke, he had ordered both tobacco and matches on the canteen order that he made on 14 February and which was delivered the following day[7]. The Unit Manager said that he became aware after the man's death that some of the staff in the unit had asked him about his order in view of the fact that he was known not to smoke. However, the man was entitled to purchase these items if he wished to do so.

Check of prisoners in segregation

It is a requirement of the Prison Discipline Manual that prisoners serving a punishment of cellular confinement must be observed by an officer at least once an hour. The Unit Manager told the investigators that there is documentary evidence to show that Dovegate's segregation unit was complying with this requirement.

[7] Each week prisoners are able to purchase items, such as sweets and tobacco, from the prison canteen.

However, the man was not serving a punishment of cellular confinement. This explains why several hours elapsed between the man last being seen alive and being found hanging. The Unit manager also told the investigators that, since the man's death, all prisoners in the segregation unit are now observed every thirty minutes.

After the man's death

The Head of Residence was asked by the Director to visit the man's family to break the news of his death in person. The chaplain who had visited the man in the segregation unit was asked to accompany the Head of Residence. The Head of Residence told the investigators that he and the chaplain left the prison at around 7pm. The man's next-of-kin was his mother, who lived in Liverpool. The Head of Residence and the chaplain went first to the police station local to the address for an officer to escort them to the mother's home. However, she had moved from the address given to the prison by the man, so by the time the correct address was found it was around 11pm. The Head of Residence and chaplain remained with the man's mother for around two hours. During this time, she contacted one of her other sons for him to come to the house. An offer was made for the family to visit the prison. The family took up this offer and Dovegate paid their expenses.

Dovegate paid the funeral expenses and also held a memorial service in the prison chapel.

A debrief for staff was held on the day of the man's death. All staff were also given the opportunity of seeing a member of the prison care team.

The allegation that the man was assaulted by officers

Before the man was admitted into healthcare on 29 January, he was first assessed and physically examined by the RMN. The RMN recorded that he noticed bruising to the right side of the man's rib cage. The RMN noted that the man had given two explanations for this injury. One explanation was that he said it had been sustained while he had been throwing himself around his cell during an agitated phase. The RMN noted that no treatment was needed. He also noted that the man had earlier accused PCO staff of inflicting the injury. On 1 February, a doctor recorded that the man had a bruise on his chest, which the RMN thought was probably the same injury that he had observed.

Information that the man might have been assaulted by one or more members of staff came to this office's attention from several sources. As mentioned earlier in this report, the man told a solicitor that several officers had assaulted him. He said that he had received treatment for his injuries, but the solicitor had not noticed any obvious sign of injury. The solicitor also told my investigators that, ordinarily, she would have reported the allegation to the prison's Director, but her workload that day meant that she had not had the time to do so.

Another source was through a report issued by the Prison Service's Professional Standards Unit[8]. That information had originated from an unidentified prisoner making a report to an officer. It would seem that the prisoner making the report knew neither the man's name nor the names of the staff allegedly involved.

Several other prisoners said that they had heard either directly from him or via third parties that the man had been assaulted by staff. None of the prisoners had said anything to the IMB or prison chaplains, and none of them made formal complaints to management.

The chaplain told the investigators that the man had never mentioned to her that he was being bullied by officers. Indeed, no prisoners in the segregation unit had ever made such a complaint and nor had she ever witnessed any such incident.

The IMB representative at the man's segregation reviews on 25 January and 15 February put down in a written statement that he had had no cause for concern about the man's physical or mental well-being and that he had appeared reasonably cheerful. On 15 February, the man had been adamant that he did not wish to leave the segregation unit to move to a standard prison wing.

There is no evidence to indicate that the man ever reported to his family that he had been assaulted.

An investigation into the alleged assault was carried out by a senior investigations officer (SIO) employed by Serco Home Affairs (the company that part owns Premier Prison Services). After evaluating the evidence, the SIO recommended that no further action should be taken. The SIO's findings included that one of the prisoners who alleged that the man had been assaulted was not a credible witness. The SIO also found that other prisoners had given evidence that both supported the officers, and that provided a possible explanation about why certain prisoners might have made the allegations. I have seen a copy of this report.

Information about the alleged assault was passed to the local police authority.

The man's clinical care and treatment

The clinical review records that the man received mental health assessments by appropriately qualified healthcare professionals, particularly during the last few months. However, the reviewer says it was unfortunate that, following the mental health assessment on 30 January he was discharged from the in-reach team's care and no clear plan of care was suggested or implemented by the senior nurse in healthcare.

The CMHN stated following her assessment that it was difficult to rule out the possibility of future self harm. Despite this, there appears to be no appropriate plan of care and the man was discharged from healthcare three days later. There is no

[8] This unit deals with matters of professional conduct that could result in disciplinary action.

documentary evidence that a hand-over was given by healthcare to the staff on the segregation unit.

A letter outlining the CMHN's concerns that the man probably had a learning disability was not received at HMP Dovegate until the day after he died. Although referral for a learning disability assessment might not have taken place before the man took his life, it would have alerted healthcare staff to the possibility and may have influenced the care provided, had they received the letter earlier.

The clinical reviewer also says that if the senior nurse had acted on the feedback given by the CMHN on 30 January and prescribed and documented an appropriate plan of care and had the letter from the CMHN been received shortly after her meeting on 1 February, the man's needs would have been more adequately catered for.

The clinical reviewer makes the following recommendations:

1. Healthcare professionals should be reminded that timely communication between clinicians is vital to ensure a high standard and continuity of care.

2. Healthcare professionals should be reminded of their responsibility regarding accurate clinical record keeping.

3. Healthcare should review its policy regarding care plans. This would enable clinicians, along with the patient, to plan, implement and deliver appropriate care. Care plans should be evaluated on a regular basis (depending on the severity of the patient's condition and individual needs), to assess whether the care offered is effective and meeting the patient's requirements.

4. All healthcare professionals have a duty of care to their patients and clients who are entitled to receive safe and competent care. This includes referring to other relevant healthcare professionals (NMC code of professional conduct).

FINDINGS AND CONCLUSIONS

The man was described by his father as a happy-go-lucky person. The staff who had daily contact with him would probably concur with that assessment, as at interview they all talked about him laughing and joking most of the time. However, it is also clear that the man's mood would fluctuate and he would make inappropriate remarks to other prisoners. This behaviour would lead to arguments and on occasion to assaults against others. In turn, the man would sometimes be the victim of assaults by other prisoners. The man's records also show that he was frequently abusive to staff and that he occasionally damaged prison property.

The Head of Residence explained that as a result of his behaviour the man was frequently moved to different wings in the prison, but that this did not help. Nor did it help when the man was transferred to HMP Lowdham Grange at the end of 2005. The man caused more problems there and so was transferred back to Dovegate in January 2006.

On 10 January 2006, the very day of his return to Dovegate, the man was involved in a further altercation when he made a racist remark. He then told staff that some black prisoners had threatened to beat him, and he was moved to the segregation unit on 12 January for his own safety. The man had spent time in Dovegate's segregation unit on previous occasions.

Several of the staff in the segregation unit knew the man from his previous stays in the unit. As was the case with the Head of Residence, a number of these staff spoke quite warmly of the man. The general view among them was that they did not consider him to be malicious. Instead, they thought that he was simply incapable of controlling his occasional outbursts, such as the remarks that he made on 10 January.

Nothing of significance occurred during the first weeks of the man's time back in the segregation unit. However, on 29 January the man told the fourth PCO that he was feeling paranoid and suicidal. The fourth PCO tried to question the man about whether he had any specific thoughts of self-harm but could not get a satisfactory answer to his questions. The fourth PCO asked the RMN to see the man and this led to him being admitted to healthcare for observation.

On 30 January, the man was seen by a visiting CMHN. In her record of the consultation, she noted that the man made a reference to feeling that he wanted to cut himself and spoke about self-harm as a way of coping. The CMHN judged that it was difficult to rule out the risk of self-harm. She also recorded that she handed over the man's care to the Senior Nurse.

The Senior Nurse could not recall seeing the man at that time. He also said that he would normally expect an F2052SH form to be opened only in the case of a prisoner being at definite risk of self-harm or suicide and not in the case of vague allusions to such acts.

As has been mentioned, the F2052SH procedure been replaced by the ACCT procedure: Dovegate converted to ACCT on 17 July 2006. While the F2052SH

procedure was in place, staff would often have to make a fine judgement about whether or not a prisoner's presentation indicated that a monitoring form should be opened. In my opinion, the comments attributed to the man by the CMHN on 30 January should have resulted in an F2052SH form being opened and this would have led to him being subject to special monitoring.

The fourth PCO's evidence included saying that the man was his usual self when he returned to the segregation unit from healthcare on 2 February. As part of the standard check of prisoners in segregation, the man was seen by healthcare nurses on a daily basis. Throughout the period 2 February to 16 February, he was noted only once to have a healthcare concern. This was on 10 February, when he refused one of his painkillers but chose alternatives that he said worked well for him.

On 15 February, the man attended a segregation review chaired by the Head of Residence. He reminded the man that he preferred not to keep prisoners in segregation and he asked him to consider where in the prison he would like to be relocated. The man asked for some time to think about his options. The IMB had no concerns about the man and thought that he seemed reasonably cheerful.

On the morning of 16 February, the man spoke to a solicitor who was visiting one of her clients. The man complained to her that he had been assaulted by staff two weeks earlier. However, during their conversation the man also spoke about his future. He told the solicitor that he thought he would be eligible for parole in 2007 and said that an officer was helping him with that. He also said that he wanted a move to another prison.

The man took lunch as usual and his plate was collected at around 12.45pm. The third PCO was escorting the prison orderly whose job it was to collect the plates. When the third PCO unlocked the man's cell door, he noticed a phosphoric burning smell, as though matches were being burned. The third PCO asked the man what he was burning, but the man simply laughed and said he was a gangster. The third PCO did not enter the cell, but from the doorway satisfied himself that there was no smoke and that nothing was burning. He looked at the light fitting and saw that it was undamaged.

The question has to be asked whether the third PCO should have entered the cell to carry out a full check of the fabric of the cell. Had there been any indication that the man was burning anything beyond just matches, it would clearly have been appropriate for the third PCO to investigate further. However, it was only the phosphoric smell that the third PCO noticed and he did attempt to question the man about it. On balance, I am not convinced that the third PCO needed to investigate further given that the man was entirely at liberty to purchase matches. The man's actions are clearly suspicious in retrospect, but would not have appeared unduly so at the time. We know that two of the holes that the man burned through the light fitting were facing the door. But according to the third PCO, those holes were not present at this time. It is, of course, possible that the man had already created the holes facing the window. But it is equally possible that it was later on in the afternoon that he created all four holes. In that case, it would merely have been matches that he had been burning just before the third PCO's arrival.

There is, of course, a separate issue connected with the light fitting. This is the fact that the fitting was able to bear the man's weight. In response to this discovery, the retaining screws were removed from the light fittings in the segregation unit cells and the fittings re-secured with mastic.

Several hours had passed between the last time the man was seen alive and being found hanging. It is a requirement that prisoners serving a punishment of cellular confinement should be observed by an officer at least once an hour. However, the man was not serving a punishment of cellular confinement. Instead, he was in segregation for his own safety as provided for under Prison Rule 45. There was therefore no reason at the time for the man to be checked on a regular basis. However, following the man's death, Dovegate has introduced half hourly checks of all prisoners in the segregation unit, regardless of the reason for them being there.

My overall conclusion is that there were no indications to the prison custody officers in the segregation unit that the man was at immediate risk of self-harm or suicide.

RECOMMENDATIONS

1. The Director must ensure timely implementation of the recently issued Prison Service Instruction on anti-ligature knives being carried as a standard item of equipment by relevant staff.

2. The Director should consider whether all of the cell light fittings in the prison should be secured in place without the use of their retaining screws.

> *Prison Service response: Light fittings are now secured by two screws instead of four in all cells on G wing lower landing, segregation unit Healthcare centre and the first three cells on all other wings in the main prison and therapy centre. This will mean that the shade is secured mechanically by the screws and mastic but will not support the weight of a person without breaking the mounting points.*

Recommendations from the clinical review

3. Healthcare professionals should be reminded that timely communication between clinicians is vital to ensure a high standard and continuity of care.

4. Healthcare professionals should be reminded of their responsibility regarding accurate clinical record keeping.

5. Healthcare should review its policy regarding care plans. This would enable clinicians, along with the patient, to plan, implement and deliver appropriate care. Care plans should be evaluated on a regular basis (depending on the severity of the patient's condition and individual needs), to assess whether the care offered is effective and meeting the patient's requirements.

6. All healthcare professionals have a duty of care to their patients and clients who are entitled to receive safe and competent care. This includes referring to other relevant healthcare professionals (NMC code of professional conduct).

> *Prison Service response: All healthcare staff have been made aware via a letter and a copy of the policy of care planning. This will be reinforced to all healthcare professionals under the NMS code of conduct during the annual appraisal cycle.*
>
> *A full response to the recommendations will follow.*