INVESTIGATION INTO THE CIRCUMSTANCES SURROUNDING THE DEATH OF A MAN AT HMP AND YOI PARC IN JUNE 2006

REPORT BY THE PRISONS AND PROBATION OMBUDSMAN FOR ENGLAND AND WALES

JUNE 2007

This is the final report of an investigation into the death of a man at HMP and YOI Parc in June 2006. He was discovered hanging in his cell in the segregation unit, suspended by a bed sheet. His death is being investigated by South Wales Police who are satisfied that no one else was involved. The Police are continuing their investigation on behalf of the coroner.

I offer my sincere condolences to the man's family and friends for their loss. I hope that this report answers their questions, but recognise that it may not alleviate their distress or lessen their grief. They describe him as an intelligent young man, and believe that, prior to his incarceration, he was showing signs of mental illness.

The man was born in 1986 in Burundi, and was 20 when he died. It is not known when he first arrived in the United Kingdom, but prior to his arrest he was living in Cardiff and working in a call centre to fund his studies. In December 2005, the man appeared at Magistrates' Court charged with a serious criminal offence, and was remanded in custody pending his trial. This was the first time he had been in prison.

The man spent the last three months of his life in Parc's segregation unit, and physical restraint by staff was used on several occasions. After I issued a draft of this report, Parc supplied CCTV footage of the one occasion when planned use of Control and Restraint was exercised on him. I and other of my colleagues, including two seconded from the Prison Service, have watched the film. It makes disturbing viewing, and confirms my concerns about the use of Control and Restraint. Officers struggled to restrain the man, whose immense strength was apparent, and their efforts lasted a very long time.

Other than contact from staff and the Independent Monitoring Board, the man was held in isolation and certainly without any involvement with his peers. All the segregation unit's procedures were properly carried out, and he was closely monitored and assessed three times by a psychiatrist. But sadly, none of this led to any change in his conditions. I judge that his treatment was at best unimaginative. Given what is clear now about the distress he must have been feeling, at worst his treatment was cruel.

The investigation was undertaken on my behalf by two of my investigators. The scale of the investigation was determined at an early stage because of the circumstances of the man's death, and the concerns raised by his family. I am also aware of the media interest.

I would like to express my thanks to the Director of Parc, her staff and the Independent Monitoring Board for their help and active cooperation throughout my investigation. I am grateful too to a doctor, of the Healthcare Inspectorate of Wales, for her assistance.

I also thank South Wales Police who have willingly shared their information, and have been assisted by Her Majesty's Chief Inspector of Prisons' report of her unannounced Inspection of Parc in January 2006. Finally, recognising the significance of diversity matters, I obtained advice from the Prison Service's race equality advisor, and am very grateful for her help.

I make one national and 17 local recommendations. I am pleased to record here that, in the time since the first draft of this report was issued, all my recommendations have been accepted.

This report has been anonymised for publication on my web site.

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

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SUMMARY

The man was born in Burundi in 1986. It is unclear when he moved with his brothers to the United Kingdom. He was a student studying in England, although living and working in Cardiff, when he was arrested and taken to HMP & YOI Parc in December 2005. He had been remanded in custody for a serious offence, and it was the first time he had been in prison. After his initial reception he was located on B wing, the young adults wing. All subsequent bail applications were refused, and he remained in custody.

Whilst on B wing, the man declared his innocence and, as a protest against being in prison, refused his food. He was placed on a Form F2052SH, which is the system for monitoring prisoners thought to be at risk of suicide or self harm. He was visited regularly by staff from healthcare and the chaplaincy, and members of the Independent Monitoring Board (IMB). He was also supported by the prison's counsellor. The man soon started to eat again, and was removed from the self harm watch.

However, he was involved in fights with other prisoners, which his family believe may have underlying issues of racism and bullying, and which resulted in adjudications and loss of privileges. After three months on B wing, he was moved to the segregation unit for his own protection after he was allegedly bullied by other prisoners. Shortly afterwards, he assaulted a fellow young adult in the unit, was placed on disciplinary report, and punished with a period of cellular confinement. He was then involved in a number of clashes with staff, which resulted in repeated use of control and restraint, further adjudications, and loss of privileges. Because the man's behaviour was unpredictable, from April 2006 until his death it was a requirement that three officers were present when he was unlocked from his cell.

The man was regularly reviewed, and he received all the mandatory visits by the IMB, governors, healthcare and chaplaincy. However, none of this led to any improvement in his behaviour, which continued to be disturbed and disruptive. After appearing in court on one occasion, he refused to return to the transport. From then until he died, he was considered to be at risk of escaping. He was put on the E list of potential escapees, wore a distinctive uniform, and was monitored at least every hour.

Control and Restraint was used on several occasions, and was filmed on the sole occasion that its use was planned. Four officers wearing helmets and masks, and carrying shields, went into the cell to remove the man's E list clothes. Another officer was present, giving directions to his colleagues. The incident lasted approximately 12 minutes, in which time his head was pushed to his chest and he was not lifted safely. It was evident that he was extremely strong and staff had difficulty restraining him, but did not withdraw until they had succeeded. The man remained in segregation for more than three months until his death, without any peer group company.

His behaviour became increasingly disturbed and unpredictable. He was assessed on three separate occasions by two different psychiatrists who both concluded that he was not mentally ill.

In the early morning of 29 June 2006, the man was found hanging by a ligature attached to the window at the rear of his cell. Despite immediate attempts to save his life, he died aged 20 years.

Since the conclusion of my investigation, the solicitor representing the man's family have made allegations of criminal behaviour by staff at the prison. The South Wales Police are carrying out a thorough investigation into all the circumstances leading to the death of the man on behalf of the Coroner. Should any criminal matters be identified they will be part of their investigation.

THE INVESTIGATION PROCESS

1. The investigation was conducted by two of my investigators who visited Parc to open the investigation on 3 July 2006. Notices were issued to staff and prisoners telling them of my investigation and its terms of reference, and offering them the opportunity to participate. My investigators examined the cell in the segregation unit where the man died, and were given unrestricted access to the prison.

2. My investigators obtained the records relating to the man's imprisonment, and further records were subsequently provided. They received full cooperation from South Wales Police, who supplied photographs of his cell. I understand that the police conclude that no one else was involved in his death.

3. More than 40 staff, prisoners and IMB members have been interviewed. Those interviewed included the prison's senior managers and the Controller.

4. My investigators have referred to the investigation reports following deaths of prisoners at Parc since 2004. They have also consulted the following reports:

   - Commission for Racial Equality (CRE) formal investigation into HM Prison Service of England and Wales (December 2003)
   - Her Majesty's Chief Inspector of Prisons (HMCIP) unannounced inspection in January 2006
   - Independent Monitoring Board 2006.

5. An independent clinical review of the medical care the man received in Parc has been provided by a doctor, of the Healthcare Inspectorate for Wales.

6. My investigators wrote to the man's solicitor to obtain background information. They established that the solicitor took over his case at his request on 30 March. The solicitor representing the man's family after his death spoke to my investigators regarding criminal allegations, and was advised to report the matter at senior level to the South Wales Police.

7. The investigators wrote to members of the public and former prisoners to seek assistance in the investigation. They interviewed a prisoner in another establishment who had information about Parc, and the transcript has been shared with the prison's Director as part of her internal investigation.

8. It became apparent at an early stage that the prison, and the man's death, may be the subject of a television programme. My investigator wrote to the television company, informing them of the Ombudsman's investigation and asking for any relevant information. No information has been provided.

9. One of my Family Liaison Officers, arranged a meeting on Tuesday 15 August 2006 with two of the man's brothers. They raised the following concerns, which my investigation attempts to answer:

    - The man had told his family that he had been beaten by officers three or four months prior to his death.
    - They believe that drugs found in his cell had been planted by staff, and want to know if he had been tested for drugs.
    - They allege that there was evidence of overt racism against anyone who was not Welsh, and felt that their brother was subject to racism.
    - Although the man was checked every hour, the family believe that two hours passed before he was found to have died.
    - His physical and mental health had deteriorated whilst he was in prison.
    - They ask on which occasions were three officers present whenever he was unlocked.
    - Psychiatrists diagnosed that he was not psychotic, and his family are concerned about the diagnosis, and want to know why he was not assessed and treated for other conditions. On one visit his brothers were told by an officer that their brother was "putting on" his behaviour, and they believe that his real mental health problems were overlooked.
    - The man's brothers spoke to whom they thought was the healthcare manager, and she told them that their brother was assessed when he entered the prison and was getting help. They describe her as rude.
    - They have the names of five prisoners, some now released, who would be willing to make statements about events at Parc. One prisoner was in the segregation unit before the man's death and allegedly saw him being beaten up.
    - The cell where the man died was repainted before their visit and they would like to know why.

10. In April 2007, Parc prison provided the investigation team with a copy of the CCTV coverage of the single occasion when the use of Control and Restraint techniques was planned. Unplanned use of control and restraint is not filmed, and no other film has been provided.

HMP AND YOI PARC

11. Parc is a category B local prison which holds approximately 900 males, including convicted adults and both convicted and remand young adults. (A young adult is a person aged between 18 and 21 years.) It is the only Welsh prison for young adult males.

12. The prison is in Bridgend, opened in 1997 and is the only private prison in Wales. It is run by Group 4 Securicor Justice Services, and the person in charge is the Director. Prisons run by private companies are governed by the terms of contracts known as Service Level Agreements (SLAs) with the state. As part of the SLA, the Home Office employs a Controller, of Governor grade, to work at the prison and ensure that the contract is complied with. The Director is not permitted to adjudicate on disciplinary matters, and the responsibility is taken by the Controller.

13. Adjudication hearings consider allegations against prisoners that they may have infringed Prison Rules. If prisoners are found guilty they can be subject of a variety of punishments. Serious cases are referred to a district judge who acts as an independent adjudicator.

14. All the cells at Parc, other than some in the segregation unit, have in-cell sanitation, natural and forced ventilation, electricity and television for standard and enhanced regime prisoners. Each wing has hot water boilers, telephones, table tennis and pool tables, showers, laundry facilities and association areas. Young offenders are permitted to wear their own clothing except when on basic regime.

15. In common with other prisons, Parc operates the Incentives and Earned Privileges Scheme which is designed to improve behaviour. The scheme is well publicised, and young adults are told about it upon entry to the prison. Depending on their behaviour, prisoners are on the basic, standard or enhanced regime.

16. Young adults are all held on B wing, which has four units. Remand prisoners on the standard regime, and those who are working, are in B1 unit. B2 accommodates convicted prisoners on standard regimes, and working young adults. The drug voluntary testing unit is in B3, and the induction unit is in B4.

Segregation Unit

17. The segregation unit has space for 24 prisoners, and is bright and clean. Both adult and young offenders are held in the unit, on separate regimes, but with the same staff. They are either held in the unit because of breaches of prison discipline or for reasons of good order, or for their own protection from other prisoners. There is no CCTV coverage of either the cells or the communal areas in the segregation unit.

18. Two cells are sparsely furnished, and used for prisoners who present a discipline problem. Cell E2:09 is the special cell, and has no furniture, bed or toilet. Cell E2:08 is known as an unfurnished cell, and has a toilet but no bed or other furniture. Use of both cells can only be authorised by the Controller. Prisoners held in cells E2:09 or E2:08 are subject to 15 minute observations by staff.

19. Prisoners can make applications each day to use the telephone, see a member of healthcare, or take a shower. They select meals from a standard menu, and collect them from a servery. Since the start of my investigation, young offenders have had access to PlayStations. Prisoners held in the segregation unit for long periods for their own protection are offered association and, where practicable, work in the unit.

20. Prisoners in the segregation unit are seen on arrival by a member of the healthcare team and a manager who sign a safety algorithm confirming their continued segregation. The prisoners are reviewed regularly by a board consisting of the Controller, a manager, and healthcare and IMB representatives.

Health Care Facilities

21. Health care at Parc is provided by Primecare Forensic Medical Services, who employ a team comprising three doctors and 25 nurses to provide a 24 hour primary care service. The prison's healthcare centre has 17 inpatient beds. Nine of the nurses have a mental health qualification.

Control and Restraint

22. Control and Restraint (C&R) techniques are used at Parc in common with all prisons in England and Wales. C&R is used by a team of three officers (with the option of having another person involved to control the legs) in order to manage a violent or unruly prisoner.

23. The deployment of a Three Officer Team is the approved method of dealing with a violent or unruly prisoner. It must only be used as a last resort after all other means of de-escalating the incident, not involving the use of force (e.g. persuasion or negotiation), have been repeatedly tried and failed.

24. The use of force is only lawful if its use is:

- Reasonable
- Proportionate
- Necessary
- No more force than is necessary in the circumstances

25. C&R techniques only use the force that is necessary to enable staff to cope competently and effectively with violent prisoners and potentially disruptive situations, with the minimum risk of injury to staff or prisoners.

26. Staff must continue to attempt to de-escalate the situation throughout the incident with the aim of releasing holds and locks. Staff must not employ C&R techniques when it is unnecessary to do so or in a manner which entails the use of more force than is necessary. The application of C&R holds may cause pain to a prisoner. If the prisoner is compliant, the holds must be relaxed.

27. Planned use of C&R may occur when there is no urgency or immediate danger. In these situations, a supervisor will prepare staff for the incident and will notify a member of healthcare in advance who will attend and observe the planned intervention. At Parc, pre-planned uses of force are routinely videoed.

28. Unplanned use of C&R may occur when there is an immediate threat to someone's life/limb or to the security of an establishment and staff need to intervene straightaway. In these situations a member of healthcare and a supervising officer will attend as soon as possible.

29. Staff arriving as the 'first on the scene' at an incident involving violence (e.g. a fight between two prisoners) must act in a common sense manner. Individual officers must not put themselves in grave danger and it may be prudent for them to await the arrival of other staff in such a situation.

30. Where fewer than three officers are present (or in the case of multiple violent prisoners, a ratio of less than three officers to one violent prisoner), and it is necessary to use force immediately, staff will need to use whatever force is necessary to protect themselves and others - as long as such force is reasonable and proportionate in the circumstances as they see them. This advice also applies to incidents that may arise during the night where fewer than three C&R trained staff are on duty in the establishment e.g. a fire in a cell and staff must intervene in order to get the prisoner out of the cell.

31. Training of staff in the actual techniques of C&R can only be carried out by qualified C&R instructors. The techniques taught are detailed in the Prison Service Training Manual

INDEPENDENT MONITORING BOARD (IMB)

32. Every prison has an Independent Monitoring Board (IMB) made up of members of the public appointed by the Home Secretary. Their purpose is to monitor the day-to-day life in the prison, and ensure that proper standards of care and decency are maintained.

33. Each IMB produces an annual report to the Home Secretary. The most recent Parc IMB annual report covers the period 1 March 2005 – 28 February 2006. In relation to the segregation unit, they reported:

> "the Board is still concerned that own interest young prisoners are being kept in the unit for long periods because at the present time there is nowhere else for them to be located. A number of young offenders subject to indeterminate sentences have also been housed on the unit with little knowledge as to how these inmates should be dealt with. The Board requested that provision be made for own interest young offenders in Wales."

34. In the first ten months of 2006, the IMB attended 70 segregation review boards, of which 49 were reviews after 72 hours in the unit, and 21 were after 14 days. The Chair of the IMB reported no serious concerns about decisions governing either the initial or continued segregation of prisoners.

HMCIP INSPECTION

35. HMCIP undertook an unannounced inspection of Parc between 9 and 13 January 2006. The inspectors considered the recommendations made at the previous announced inspection, and the extent to which they had been achieved. I here highlight those recommendations which are relevant to the man's treatment.

Diversity

36. The report commented that black and ethnic minority prisoners made up a small percentage of the population, and there was only one member of staff from an ethnic minority group. Few black or other ethnic minority people lived locally, and there was no evidence of a specific recruitment drive to attract staff from further afield. The inspectors found that, despite criticism in the CRE report three years earlier, a diversity action plan had not been produced.

37. There were no positive images reflecting racial or cultural diversity on display in the establishment or other visible promotions of diversity. The Race Relations Liaison Officer had recently produced a good practical guide and had begun to disseminate it through staff briefings.

38. The inspectors surveyed black and other ethnic minority prisoners who reported negative perceptions, which indicated that positive action was needed to ensure that the prison's regimes did not discriminate indirectly, and they had equal access to all services. The inspectors noted some recent progress in improving the reporting systems, collecting and analysing data and networking with external agencies. They recommended:

    - ensuring a wider audience for the Race Relations Management Team
    - all staff to be trained in race relations and diversity including their own diversity policy
    - deficiencies identified in the CRE report should be addressed
    - there should be a specific recruitment drive to attract black and other ethnic minority staff to work at Parc
    - discriminatory patterns should be highlighted through ethnic monitoring and appropriate action taken
    - completed investigations of racist incidents should be monitored independently and routinely
    - staff and prisoners who display racist behaviour should be challenged
    - victims and reporters of racist incidents should be protected
    - there should be displays throughout the prison, and other activities promoting diversity.

39. Since the HMCIP inspection in January 2006, Parc has produced an action plan which promotes racial equality, and endeavour to remedy any discrimination identified through monitoring and intervention. The prison is part of an initiative with the local Valleys Race Equality Council (VALREC), who act as consultants on all hate crimes, whether linked with race, religion

or homophobia. VALREC is contracted to deliver training to all staff and prisoner representatives, which is accredited as good practice by the CRE. VALREC is to provide advice, assistance and support through monthly surgeries that are accessible to all prisoners. They are also developing a pilot scheme that addresses the attitudes of people convicted of racially aggravated offences. VALREC will work with black or minority ethnic young people who feel isolated and disconnected in a custodial setting.

40. Parc has upgraded the role of the diversity officer and suicide prevention coordinator to a member of the management team and is developing a use of an electronic database to capture all allegations of racism and bullying.

Segregation unit

41. HMCIP found that, on a typical day, seven of those held in the unit were adults and eight were young adults. Six of the young adults were held for their own protection, referred to as ‘own interest’. Of the 15 in the unit during the inspection, seven had been segregated for two weeks or less, but the longest period of continuous segregation of a young adult was more then eight months. During the PPO investigation, one young adult had been in the unit for his own protection for 12 months.

42. HMCIP concluded that the segregation unit was well managed, and there were good relationships between staff and prisoners. The unit was clean, properly equipped and there was no excessive graffiti. There was a fenced exercise yard with a covered area so that prisoners could get out into the fresh air even in inclement weather.

43. HMCIP made recommendations in relation to prisoners in segregation:

- the reason for the high use of force against young adults and juveniles should be identified and the underlying causes addressed
- arrangements for education and other regime opportunities for longer stay segregation unit prisoners should be improved and provided consistently
- there should be additional activities for young adults segregated for their own interest
- reasons for the use of the special cell accommodation should always be recorded
- the special cell should not be used for prisoners who self harm.

Bullying

44. HMCIP found that Parc had an up to date bullying strategy which was included in a prisoner’s induction, and staff had received training in it. A course for bullies had been developed, but was little used. The inspectors considered that there was no protocol to support the victim, and the implementation of the strategy was ineffective.

45. HMCIP said that the violence reduction co-ordinator had recorded 67 incidents of bullying in the 12 months prior to January 2006. Of those, 52 had occurred on B wing. There was no evidence that managers had noted the disproportionate figures, or attempted to identify and address any underlying causes. It was unclear how many more incidents there had been as the violence reduction coordinator was not always informed. At the time of the inspection in January 2006, no prisoners were being monitored for bullying behaviour.

46. The inspectors identified the following additional concerns:

- identified bullies not being observed
- implementation of anti bullying courses
- no investigation into the bullying activity on B wing nor an action plan developed
- there should be documentation and a support protocol for victims of bullying. Staff should be alert to any bullying of vulnerable prisoners or their visitors on the way to visits and should intervene if necessary
- a prisoner representative should attend violence reduction committee meetings.

Use of force

47. The inspectors reported that staff recorded that they used force to restrain prisoners on 216 occasions the previous year. The prisoners' survey said that black and minority ethnic prisoners and young adults were more likely to be subject to force than white adult prisoners. However, HMCIP found no evidence to substantiate the claim about black and minority ethnic prisoners, but did confirm that regarding young adults. HMCIP considered 35 cases. The majority (31) of prisoners in the sample were white, and only four were not. The majority (29) of prisoners in the sample were young adults, and force had only been used with six adults.

Self Harm and Suicide

48. The inspection team found that there was an active and keen suicide prevention coordinator, but she was not fully supported by other officers and all managers. The quality of the suicide or self harm monitoring forms (F2052SH) was poor, and prisoners on an open F2052SH were held in the segregation unit contrary to correct procedures.

HMCIP THEMATIC REVIEW OF RACE RELATIONS IN PRISONS

49. In December 2005, HMCIP published Parallel Worlds, a thematic review of race relations in prisons. The research included survey material from 5,500 prisoners of all racial groups.

50. It is a comprehensive document which found that much progress has been made and processes for addressing racism and discrimination were in place. However, it said that there is no shared understanding of race issues within prison. Prisoners from visible minorities reported poorer experiences than white prisoners, and overwhelmingly said that they felt less safe, less respected and had poorer access to the regime and facilities.

KEY EVENTS

December 2005, B wing

51. The man appeared at Magistrates' Court in December 2005 charged with a serious criminal offence and was remanded in custody. Prison escort contractors took him to Parc, and he passed through reception where he was seen by an Officer and a Healthcare worker who completed the First Reception Health Screen. It was indicated on the form that a medical psychiatric report was not required, and that the man had not been in prison before. He said that he had not seen a doctor recently, was in good health, not taking medication, and had no recent injuries. The man said that he did not suffer with asthma, diabetes, epilepsy fits, chest pains or tuberculosis, sickle cell disease or allergies, and had no concerns about his physical health. It was further noted that he did not abuse alcohol or drugs.

52. A Cell Sharing Risk Assessment (CSRA) form was completed by the officer who recorded that the man was of medium risk of harm to others, meaning that there was no immediate risk but his situation needed to be reviewed regularly. After going through the reception process, he was taken to Unit B where he was given a brief introduction to prison procedures by a unit officer. The man's reception process was completed on four days later. It is recorded that he was also seen by the prison chaplain.

53. At 7:30am five days later on the man was taken by the prison escort service to Magistrates' Court where he was further remanded in custody. He returned to the prison at 11:45am, and was placed in the same cell.

54. A unit officer spoke to the man the next day,as he had become aware that he had not been eating. The man told the officer that he was innocent of any offences, and was not eating in order to make a statement of his innocence. The officer shared the information with the Duty Director and healthcare.

55. A food monitoring sheet was opened on the following day which recorded the man's food intake, and he was assessed by the prison doctor, who noted that he had been refusing food for three days. The doctor recorded that there were no significant problems in relation to the man's physical or mental health, and no self harm concerns. He recorded that, as there were no mental health concerns, his right to refuse food must be respected. A urine test was carried out, and the results were normal.

56. The man was seen by the Safer Custody Officer, later the same day. She recorded in his daily supervision record that the man said he was not eating because he should not have been imprisoned on the basis of one allegation from a housemate, and because his solicitor had not been to see him. The officer contacted the man's solicitor on his behalf and arranged for his solicitor to visit. The man's solicitor visited him on 2 January.

57. On 3 January, the man was seen again by the Safer Custody Officer. She noted that the man was adamant that he was not going to eat prison meals, and nothing would change his mind. In addition to being visited by the officer, the man was allocated a personal officer to discuss any concerns. He was in a cell on his own and had in cell television. Although he refused prison meals, he did eat food such as Pot Noodles which he purchased with his own money.

58. The Safer Custody Officer referred the man to a qualified counsellor employed by the prison to work on B wing. The counsellor said in interview for this investigation that he found the man a very pleasant person. He thought that the man had stopped eating to draw attention to himself as he was angry at being in prison and his solicitor had not visited.

59. The counsellor was able to provide the man with comfort and support, and to explain different ways that he could cope in prison. The man wanted to see his solicitor which the Safer Custody Officer had arranged. The counsellor, together with the Safer Custody Officer, tried to encourage the man to eat so that he had more strength. They looked at coping mechanisms, and encouraged him to explore what he was actually feeling. The counsellor described the man as having a lot of anger, a lot of sadness, and a lot of confusion as to what was happening to him, and what was going to happen to him.

60. The counsellor continued to counsel the man regularly and saw him on a number of occasions whilst he was on B wing. However, the counselling stopped as a result of his transfer to the segregation unit.

61. The man was also visited by a member of the IMB, and they talked together for about 20 minutes. She described him as obviously disturbed and worried. He gave her the impression that he was angry, and was adamant that he had not committed the offence he was charged with. They talked about his background and life outside prison, and she said he was disheartened about the practicalities of returning to his studies. She tried to reassure him the world of education was always open to him.

4 January 2006, F2052SH opened

62. The IMB member was so concerned for the man that she visited him again on 4 January on B wing, and was surprised to learn that he had begun a hunger strike. She tried to encourage him to eat. A Form F2052SH was opened the same day because of concerns raised by staff that the man had not been eating. One officer wrote that a move to the Healthcare Centre would be a benefit, as he could be monitored more closely. The man was reviewed again by the doctor, but was not admitted to the Healthcare Centre. Instead, the doctor requested that the man be placed under observation by healthcare staff, and moved to a shared cell, although this did not happen.

63. The next day, the man was taken to and from court by escort contractors, returning at 2:55pm. The doctor saw him again, and noted that he had lost 5 kg in weight in the fortnight since his admission.

64. On 6 January, a review of the man's F2052SH review was conducted which he attended. He gave no reason for refusing prison meals, but it was noted that he had eaten his meal that day for the first time in ten days. It was noted that he interacted well throughout the review, and appeared healthy and coherent, saying he would continue to eat and did not want to be forced to eat. The review decided to keep the F2052SH open, to monitor the man closely, and review again in 14 days. He was observed by wing staff, and was visited by the chaplain, IMB and members of his family. A Returned Food Register was kept, and it recorded that he started eating again on 8 January after which he ate normally.

65. The man attended a gym induction session on 10 January. The next day his medical records state that he was not eating again, and complaining of constipation for which he was prescribed a laxative. However, other records show that he continued to eat normally. The following day another member of the IMB, visited the man. She thought he had ended his hunger strike and that officers on the wing were pleased with his progress. It was noted in his daily supervision record that he was eating, drinking and associating with other prisoners. On 14 January, the man was given a nurse triage appointment for 16 January, but he did not attend.

66. On 15 January at 2:35pm, two officers saw the man fighting with another prisoner. The officers stood between the prisoners, and requested both to return to their respective cells. The officers calmed the situation without using force, and the man returned unassisted to his cell. He was examined afterwards, and was free from injury. An 'injury to prisoner form' was completed, the first of 17 completed whilst he was at Parc. The form has to be completed whenever staff use force to restrain prisoners. The man was placed on disciplinary report for fighting.

67. The Daily Supervision and Support records from 4 to 20 January were examined for the investigation, and they show that the man was observed by wing staff on average eight times over 24 hours. He told staff that he was coming to terms with being in prison, but asked for a form so he could complain about how he was treated beforehand. My investigator has been unable to establish if the man was given any writing materials to make a complaint.

16 January, adjudication hearing

68. The day after the fight, at 8:50am on 16 January, the man was taken to the segregation unit for the adjudication hearing. He was found guilty of fighting, and punished with loss of privileges for seven days. He returned to B wing later in the day, and at 4:45pm was placed in a cell. The rules and

regulations of the wing were explained to him again. The following day, an officer noted in the man's daily supervision record that he was a very quiet prisoner who did not cause any problems to staff.

69. In interview, the officer said the man was initially no problem at all. He generally complied with the rules, was very quiet and kept himself to himself. However, his behaviour began to deteriorate, sometimes he was confrontational with staff, and had a bad attitude towards them. At other times, he was polite, civil and had a very good approach when they spoke to him. On 19 January, the man was a visited again by his brothers.

20 January, F2052SH closed

70. The F2052SH self harm review took place on 20 January. It noted that the man had been eating regularly since 10 January, and was no longer a concern to unit staff. The F2052SH was closed. He was described by an officer as playing pool on the wing and being more sociable. The officer described him as coming out of his shell and speaking to staff and prisoners. The man was also having showers and taking care of his personal hygiene. On 23 January, the man was located to B4 wing in a cell. The same day he was visited by his brothers, and his solicitor.

9 and 10 February, use of force

71. On 9 February at 7:30pm, the man was seen by an officer on B4 landing exchanging blows with another prisoner. Two officers shouted to them to stop fighting, stood between them and escorted them to their respective cells. The officers calmed the fight, without using force. The adjudication hearing took place the next day, and both the man and the prisoner received seven days loss of privileges. The man was moved to another cell

72. Later on 10 February at 7:30pm, three officers saw the man run over to the pool tables and start punching the same prisoner in the head. One of the officers shouted to the man to stop, but he continued to throw punches. The officers restrained the man using approved Home Office control and restraint techniques, and took him to his cell. They noted that he did not sustain any injuries. In both days' incidents the appropriate Record of Injury to Prisoner Forms were completed.

73. The man was placed on a further report for fighting and in a written statement said:

> "To whom it may concern/prison adjudicator,
>
> I am writing this letter as one of apology and to explain my action which I understand is not acceptable and definitely disruptive. On 10 February, I assaulted another inmate by the name of X. I was wrong for doing so have apologised before and wish to do so again. My reason for writing this letter is to give you an understanding as to what went on and to

show that I wasn't the aggravator. As I tried to explain to the governor there has been a history (bad) between me and X.

There was an occasion in the prison gym where I had asked X to use a certain piece of equipment. I was told you can't use it he's next he's a coon although referring to his friend. The racist abuse was clearly aimed at me as his friend was not a person of colour.

Another incident occurred were I got into a fight with X as I was hanging around speaking to a mate, although X made the initial attack and I was barely defending myself we were both reported and put on losses.

On the evening of 10 February I was verbally assaulted by X again as he looked over where I was sitting and screamed 'what' an officer witnessed this incident and could be called upon if needed. Although I walked away from this certain incident. I became agitated and when I went back to sit with friends who had agreed that I hadn't made any invitation, friendly taunting aggravated me more and I wrongly lost my temper and attacked X. I apologise again for my actions and can say they will not happen again.

Signed,

'The man'

74. There is no evidence that the man's allegation of racism or underlying bullying was reported or investigated.

75. The man attended the adjudication hearing on 13 February. The case was adjourned in order that it could be heard by the independent adjudicator. The next day, 14 February, the man received a visit from his brother. On 24 February, he received a written warning for failing to attend work.

28 February, adjudication hearing

76. On 28 February, a District Judge attended Parc and presided over the adjudication for the fight on 10 February. The man was not legally represented, pleaded guilty and was sentenced to an extra 21 days imprisonment. The additional days would have been added to his sentence had he been found guilty of the charges he faced and had received a custodial sentence. On 2 March, his brothers visited him again.

4 March, drugs found in cell

77. At 3:05pm on 4 March, as a result of information that the man was in possession of illicit drugs, four officers searched his cell. They found a brown substance wrapped in a cigarette paper. The officers reported that the man became agitated, threatening and abusive towards an officer and alleged that the drug had been planted. He was physically restrained by the officers. The man eventually became passive and was examined by a

nurse. She noted he had sustained a small cut inside his mouth, but it did not require treatment.

78. The man was placed on a further disciplinary report for being threatening and abusive towards staff, and for allegedly having a wrap of heroin in his cell. An officer completed a prison security information report (SIR) in relation to the brown substance. My investigator has found no evidence that the brown substance was analysed. However, the man pleaded guilty to possessing the drug at the adjudication hearing on 20 June.

79. On 5 March, a Registered Mental Nurse (RMN) saw the man. (the RMN has now left Parc, and my investigator has written to ask her to participate in this investigation but without any reply.) The medical record notes that the man's brother thought that he was mentally ill, which they had shared with a member of the staff. This was the first indication in the records that he might have had a mental illness. There is no evidence that the RMN asked the man about his brother's concerns, and no evidence of any other follow up, either with him or his family, despite the fact that his brothers were regular visitors.

80. At 6:50pm on 9 March, the man was on association on B wing when he was seen grappling with another prisoner. They stopped when ordered to do so by an officer, and both prisoners were reported for fighting. In a written response to the charge, the man explained that he had an altercation over using the telephone, and that he thought his actions were appropriate.

10 March, adjudication hearing, moved to segregation unit

81. The next day, 10 March, the man attended the adjudication hearing and was punished with ten days cellular confinement. He was moved to a cell in the segregation unit. He was moved again to another cell on 14 March, and remained there until 19 March.

16 March, returned to B wing

82. The doctor saw the man in the segregation unit on 16 March, and assessed him as fit and well. He was then returned to B wing where he remained for the next week.

23 March, returned to the segregation unit

83. On 23 March, the man was taken by the security manager to the segregation unit for his own interest after allegedly being bullied whilst on a visit. My investigator has found that, although the man was said to have been taken to the unit for his own protection, there are no records of him having a visit that day, or of being bullied. He was located in cell, and a segregation safety algorithm was completed which recorded that he had been bullied on a visit.

84. A third member of the IMB, was informed of the man's relocation and went to the unit to see him. He found him sitting on the floor of his cell. The member of the IMB described him as very angry and aggressive. The man alleged that he was being bullied by some officers. The IMB member enquired with the duty manager, if the man could have some writing materials to put his complaint in writing. The IMB member was informed that, because of his behaviour, he would not be allowed to have writing materials until he calmed down. The man lost his temper, and IMB member withdrew from the cell. The allegation of bullying by officers was not reported or investigated.

24 March, segregation review board

85. As required, a segregation review board was held on 24 March within 24 hours of the man being located there. The board consisted of the controller, an officer, a manager, an IMB member and a nurse. They decided that the man should remain in the segregation unit until his next review on 31 March.

86. An officer, who works in the segregation unit, described the man as five foot seven and of slight build. He had dreadlocks which were five or six inches long, and at first he wore his own clothing. The officer described the man as initially a polite prisoner, who interacted well. They had a mutual interest in Cardiff, and the man told him that he was studying at university and about the alleged offence. The officer said that the man used to watch television and read books, and he would give him newspapers to read. The man used to press his intercom to request to speak to the officer, and they frequently talked together. He described him as mixed up, and having mood swings. He also said that he spat repeatedly, and kept plastic bags and bowls full of saliva in his cell. He described the man attacking officers, and urinating in his clothing.

87. On 27 March at 7:45am, the man was moved to another cell in the segregation unit after he assaulted a fellow prisoner as he walked past his

cell, and tried to drag him inside. Three officers used control and restraint techniques to restrain him from committing a further assault. The man was seen by a nurse who reported that he had not sustained any injury.

88. The incident was witnessed by another prisoner in the segregation unit who worked as a wing cleaner. He explained that he and the prisoner walked past the man's cell, and the man grabbed the prisoner from behind. The wing cleaner said nothing really happened, they had a little scuffle which was broken up by staff. The wing cleaner said after this incident he saw the man being restrained by staff on a few occasions, and he thought that the methods used were appropriate.

27 March, adjudication hearing

89. On 27 March, the adjudication hearing took place in front of the Controller, who imposed five days cellular confinement as the man was already on the maximum losses for a young offender. He was seen between 6:30pm and 7:30pm that evening by his solicitor.

31 March, segregation review board

90. On 31 March, the segregation review board, which consisted of the Controller, two managers and an IMB member, decided that the man should remain in the segregation unit for his own interest.

91. Although the prison's counsellor had stopped having regular sessions with the man, he saw him three or four times when he was in the segregation unit on other business and formed the opinion that he was very scared. On the last occasion, an officer commented to him that the man was constantly urinating in his clothing. The officer told him that they had to drag his mattress out every morning because it was full of urine. The counsellor said that he was aware of a rumour that the man had been beaten in the unit, but he had no evidence of it taking place.

92. On 1 April at 6:50pm, the man was moved to another cell at his own request. During the move the man was given permission to go back and forth from his previous cell to pick up his belongings. After being locked in his cell, he rang the buzzer and asked to return to his old cell to collect some legal documents. An officer told the man that she would collect them for him, but when the door was being shut the man put his foot in the door to prevent closure. She instructed him to move his foot, which he did and once inside, he complained that his foot had been injured. A nurse came to assess his foot, but the man refused to let her examine it. However, she was satisfied that there was no injury, as she saw him walking. The man was placed on report for intentionally obstructing an officer in the execution of her duty, and the adjudication hearing was scheduled for 25 April.

93. On 2 April at 10:52am, an officer responded to the man pressing his cell intercom and kicking his door. When the door was opened, it was evident that water had been thrown through the window from the exercise yard.

The officer reported that he became threatening and abusive towards her, shouting in her face and waving his arms. She told him to sit on his bed and calm down, but he did not comply with the request. The officer said that he made a sudden movement in her direction, together with three other officers the man was restrained using control and restraint methods. The man complained of a pain in his ribs, but there were no visible signs of injury and he was not deemed to require medical attention. The adjudication hearing was listed for 23 May. There was no investigation of the water thrown through the cell window.

94. Later that day at 4:10pm, the man refused to go back into his cell until he was able to have a telephone call. The segregation supervisor, told the man that he could not have a telephone call and ordered him back into his cell. He refused to return, and was forcibly returned by two officers using control and restraint methods. The incident was observed by an IMB member, and a member of the healthcare staff was asked to examine the man.

95. Ten minutes later, at 4:20pm, the duty nurse, a nurse, was escorted to the man's cell with four officers in attendance. They reported that the man ran at one of the officers, and was again physically restrained by staff. The duty manager, arrived to oversee the de-escalation of the incident. The nurse then examined the man. She described his eyes as rolling, but was satisfied that he required no medical intervention. This incident was also reported for adjudication on 23 May.

96. On 3 April, the man was taken to Crown Court, and at 2:00pm he refused an order to return to the escorting van to go back to the prison. He was placed on report for failing to comply with an order.

97. At 4:10pm, the man was returning to his cell after having a shower. He demanded a telephone call, although it was explained that he had no credit left on his phone card. He was ordered to return to his cell by an officer, but refused, and was placed back there by four officers using control and restraint techniques. Ten minutes later, a nurse came to examine him, accompanied by four officers. They reported that the man had charged towards an officer, and that spontaneous control and restraint was used by the officers. The duty manager arrived on the scene. The nurse recorded that the man's eyes were rolling, and he was placed on his back but again became verbally aggressive towards staff. She was satisfied that no further medical treatment was required.

4 April, segregation review board

98. The following day, four officers went to the man's cell at 4:25pm. They wanted to move him to another cell, because of fears that he would try to escape from the prison. The man was treated as at risk of escaping because of his refusal to get in the transport at court the previous day. The officers reported that the man ran towards an officer in a very threatening manner, and they restrained him using control and restraint techniques and

lowered him to the floor. He was moved to the other cell, where a nurse assessed that there was a minimal period of violence and no other injuries.

99. The segregation review board was held the same day, with the Controller, two managers, a member of the IMB, a nurse and the man. His case was discussed, and it was decided that he should remain in the segregation unit. The man was offered the support of a mental health nurse (RMN) but refused. There is no record of the man's behaviour whilst attending his review. The doctor saw him two days later on 6 April and noted he was fit and well.

100. The next day, an officer completed an SIR in which he reported that a night officer had reported at the morning's handover that the man had asked to be let out of his cell and out of prison. The officer reported that the man had said that he could not stay in prison any longer, and that officers should be careful when unlocking him. It was the view of both officers that the man was thinking about attempting to escape.

101. As a result of the information in the SIR, the then head of security, decided to place the man on the E list, which is a list of prisoners thought likely to mount an escape attempt. E list prisoners wear a distinctive overall when they are being moved, and their movements are monitored every hour. He remained an E list prisoner until his death. The man was seen again by a member of the IMB who recalled that he was unhappy about being photographed as part of his E list status.

7 April, moved to special cell

102. On 7 April at 7:15am, three officers were unlocking the man for his breakfast. They asked him to stand at the rear of the cell before they opened the door. As the door was opened, the man moved towards one of the officers holding a plastic cutlery knife. The officer's key chain was attached to his belt, with the keys in the door in the approved manner. The door was forced open wider which snapped the officer's key chain. The man was physically restrained by the officers using control and restraint methods.

103. On the instruction of the duty manager the man was moved to the special cell. A senior nurse attended at 7:40am, but was unable to examine the man because of his violent behaviour. She could not see any injuries, and recorded that RMN follow up should be arranged when he was calmer. The doctor also attended but could not examine the man who was sitting behind his door refusing to be seen. He eventually agreed to talk to a nurse. He told her that he was not mentally ill, but said that he felt that segregation and prison were detrimental to his mental health. He said that he wanted to be released from prison or moved back to B block.

104. The man was also seen by, another member of the IMB, who recalled that the Governor was talking to him to try to calm him down. When the IMB member returned to the man's cell later on, he was banging the door with

his feet. She described him as very aggressive, and said that he did not want to see anybody or do anything. She said that the other prisoners were out of their cells, and they wanted to get revenge on the man because of the noise he was making.

8 April, moved out of special cell

105. On 8 April, the man was moved out of the special cell into another cell. He was visited again by the IMB member who noted that he seemed fine but was still proclaiming his innocence. He was seen by the doctor on 8 and 9 April and assessed as fit and well. The man had a visit from one of his brothers on 9 April.

12 April, psychiatric assessment

106. A community consultant forensic psychiatrist, saw the man for the first time on 12 April, together with her colleague. She described the man as an articulate young man who presented as quite pleasant during the interview. Staff had told her that they had concerns regarding the man's violent behaviour. He told her that he found it very hard being in prison, as it was his first time. When she asked about the violence, the man explained that he had to defend himself.

107. The psychiatrist said that, during the interview, she had no sense that the man was mentally ill. She asked about psychotic and depressive symptoms, but found no evidence of either. The man asked for a psychiatric report, which he said would be a means of getting out of prison. The psychiatrist said that she did not consider that the man needed to transfer out of prison, and she not see any evidence of mental illness.

108. The man's solicitor visited him at Parc on 12 and 13 April. The visits took place in the main area for legal visits, and the solicitor said that they passed without incident. He said that at no time during the visits did he notice anything particularly wrong with the man who was lucid, able to understand advice and provide detailed instructions.

109. On 14 April, a RMN reviewed the man who complained of losing blood and his left side being frozen. The nurse found no physical problems on examination. This is the first entry in the records which may indicate that delusional beliefs were present. A doctor saw the man on 14, 15,16,17,18 and 19 April as part of the daily segregation routine and noted that he was fit and well. On 17 April, the man's brother visited again.

19 April, segregation review board

110. A review board was held on 19 April, with the controller, two members of the IMB, an officer, a manager, a nurse and the man. His case was discussed, and it was decided that he should remain in the segregation unit. There is no record of how the man behaved during the review.

111. On 20 April, he was moved to another cell and the next day had a visit from one of his brothers and a friend.

112. At 11:05am two days later, an officer was escorting the man from the exercise yard back to his cell. He said that, as he was about to close the cell door, he tried to push past him, demanding a shower. The man punched the officer in his left eye and control and restraint techniques were used to force him back into the cell. Control and restraint was used by the officer with assistance from four other officers. The incident was supervised by the duty manager, who talked to the man to try to get him to comply with instructions. The officers reported that the man continued to struggle, was abusive and accused staff of being racist. The allegation that staff were racist was not reported or investigated. The man was moved to the special cell, and a nurse attempted to assess whether he had any injuries. However, because he was behaving aggressively, shouting and moving around the cell, she was unable to assess him.

23 April, adjudication hearing

113. On 23 April, the man appeared before a Judge who carries out independent adjudications, for the adjudications following the incidents on 1, 2 and 3 April, and was given an extra 39 added days to be appended to any subsequent court sentence of imprisonment.

114. At 9:15am the next day, 24 April, an officer accompanied the doctor to all the prisoners in the segregation unit. He asked the man to go to the back of the cell, and opened the door. The man rushed towards the officer, and was restrained by four officers. A senior manager, was in the unit and saw the man being restrained. A member of the IMB visited the man, but he did not want to talk to her. He was later moved to the unfurnished cell.

115. The man's solicitor was due to visit that morning at 9:30am, but received a telephone call from an officer. The solicitor was told that there had been a violent incident overnight, and the prison considered that the visit should not take place as the solicitor's personal safety was at risk. It is not known whether the man was consulted about the impending solicitor's visit. The solicitor did come to the prison and was refused admission, as it was reported that the man was acting so aggressively that a visit would be impractical.

116. On 25 April, the man was taken by prison escort services to Crown Court, and his solicitor saw him in the cell complex below the court. The solicitor said that the man's behaviour was extremely odd. He initially appeared well, but then became extremely agitated. The man questioned the solicitor's origins, the existence of a barrister whom he thought was conspiring against him, and repeatedly demanded release on bail. The solicitor said that the man did not appreciate that his bail applications had been exhausted, and he had no prospect of it being granted.

117. The man walked out of the court hearing, returning down the stairs back to his cell. His solicitor and counsel went to see him, watched by three officers standing outside the door. The solicitor said that he paced up and down the room, holding a polystyrene cup and continually spitting into it. He appeared extremely tense, and the solicitor thought that at any time he was likely to become violent.

118. A young adult offender, was also at the court that day. He knew the man from B wing, and was surprised to see him as he thought he had been released. He heard the man banging on the cell door and shouting, and was allowed inside to help calm him down. He said that, whilst they were on B wing together, the man was 'normal' but now considered he was suffering with a mental illness. He said that the man calmed down whilst he was with him.

119. The man assaulted a member of the escorting staff whilst returning to the prison. After his return, he was medically examined at 2:55pm by a nurse who noted that he was fine and had no injuries. An SIR was completed regarding the assault.

120. Later that day, at 6:00pm, four officers were issuing the man with some water and instructed him to go to the back of the cell. One of the officers held a shield when he opened the cell door, and the man rushed towards the door and hit the shield. The door was closed and the duty manager informed. The man was seen by a nurse at 6:05pm. The nurse recorded that no injuries were seen or complained of.

121. A member of the IMB saw the man in his cell on 27 April. He was sitting on the floor, calm but had nothing to say. He had seen the man on several occasions, and described his behaviour as ranging from very aggressive to very calm and polite.

27 April, psychiatric assessment

122. The same day, the psychiatrist interviewed the man for the second time. The psychiatrist recalled that the prison doctor told her that at times the man's eyes became wide, and that he became sexually aroused before or at the time of an assault. She was also told by staff that he soiled his clothes deliberately. The psychiatrist said that it was a difficult interview because officers with shields were present. The man sat at one end of the table and the psychiatrist at the other.

123. The man told the psychiatrist that he had been seeing spaceships, but did not appear distressed or frightened, and it was said as a joke. He then said that he did not see the spaceships, but heard them. He also spoke about ghosts and demons, but did not say he was feeling depressed. Again the psychiatrist did not consider that the man was mentally ill, but rather that he was angry about being in prison. When she asked about his assaults on staff, the man said he knew what he was doing at all times. She thought that an electroencephalogram (EEG), which is a test for organic brain

disease such as epilepsy or brain tumour, might be beneficial. The test was not carried out. The psychiatrist recommended that the man remain in the segregation unit.

27 April, case conference

124. A case conference also took place on 27 April, attended by segregation unit officers and a senior nurse. They agreed that the man would be moved to a normal cell and have his bedding returned. He would be monitored daily by the doctor, and observed by segregation staff every 30 minutes. The residential senior manager, and the deputy controller, issued a management care plan for the man. The plan included the following information and instructions:

> “The man has over recent weeks displayed a very aggressive and unpredictable attitude towards prison staff. This has resulted in a number of actual and attempted assaults on the staff he has come in contact with.
>
> The following is the management plan designed to ensure staff that are charged with caring for the man, do so in as safe conditions as possible:
>
> ▪ Whilst in a normal location segregation unit cell the man will be subject to thirty-minute observations, this will be recorded on a Special cell observations form.
>
> • PCO5 I/C Segregation unit and a minimum of three members of staff are required at all times to unlock the man for any purpose, a short shield will always be utilised.
>
> • PCO5 I/C Segregation unit will carry a set of ratchet handcuffs at all times. This is to ensure that the prisoner can be restrained by use of ratchet handcuffs, as C&R techniques have very limited effectiveness on the man.
>
> • The man will be allowed a mattress in his cell during the day. After serving his evening meal he will be issued with a sheet, a pillow and a strip blanket, which will be removed the following morning after Breakfast.
>
> • The prisoner must be stood at the back wall when staff enter the cell. If he refuses this instruction staff will not enter unless in an emergency i.e. Self-harm.
>
> • Staff will take all meals to the man’s cell. All meals will be served on a polystyrene plate, a polystyrene cup will be provided for cold drinks only.
>
> • The man will have access to a period of exercise and a shower each day, the PCO5 I/C Segregation unit and a minimum of three

members of staff with a short shield will supervise the man at all times.

- Whilst the man is on the unit, or in the shower the segregation unit will be in a patrol state, no other prisoners will be out of their cells and all unit doors, offices and stores will be locked.

- The man will be strip searched prior to his exercise period and prior to being relocated in his cell.

- Unit cleaners will clean the man's cell whilst he is on exercise, unit staff prior to him being re-located in his cell will then search it.

All staff need to be aware that they are dealing with a violent unpredictable young man and must be on their guard at all times when unlocking his cell or supervising him on the unit.

The duty director in consultation with the controller can only countermand these instructions. The PCO5 I/C Segregation unit will inform the duty director of any significant changes in behaviour/attitude of the prisoner."

125. These arrangements, including the use of a shield and requirement for 'back wall unlock', remained in place until the man died. However, the plan was only ever put in place during crisis for a short period

126. The doctor saw the man each day, merely noting that he was fit and well. On 28 April, his solicitor wrote to the prison health department, suggesting that he should be referred to the psychiatric team which visits the prison. A reply was sent to the solicitor to the effect that the man had already been subject to a psychiatric assessment.

127. The man's solicitor and his counsel met him at Parc on 2 May. The meeting took place in the segregation unit, with two prison officers standing at the door with shields. The solicitor described the man as perfectly amicable, and even jovial. He apologised for his behaviour the previous week. There was no repetition of the disturbed behaviour the solicitor and counsel saw at court, nor any sign of aggression or violent behaviour.

2 May, segregation review board

128. The following day, 2 May, the man was seen between 10:45am and 11:45am by two immigration officers.

129. A segregation review board was held later in the day, with the controller, a manager, an officer, a member of the IMB and a nurse present. The man was not present on this occasion. The board was told that he had no medical or mental health issues. Because his behaviour was unpredictable, they decided that he should remain in the unit and be reviewed again on 17 May.

130. The medical records note that a RMN discussed the man with the psychiatrist because of the concern that the man became inappropriately sexually aroused when he was restrained. The psychiatrist advised that the man should be reviewed again by a psychiatrist at the next opportunity.

131. The man's segregation history sheet on 5 May records that he said that he had a problem. He asked to go out, saying that there was someone waiting for him outside the prison. He was described as very strange, and it was said the officers still needed to use a shield as they could not predict his next move. He was seen again by the doctor who recorded in his medical record that he was fit and well.

132. A member of the IMB saw the man on 10 May and recalled that he seemed agitated.

11 May, psychiatric assessment

133. On 11 May, the man was assessed by a specialist registrar in forensic psychiatry, in the segregation unit. The interview lasted approximately 15 to 20 minutes, and throughout three officers remained at the door. The specialist psychiatrist had spoken to segregation staff about the man's behaviour. She described him as polite throughout the conversation, and she did not detect any evidence of hostility or irritability towards her.

134. The man said that he had no previous psychiatric history and had not seen any professionals about his mental health, but did mention that his brother had talked to him about paranoia. The specialist psychiatrist referred to his remarks about feeling that blood had been let out from his body, and he said that he did not have that sensation. She established that it was not a delusion or a hallucination. She also referred to his previous references to spaceships, at which he smiled and said that he did not want to talk about them. He confirmed that he had been eating and doing as much as he could do within the segregation unit.

135. The specialist psychiatrist found no evidence of paranoia or psychotic illness. She also considered that the man did not present as depressed, and found no evidence of thoughts of suicide or self harm. The specialist psychiatrist said she told the segregation staff that she found no evidence that the man was mentally ill.

136. On 12, 13 and 14 May, the doctor saw the man as usual and noted that he continued to be fit and well. On 15 May at 8:25am, he was in the exercise yard when an officer reported that he ran towards her in a threatening and abusive manner. He was restrained by four officers, using control and restraint methods. He was placed on a disciplinary report for his behaviour.

17 May, segregation review board

137. A segregation review board was held 17 May, with the deputy controller, in attendance together with a manager, an officer, a member of the IMB, a

nurse and the man. It was noted that the man's behaviour continued to be unpredictable, and he was advised to speak to staff when he faced difficult situations. No healthcare issues were reported. The daily doctor's visits took place, and the man was reported to be fit and well. He was visited by two of his brothers on 26 May.

31 May, segregation review board

138. The man was also present at the board on 31 May, together with the controller, a manager, an officer, and two members of the IMB. The review panel heard that the man had been behaving properly, but had the ability to change his mood very quickly. It was decided that he should remain in the segregation unit. No healthcare issues were reported.

139. An officer recorded in the man's segregation history sheet that, when the man's flask was issued, he asked the officer to let him out as he said that God had told him that he should not be locked up. A few days later, on 5 June, he refused his breakfast, lunch and evening meal. He was moved to another cell, but would not talk or respond to staff. The doctor checked that he was well.

140. At 5:00pm the next day, 6 June, an officer opened the man's cell door in order to give him his evening meal. The officer reported that the man rushed towards his shield, and was restrained by five officers, with two more officers supervising. The man was stripped of his E list clothing, and given pyjamas to wear. He was also given his meal. A nurse assessed him ten minutes later, and no injuries were reported. The man was subsequently placed on a disciplinary report. The next day he was seen by a doctor who observed him walking around his cell.

141. Two days later, at 7:35am on 8 June, two officers opened the man's cell to issue his E list clothes. They reported that, when the door was opened, the man lunged towards on of the officers. With the assistance of four officers, he was physically restrained and his clothing forcibly removed by order of the duty manager. He was examined by a nurse, who noted that he had not sustained any injuries. The man was again placed on a disciplinary report.

142. Later that morning, at 11:10am, the duty manager asked the man to move to the back of his cell. He refused to do so, and the duty manager believed that he had a concealed weapon. Four officers and the duty manager physically restrained him using control and restraint techniques, and moved him to the special cell. They reported that he continued to fight, and had to be stripped of his clothes under restraint. The duty manager cut the man's top from him, and placed him in strip conditions. The use of force on this occasion was pre-planned, and so was video recorded by officers.

143. The four officers wore protective clothing and were accompanied by the duty manager who can be heard issuing directions and occasionally speaking to the man. He resisted the officers' efforts throughout, and his strength was evident such that the officers struggled to accomplish their

goal. There was no evidence that they considered withdrawing to allow the man to calm down. Although an officer usually used two hands to support and protect the man's head, on one occasion a single hand was used to push his head on to his chest. He was lifted from one cell to another in an unsafe manner. As his clothes were cut off, a towel was placed over his buttocks, but removed more than once. The incident lasted approximately 12 minutes, seven minutes to remove him from the first cell and five minutes to leave him in the second.

144. A nurse assessed the man in the cell, and recorded that there were no visible injuries. The doctor interviewed the man later in the day, and found no overt signs of psychosis. The doctor recorded that the man could be quite articulate, which made his behaviour even more bizarre and inexplicable. The doctor decided that he should be kept in an unfurnished cell, under nursing supervision, and did not make an RMN referral.

145. The same day, an officer reported on a SIR that, whilst walking the man from the visits area, he was very inquisitive about the use of the officer's keys. At 6:00pm that evening, the man was given his meal and drinking water by a control and restraint team consisting of four officers. As soon as the officers left the cell, the man pushed his food under the door. He was seen by a nurse, who witnessed the incident. She noted that no injuries were observed, but the man remained volatile. He was seen by the doctor on 10 and 11 June. On 12 June, the doctor recorded that he had become withdrawn and sullen, and continued to be capable of violence.

146. On 13 June, a Registered General Nurse (RGN) was called to the segregation unit. The man had taken off his clothes, and was lying on the floor. He was chanting that he was white, and refusing to acknowledge officers. The nurse noted that the RMN had been informed, but there is no record that an RMN responded.

14 June, segregation review board

147. The man was not present at the segregation review board on 14 June, because of his unpredictable behaviour. The board consisted of two managers, the controller, a nurse, a member of the IMB) and an officer. They decided that the man should remain in the segregation unit until 28 June.

148. The man's solicitor visited again on 15 June. The visit took place in the segregation unit. During their conversation, the solicitor said that there were no signs of any difficulties or outbursts, and he described their discussion as meaningful. The man was visited by his brothers on 19 June.

20 June, adjudication hearing

149. It was noted in the segregation history sheet for 20 June that, for the second time that day, the man urinated in his clothes. This was repeated during the adjudication hearing. The hearing was in front of a District Judge, who

imposed an additional 42 days imprisonment for the incidents on 4 March, 22 and 24 April, 15 May and 6 and 8 June. The man did not dispute that heroin had been found in his cell, but wrote the following statement:

> "The powder must have been planted in my cell. I never saw any powder or any heroin. Some officers came in. They searched my cell. They told me to leave and move from my cell. I found that suspicious. I stayed by the washing machine when I came back I was told what had been found. I was beaten up. I have now decided to plead guilty. Too much bother to argue my case."

150. The man had a further visit from his brothers on 22 June. Four days later, on 26 June, he appeared by video link to Crown Court. His solicitor recorded that he was reasonably cheerful, and there were no signs of any difficulties. He was described in his history sheet as appearing okay, and took a shower and exercised.

151. On 27 June, the man again appeared fine, and complied with all staff instructions. However, he was not eating properly and refused offers of exercise. The doctor recorded that he was fit and well.

28 June, segregation review board

152. Before the segregation review board took place, a member of the IMB went into the man's cell to talk to him. Their conversation lasted for five or six minutes. She described him as quite agitated, very thin and complaining of back pain. She was told by an officer that he had seen a doctor that morning, and would do so again the next day. As the man was so thin, the IMB member was concerned about his weight and tried to persuade him to eat. She asked him if he had had any lunch, to which he replied that he had a sandwich and some chips. She told him that he should eat as he was a young man with a lot to live for and needed to keep his strength up. She said that she would return to see him on 30 June. That day, the man ate his dinner, together with a cheese sandwich, crisps, chocolate biscuit, apple, doughnut and a dish of chips.

153. The man did not attend the board because his behaviour was erratic. The board consisted of a different controller, a manager, an officer, a nurse and a member of the IMB. The board decided that the man should remain in the segregation unit and be reviewed on 12 July.

154. After the board, the IMB member was informed that the man had continuously pressed his cell buzzer, asking to see her again. She went back to see him, escorted by an officer. She described the man as calmer than he had been an hour earlier. He said that he had come to terms with what he had done, and knew why he was in prison. An officer replied that this was a good thing. The IMB member said that it was like speaking to two different people within an hour. As she left, she told the man that she would visit again on Friday. She then contacted another member of the IMB

to ask her to visit the man the following day. The second conversation also lasted for five or six minutes.

155. An officer started work in the segregation unit at 8:30pm. He was the only officer working in the segregation unit that night. He checked that the man was in his cell at 8:31pm, then continued to check his cell approximately hourly throughout the night. The officer said that at each check the man appeared to be asleep in bed. The checks were electronically monitored on the cell call system at 9:36:41pm, 10:32:11pm, 11:34:15pm, 00:35:19am, 01:24:10am and 02:33:03am.

29 June

156. The officer next checked the man's cell at 3:30am, and switched on the cell light from outside the cell to look through the observation panel. He saw the man standing at the rear of the cell in a slumped manner and apparently supporting himself against the back wall. The officer believed that the man had hung himself, and immediately used his radio to call code red to the control room. (Code red is the prison's code for a full medical emergency, and that assistance is required.)

157. A prisoner in the segregation unit that night said that he heard the night officer crying and shouting 'what you have done?'.

158. The officer used his night keys and entered the cell. He supported the man's body with his left arm, and saw a ligature made from a piece of bed sheet around his neck. The other end of the ligature had been placed through a hole in the perspex of the window. It appeared that he had burnt a hole in his cell window using a cigarette and lighter. He had then threaded his bed sheet through the hole to make a ligature.

159. The officer ripped the ligature away from the window. At this point, the night manager and known as Oscar One, arrived and took the man from the officer. They placed him on the cell floor, and immediately started cardio pulmonary resuscitation (CPR) together with two members of healthcare staff.

160. Two qualified paramedics with the Welsh Ambulance Service, were allocated a call to the prison at 3:35am. They arrived at 3:40am and were taken straight to the segregation unit. One of the paramedics saw the man lying on the floor on his back with a blue coloured ligature around his neck, the same colour as the bed sheet. There was a deep ligature mark around the man's neck. They examined him, and found no pulse, blood pressure, or breathing respirations. They connected an Electro Cardio Machine (ECG) to the man to confirm if there was any output from his heart, but there was none. He was in a state of asystole, which means there is no heart rhythm and the heart was dead. His body was cold, and the first signs of rigor mortis were setting in. At 3:53am, the paramedic, pronounced that the man had died.

161. The police and the on call prison doctor were called, and the doctor confirmed the man;s death at 5:20am. The police preserved the cell for photographs and forensic examination. They initially treated the cell as a crime scene, taking photographs and removing the perspex window for further examination. They also removed a handwritten note, which has been kept by the police.

162. As soon as practicable, the Director of Parc, a manager and a Roman Catholic chaplain, left the prison, to inform the man's brothers of his death. That visit and subsequent contact with his family is documented by the manager, who acted as the Prison Family Liaison Officer. The prison offered to pay the funeral costs for the man's funeral, and subsequently enabled the brothers to visit the cell where he had died. The man's brothers were disappointed to find that the cell had been freshly painted.

163. The Director of Parc, held a staff debrief after the man's death. Those staff and prisoners interviewed for my investigation said that they felt supported by the prison.

POST MORTEM AND TOXICOLOGY

164. A pathologist carried out a post mortem examination on the man on 30 June 2006 at hospital. He commented:

> "I have access to the man's Prison Medical Record in which there are sixteen sheets headed "report of an injury to a prisoner" and five sheets indicating the use of special accommodation/mechanical restraints. The record makes clear behavioural difficulties had been identified and there were entries describing consultation with two Forensic Psychiatrists. These doctors do not appear to have felt that the man fulfilled criteria for mental disorder. I can see no record of intent to self harm being identified. There appears to be regular review of his accommodation - in a segregated cell.
>
> "At 5:20am on 29 June 2006 there is a note detailing the finding of the man with a ligature tied around his neck suspended through a hole burnt through a perspex panel. He is recorded as having rigor mortis and the body was said to be cold. He was declared dead.
>
> "The post mortem findings do not suggest any recent struggle, assault or violent restraint. There is no sign of recent self harm. The ligature mark indicates suspension, in keeping with hanging and whilst the absence of bleeding into the neck or petechiae in the eyes and face means that it cannot be confirmed that the ligature must have tightened around his neck during life, it must be recalled that such 'pale faced' hanging without any injuries are the most common findings in self inflicted hanging. The ligature mark indicates that he must have been suspended. There is no evidence indicating the necessary involvement of any other person although it is advisable to carry out toxicological analyses to ensure that he would have been capable of carrying out this action and also - were he to be on any medication - to address issues relating to state of mind.
>
> "With a severed ligature and no photographs of the scene I am not in a position to state whether or not the deceased would have been able to effect self suspension. Were, however, evidence to be available that self-suspension were feasible and no evidence to suggest the involvement of any other person, then it would be my opinion that his death was adequately explained by:
>
> "1a Hanging."

165. The pathologist carried out the post mortem toxicology examination. His findings were reported to have given no cause for concern. No traces of alcohol, paracetamol or opiates were found.

ISSUES CONSIDERED IN THE INVESTIGATION

The man's health and wellbeing

166. It would appear from the evidence available that when first admitted to Parc, the man exhibited no psychiatric symptoms that would have caused concern. His first refusal of prison meals seems to have been a protest against his incarceration as he believed himself to be innocent. Although he was appropriately monitored under the suicide and self harm monitoring arrangements, he was not moved to a shared cell despite the request from nursing staff. The company of another prisoner might have assisted the man to adjust to his environment.

167. The first documented evidence that the man might have psychiatric problems followed the worries reported by his brothers. These were eventually followed up by a mental health nurse. It is most unfortunate that this was not deemed a priority, and that more information was not obtained from the family.

168. The system for acquiring a specialist medical opinion in Parc is that officers concerned about a prisoner's health request a nursing assessment. The nurse then discusses the case with a doctor or another nurse and obtains a specialist referral, usually within two days. The treatment recommended by the specialist would then be discussed with healthcare staff and followed through. As the man's behaviour continued to be disturbed, prison staff followed the procedures correctly, and referred him for a specialist psychiatric opinion. He was assessed three times, and on each occasion found to have no mental illness.

169. The first psychiatric medical opinion indicated there was no evidence of mental health problems. However, two days later,the man started talking about having lost blood. More delusional beliefs, such as ghosts, demons and spaceships, were expressed, and a second psychiatric opinion was arranged. The psychiatrist confirmed her earlier diagnosis that he was not mentally ill, but was having difficulty dealing with imprisonment. An EEG test for organic brain disease, such as epilepsy or brain tumour was recommended. It is unclear why it was not carried out. An EEG technician could have attended the prison to carry out the test if this was more appropriate in the circumstances.

170. Subsequently, a mental health nurse informed the psychiatrist of concerns about the man's increased levels of aggression and sexual arousal. There is no evidence that these issues were ever dealt with. This is the last documented input from a mental health nurse. The only other documented evidence of RMN involvement was when the code red was called on the morning that the man died.

171. A second psychiatrist assessed the man a month after the first. The psychiatrist was aware that he had been talking about ghosts, dark shadows, losing blood and feeling weak. However, the psychiatrist noted

that he did not want to talk about his earlier remarks and did not consider him to be mentally ill.

172. I must not substitute my lay opinion for that of mental health professionals. But none of the man's references to blood loss, spaceships and the like are consistent with normal behaviour. There is further evidence of behaviour not entirely consistent with normality, such as that the man was guarded in conversation, mistrusted people and chose to write rather then converse. A further cause for concern, as reported by officers, was that he lay on the floor, chanting that he was white. Although attended to by a general nurse, who in turn informed a mental health nurse, it appears that no RMN responded to the request for an assessment.

173. Aspects of his day to day personal care, such as food refusal, incessant urinary incontinence and retention of cups of saliva, also suggest a young man in need of care and professional support. Throughout his time in custody, the man repeatedly broke Prison Rules. These were dealt with as discipline matters and incurred increasingly severe punishments.

174. While his behaviour and mood continued to be bizarre, no further efforts seem to have been made to understanding or treating it. He was held in segregation, in conditions which were spartan. It could be argued that being kept on a segregation unit for a protracted period of time in prison with no peer group company did nothing to enhance the man's mental health. For example, placement in the healthcare centre would have permitted constant assessment. Alternatively, a referral to a psychologist could have been considered. At the very least, resumption of the counselling sessions would have been a humane response. It is regrettable that a young man, whose behaviour was so disturbed, should not have been monitored more closely and frequently by specialist mental health professionals. Notwithstanding the psychiatric assessment that he was not mentally ill, the man's behaviour continued to be erratic. A longer assessment, for example as an inpatient in healthcare, might have led to a greater understanding of his needs.

The Director should allow prisoners in all parts of the prison, including the segregation unit, to have the same access to the counselling service.

The man's location at Parc

175. HMP Parc is the only prison in Wales which holds remand and sentenced young adult males, including those who are vulnerable or who require segregation. One reason the man remained at the prison was because, as a remand prisoner, he was required to attend frequent court hearings in Cardiff. However, Parc's resources for dealing with his changeable and disruptive behaviour were soon exhausted. Had he been sentenced, it would have been easier for him to be transferred to an alternative prison in England. The probable drawback would have been a longer journey for his brothers when they came to visit him.

The Prison Service should review the provision of places for young adult males in Wales, and ensure that there are sufficient resources for vulnerable or disruptive prisoners.

Drugs found in the man's cell

176. When drugs were found in the man's cell, he protested his innocence and claimed that the substances had been planted. Despite his protests, he pleaded guilty at the adjudication on 20 June and, as a consequence, his claim was not investigated separately. Moreover, my investigator was unable to establish an evidential chain from the finding of the substance to its analysis. He is therefore of the opinion that the finding of guilt was flawed given the way in which staff learned that there were drugs in the man's cell and the unlikely hiding place (under the pillow). The man had no history of drug use.

The Director should review the procedures for investigating and collecting evidence when substances believed to be drugs are found.

Bullying

177. The initial explanation for the man's removal to the segregation unit was that it was for his own protection, as he was said to have been bullied on a visit. It was the man, the alleged victim, who was taken off the wing and not the alleged perpetrator. Whether or not the move was appropriate, the allegation was not followed up and any bullying went unheeded.

The Director should review the prison's anti-bullying policy, particularly in relation to young offenders, and check that all acts of violence between prisoners are fully investigated to establish any underlying issues.

I endorse the recommendation made by the HMCIP that staff should be alert to any bullying of prisoners or visitors on their way to visits and should intervene and ensure the incident is properly recorded and investigated.

E list status

178. The man was initially made an escape list prisoner on the basis of his refusal to return to prison transport. He remained on the list as he talked of not belonging in prison, and was said to have shown a keen interest in an officer's keys. Neither individually nor collectively, do these represent strong grounds for keeping a disturbed and vulnerable young man on the E list. Indeed, I doubt that the man's continued E list status was appropriate. However, I have found no evidence that his escape status was subject to review or challenge.

The Director should review the procedure for placing a prisoner on the E list and ensure that regular review's are conducted.

Location in the segregation unit

179. The man was moved to the segregation unit in March 2006, and remained there until he died. It is apparent that he presented significant discipline problems to prison staff throughout most of his time in the unit. There were many occasions when control and restraint techniques were used, though they reduced from eight in April to one in May and one in June.

180. In light of the risk he posed to staff, I can understand why he remained in segregation. However, I also note that a period of more than three months in austere conditions and isolation must have taken its toll upon the man's physical and mental health. He was a vulnerable young man of 20, an African in a Welsh prison with no previous experience of custody. To keep a young offender in segregation for this length of time was at best unimaginative. At worst, it was cruel.

The Director and senior management team at Parc should review the use of segregation, in particular for prisoners who are young, vulnerable or both.

Diversity

181. The man's family has alleged that he was the victim of racism. Indeed, throughout this report I have been conscious that I am writing about a young man, originally from war-torn Burundi, held in a prison that (both from a staff and prisoner perspective) is overwhelmingly white. However, in the course of extensive interviews with staff and prisoners at Parc, my investigators have detected no evidence of overt racist attitudes (though they are unlikely to be displayed to an investigator.) The prisoners we spoke to appeared to be sensitive and mainly tolerant to the man's individuality, even when his actions, such repeatedly kicking his cell door, singled him out from others. Numbers of staff demonstrated positive attitudes, and referred to the benefits of their diversity training, although this is not a complete indication of whether or not discrimination exists.

182. I am also aware that the number of complaints of racism at Parc is low. However, my investigators have noted that, since the investigation began, a Diversity Manager has been appointed and the numbers of complaints have increased. The prison considers this is due to increased awareness of the importance of recording.

183. Nevertheless, there are aspects of the man's treatment which did not conform to best diversity practice. His family raised concerns about overt racism against anyone who is not Welsh, and felt that he was a victim. My investigators found evidence that the implications of his minority ethnic background were not considered, and investigations of allegations of racism were not carried out.

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184. In February, the man wrote in a statement for an adjudication that another prisoner had used racist language. In April, he accused staff of behaving in a racist manner when he was restrained. There is no evidence that either allegation was reported as a racist incident, investigated or followed up.

185. HMCIP found that the majority of the prison's reports of bullying were on B wing. The man was involved in three incidents of violence with white prisoners on the same wing. Although the incidents were properly recorded and dealt with as breaches of Prison Rules, there is no evidence that the prison considered any possible underlying issues such as bullying or racism.

The Director should remind staff that, when an allegation of racism is made, it should be recorded and investigated.

The Director should review the Diversity Action Plan in the light of this report, and extend its scope to reflect my findings. In particular, the objectives of diversity and suicide awareness training should be harmonised, rather then seen in isolation.

Use of force

186. The man's family alleged that he was beaten up by prison staff three or four months prior to his death. My investigation found no evidence that he had been beaten by staff, although it has been documented that he was subject to repeated use of force using control and restraint techniques. On all those occasions, the required documentation was completed. Video footage was taken on one pre-planned occasion when officers used force and a prison manager supervised events. The film makes disturbing viewing. Officers struggled to remove his clothes, and he continued to resist their efforts throughout. The episode lasted approximately 12 minutes, and there were a number of failures evident.

187. All the staff interviewed for the investigation confirmed that their training in control and restraint was up to date. Staff who were not involved in use of force confirmed that they were aware of approved methods being used in the prison.

188. When the man was on B wing, he was involved in at least two fights with other prisoners which were diffused peacefully by staff without the need for control and restraint techniques. However, it is not self-evident that the same efforts were made by segregation unit staff. Control and restraint was used on 17 occasions, and on one occasion his clothes were cut off him. There is no evidence that any attempt was made to calm and defuse the situation by giving him time to consider his position, or by talking to him, other than to issue instructions.

The Director should remind segregation staff of the absolute requirement to use the minimum force necessary, and to seek

alternative ways of resolving difficult situations, including encouraging a dialogue with prisoners.

Segregation unit

189. The segregation unit at Parc holds both adult and young offenders. Moreover, Parc has no facilities for vulnerable young adults needing protection, other than in the segregation unit. I have referred already to the recommendations of HMCIP and to the views of the IMB. I am concerned that the segregation unit is used for both adult and young adult offenders, with the same staff, but on separate regimes. At the time of my investigation, a young adult had been in the segregation unit for no less than 12 months, with little prospect of suitable accommodation being found in the immediate future.

190. There was little evidence that the personal officer scheme was working, and officers took collective responsibility for all prisoners in the segregation unit. An effective personal officer scheme should enhance relationships with prisoners, and lead to a greater understanding of their individual needs.

191. Throughout his stay in the segregation unit, the man was subject to close monitoring by staff either because his behaviour was disruptive, or because he was an E list prisoner. There is an electronic record of the checks and, although his family believe that more than two hours passed between the last check and the discovery of his body, the records seem to confirm that this was not the case. Nevertheless, it is surprising that there were signs of rigor mortis when the man was examined by the paramedics.

192. A manager, the chaplain, and a member of the Independent Monitoring Board must visit each prisoner in the segregation unit every day as a safeguard. Each of them has very different roles, and prisoners may have individual needs which they would not wish to share with others. The daily record of the man's conduct in the unit is inadequate, and much of the information in the report has been obtained from the use of force forms, his medical records, and from interviewing staff. The daily record does not detail any efforts staff made to engage with him.

193. Each prisoner held in segregation has to be reviewed at defined periods by a segregation review board, and the man's took place as required. The chair of the IMB reported that his members attended 70 boards from 1 January to 1 October 2006, and had no concerns about the care and treatment of prisoners. The number of staff attending boards, their continuity of attendance and their efforts to include the man are commendable. However, it is disappointing that the boards appear to be a passive process, rather then one which encouraged prisoners to move on, and return to the wing or a different establishment.

The Director should review all aspects of the operation of the segregation unit, including the effectiveness of the segregation review boards.

194. Unlike segregation units in many other local prisons, there is no CCTV coverage of the communal areas. Although CCTV coverage might not have prevented the man's death, it would have provided corroboration of the accounts given by staff. Furthermore, CCTV coverage would protect staff against malicious allegations made against them.

The Director should consider the installation of CCTV within the communal areas of the segregation unit.

195. The man was not deemed to be at risk of harming himself, and had not been placed in a safer cell. His cell had a number of potential ligature points, including perspex windows. He burnt through his window, using his lighter and a plastic utensil, and was able to thread his bed sheet through the hole to make an anchor point for the ligature.

The Director should review the use of perspex for windows at Parc.

196. During the time that the man melted through the window, the fire alarm in the segregation unit was not activated.

The Director should review the effectiveness of the fire alarms in the segregation unit.

Suicide and self harm awareness

197. The National Offender Management Service's Safer Custody Group has advised me that national training in suicide and self harm awareness does not include specific guidance for staff in segregation units. However, since my office became responsible for the investigation of deaths in custody, I have been very troubled by the number of deaths occurring in segregation.

The Director should take advice from the National Offender Management Service Safer Custody Group and ensure that suicide and self harm training includes awareness of issues arising from:

- **the individual circumstances of a prisoner, including their ethnicity**
- **their location, especially the segregation unit.**

The role of clinical staff within the segregation unit

198. Prison Service Order 1700 applies throughout all prisons in England and Wales, including those in the private sector. It places specific responsibilities on medical and nursing staff for all prisoners in a segregation unit, and additional responsibilities for those located in the special cell. The man's records show that these duties were carried out. However, it appears they were performed as administrative tasks and in my view, they did not fulfil the intended function of promoting a prisoner's health, safety and well being. On too many occasions the man was merely recorded as fit and well. I would have expected, healthcare professionals to

have looked critically at the treatment he received, both in respect of his location and the use of force.

199. When prisoners are subject of use of force they must quickly be assessed by a nurse. Although I have no doubt that this occurs, it appears that the nurse usually stands outside the cell, speaking to the prisoner through the observation flap. Whilst staff must be safe, every effort should be made to enable the nurse and prisoner to have face to face contact.

Primecare should review their monitoring of prisoners in the segregation unit, especially at review boards, and when force has been used.

Policy for dealing with an apparent death

200. Parc's policy for responding to a prisoner who appears to have died is derived from national Prison Service guidance. Staff are required to summon help and request emergency medical assistance as soon as possible. If a ligature has been used, staff should support the prisoner, cut the ligature and place the prisoner on a flat solid surface. They should check for signs of life, and if the prisoner not breathing, resuscitation should be attempted unless the prisoner is clearly dead. The officer finding the man correctly followed all the required procedures.

The man's contact with his family and solicitor

201. Whilst in custody, the man received regular and frequent visits from his family, a friend and his solicitor. His family mentioned concerns over their brother's mental health to prison staff, although the full extent of their worries does not appear to have been documented. Family members were not consulted for full details of his mental health, or asked to assist with any aspect of his care whilst he was in custody. This would have been an opportunity for the prison to work with the people the man cared for, in an attempt to better meet his needs.

202. On one occasion, the man's solicitor was told that, due to an incident overnight, the prison considered that the risk to the solicitor was so great that the visit should not take place. The solicitor attended the prison and was refused admission, as it was reported that the man was acting so aggressively that a visit would be impracticable. My investigator believes this was a further missed opportunity for the prison to work openly and transparently with the man's solicitor, and to engage with him in his care plan.

The Director should consider liaising with a prisoner's family, solicitors and others in formulating a care plan.

Painting the cell

203. The man's brothers visited the segregation unit and the cell where their brother died. Believing they were acting in the best interest of his brothers the prison had had the cell painted. My investigator does not believe there was a sinister motive, the cell having been forensically examined and photographed by the police prior to them handing it back to the prison.

The Director should remind Family Liaison Officers to consider the family's needs before painting a cell where a prisoner has died.

Other family concerns

204. The man's family complained that they had spoken to a healthcare manager, whom they said was named X, and described her attitude as rude. My investigator has interviewed the healthcare manager, who is not called X, and she denies any contact with the man's brothers. There are no members of healthcare staff with this name, and it is possible that the man's family misheard the name of the person they spoke to. I have asked the prison to look into this further.

CONCLUSIONS

205. The man was a young man, born in Burundi, whose brothers believed he had a promising future ahead of him. He was remanded to prison awaiting trial for a serious criminal allegation. It was his first time in prison, and he had no previous convictions. All bail applications were refused. The prison had a duty to keep him safe, but were sadly unable to do.

206. At first, he was held on the young adults wing where he went on hunger strike to protest his innocence. As a result, he was placed on a self harm watch, and removed from it only after he began eating. This brought him to the attention of wing staff, the chaplaincy, the safer custody officer, and the IMB, who all had contact with him. He was involved in fights with other prisoners, which resulted in him losing privileges and being subject of adjudications and cellular confinement.

207. On 23 March 2006, the man was taken to the segregation unit for his own protection, after allegedly being bullied whilst on a visit. Whilst in the unit, he was involved in a number of incidents which resulted in repeated use of force by staff, many adjudications, and further periods that amounted to solitary confinement. My viewing of the CCTV coverage of the one episode of pre-planned use of C&R reinforces my concern about the manner of the man's treatment. He was without doubt a strong young man who presented numerous difficulties for staff. Nevertheless, he was entitled to be treated proportionately, safely and with dignity.

208. There is little evidence that the man associated with anyone of his own age, although on one occasion when he was behaving bizarrely in court another young prisoner sat with him and had a beneficial, calming effect. My concerns about the use of the segregation units, especially for those who are themselves vulnerable, have been made in a number of reports. I am particularly concerned that a young man, isolated in any event on account of his background and ethnicity, should have spent so long in segregation. I note that Parc does not have a dedicated vulnerable young adults wing, and Wales does not have an alternative prison for young adults.

209. The man was psychiatrically assessed on three occasions, and found not to be suffering from mental illness. No further thought was given to an explanation for his disruptive and disturbed behaviour. His detention was regularly reviewed at review boards which decided that his continued detention in the segregation unit was the only option.

210. Opportunities to engage his family and solicitor in his care plan were missed. They have raised important concerns about racism and about his care at Parc. I am pleased to note that, in the course of many hours in the prison and free access throughout, my investigators have not witnessed any racist attitudes or behaviour from either staff or prisoners. However, others such as HMCIP and the CRE, with greater expertise and resources then my own, have made criticisms which have been accepted and action plans put in place.

211. Sadly, as far as the man was concerned, those plans were inadequate and did not ensure that he was treated in a sensitive way. A diversity perspective should have been brought to bear on all aspects of his imprisonment, especially when it was apparent to some that his mental health was deteriorating when he was in the segregation unit. Coming from a war-torn country, and being a black African in a overwhelmingly white Welsh prison, are not excuses for violent behaviour. Prison staff have a right to go about their jobs without the prospect of violence. However, it is disappointing that the man's treatment was so one-dimensional and unimaginative. In retrospect, it is also now clear how much distress he must have been feeling.

212. The man died a lonely death, having been in segregation for over three months. He had no peer group company and was effectively in solitary confinement. No issue has caused me more concern since I became responsible for the investigation of all deaths in prisons than those deaths occurring in segregation units. Like all too many prisoners who end up in segregation, the man presented as a discipline problem but was increasingly vulnerable himself.

RECOMMENDATIONS

National

1. The National Offender Management Service should review the provision of places for young adult males in Wales, and ensure that there are sufficient resources for vulnerable or disruptive prisoners.

Local

2. The Director should allow prisoners in all parts of the prison, including the segregation unit, to have the same access to the counselling service.

3. The Director should review the procedures for investigating and collecting evidence when substances believed to be drugs are found.

4. The Director should review the prison's anti-bullying policy, particularly in relation to young offenders, and check that all acts of violence between prisoners are fully investigated to establish any underlying issues.

5. I endorse the recommendation made by the HMCIP that staff should be alert to any bullying of prisoners or visitors on their way to visits and should intervene and ensure the incident is properly recorded and investigated.

6. The Director should review the procedure for placing a prisoner on the E list and ensure that regular reviews are conducted.

7. The Director and senior management team at Parc should review the use of segregation, in particular for prisoners who are young, vulnerable or both.

8. The Director should remind staff that, when an allegation of racism is made, it should be recorded and investigated.

9. The Director should review the Diversity Action Plan in light of this report, and extend its scope to reflect my findings. In particular, the objectives of diversity and suicide awareness training should be harmonised, rather then seen in isolation.

10. The Director should remind segregation staff of the absolute requirement to use the minimum force necessary and to look at alternative solutions in resolving difficult situations. Including encouraging a dialogue with prisoners.

11. The Director should review all aspects of the operation of the segregation unit, including the effectiveness of the segregation review boards.

12. The Director should consider the use of CCTV within the communal areas of the segregation unit.

13. The Director should review the use of perspex for windows at Parc.

14. The Director should review the effectiveness of the fire alarms in the segregation unit.

15. The Director should take advice from the National Offender Management Service Safer Custody Group and ensure that suicide and self harm training includes awareness of issues arising from:
    - the individual circumstances of a prisoner, including their ethnicity
    - their location, especially the segregation unit.

16. Primecare should review their monitoring of prisoners in the segregation unit, especially at review boards, and when force has been used.

17. The Director should consider liaising with a prisoner's family, solicitors and others when formulating a care plan.

18. The Director should remind Family Liaison Officers to consider the family's needs before painting a cell where a prisoner has died.