# Investigation into the circumstances surrounding the death of a man at HMP The Verne in April 2010

**Report by the Prisons and Probation Ombudsman for England and Wales**

**January 2011**

This is the report of the investigation into the circumstances surrounding the apparently self inflicted death of a man at HMP The Verne. In April he was found in his cell in the segregation unit with a ligature around his neck. He was 40 years old when he died. I offer my sincere condolences to his close friend and all those touched by his death.

The investigation was carried out by an investigator. I would like to thank the Governor and all her staff for their co-operation with the investigation. I am particularly grateful to the safer custody governor who provided valuable assistance to the investigator.

NHS Dorset (formerly Dorset Primary Care Trust) commissioned a clinical reviewer to undertake a review of the clinical care the man received at The Verne. I am grateful for his timely review.

The man had been in prison for 19 years when he died. During his sentence he harmed himself on several occasions, once seriously. He had also been in trouble on a number of occasions and was making slow progress towards release.

In March 2010, a quantity of cannabis was found in two pairs of shoes sent to him in the post. As a result, he was segregated while staff tried to arrange his transfer to another prison. Some of his friends told staff that he had been pressured into receiving the drugs. They said that he had been using heroin while at the prison and might have got into debt with other prisoners.

According to staff, the man gave no outward signs of struggling to cope in segregation and they had no concerns about him. However, segregation units are places of isolation and are not designed to hold prisoners for long periods. Prisoners who spoke to him while he was segregated thought he was becoming frustrated with his situation and were worried about him. Their concerns were not passed to staff, however.

I make ten recommendations as a result of this investigation. Several highlight my serious concerns about the use of segregation at The Verne and I urge the prison management team to act on my recommendations and carry out a full review. I also highlight omissions in providing mandatory training to staff, investigating allegations of bullying or intimidation and the prison's emergency response procedures. I make two healthcare related recommendations, one of which is very similar to a recommendation I made in relation to a death at the prison in 2008.

This final version of the report includes the National Offender Management Service's response to the recommendations made. I am grateful to the man's next of kin for considering the contents of the report at the draft stage.

This version of my report, published on my website, has been amended to remove the names of the man who died and those of staff and prisoners involved in my investigation.

**Thea Walton**
**Acting Deputy Prisons and Probation Ombudsman** **January 2011**

**CONTENTS**

## SUMMARY

In October 1990, the man was remanded into prison charged with murder. He was convicted the following year and received a life sentence. He was told that he must serve at least eight years in prison before he was eligible for release.

During his first years in prison, he suffered with depression and harmed himself on several occasions. He also moved prisons regularly, sometimes in order to fulfil the requirements of his sentence plan and progress towards release. At other times, the moves were a result of him having proved difficult to manage. He often spent time in the segregation units, sometimes by choice and sometimes because of his poor behaviour. (Segregation units are also known as care and separation units, however, for ease I shall use the former term throughout this report They are small, separate units within the prison for prisoners who cannot be managed on the main wings for some reason. Segregated prisoners are held in single cells and have a restricted regime.)

In 1997, the man made a serious attempt to kill himself. He was found on his cell floor in the segregation unit at HMP Garth with a ligature around his neck. Staff were successful in resuscitating him. In the following years, he harmed himself on other occasions, albeit less seriously. For a time he was prescribed antidepressants, but generally said he preferred to manage his depression without medication.

He was given category D status (the lowest available category) in 2007 and moved to an open prison. Following an allegation that he and a female member of staff shared an inappropriate relationship, he was returned to closed conditions, pending an investigation. The investigation found no evidence that he had done anything wrong and he returned to open conditions in 2008. On this occasion, he broke the prison rules and within a few months had returned to a category B prison. He made slow progress towards release.

In December 2009, the man moved to The Verne where staff found him to be a cheerful, friendly prisoner. However, within his first months at the prison, he had got into trouble. There were suggestions that he might be involved in gambling. His friends said that he began using heroin again.

He saw the prison doctor in January and discussed his history of depression and stress. At his next appointment, at the beginning of February, he told the doctor that he thought of suicide several times every day. The doctor suggested that he be placed under suicide and self harm monitoring procedures. He refused to co-operate and so the doctor did not begin the process. He did refer him to the mental health nurse, however, who saw him two days later. She thought that his mood had improved and had no concerns about his risk to himself.

On 19 March, a large quantity of cannabis was found in two pairs of shoes sent by post to the man. Staff decided that he should be segregated until he could be transferred to another prison on the basis that he no longer fitted the prison's strict acceptance criteria. Other prisoners told staff that he had been pressured into accepting the drugs by another prisoner. Some thought he had got into debt. It appears that nothing was done to investigate the claims.

The man did not face a disciplinary charge in relation to the drugs find but remained segregated. Staff working in the unit and those visiting him there described him as seeming upbeat and positive. He gave no indications to them that he was struggling to cope or feeling vulnerable. However, prisoners who spoke to him said that he was frustrated at being segregated for so long. Although he gave them cause to worry, they did not pass their concerns to staff.

During a routine check in April a member of staff found him in his cell with a ligature around his neck. Staff realised that he was already dead and made no attempts to resuscitate him. When the paramedics arrived shortly after, they confirmed that he had died.

I make ten recommendations as a result of this investigation. A number are the result of my serious concerns about the use of segregation at The Verne. I urge the prison management team, along with support from the National Offender Management Service (NOMS) headquarters, to carry out a review of this. Two of my recommendations concern healthcare (one of which I have made previously), the remainder are for the Governor of The Verne.

I accept that, in the weeks and days leading to his death, the man gave few outward signs, and none to staff, that he was struggling to cope. However, I and others interviewed as part of the investigation believe that he was affected by his segregation.

## THE INVESTIGATION PROCESS

1. The Ombudsman was notified of the man's death on 8 April 2010. The investigation was allocated to an investigator. She visited The Verne on 13 April to open the investigation. She was provided with copies of his prison and medical records, including those covering his time at The Verne.

2. The investigator issued notices inviting staff and prisoners to contact her with any information they thought might be relevant to the investigation. Two prisoners and two members of staff contacted her as a result and were interviewed. A number of other prisoners and members of staff were also interviewed in May. One prisoner, who had been transferred to another prison, made a written complaint alleging that the man had been bullied by segregation staff. The complaint was passed to the investigator and the prisoner was interviewed.

3. The local PCT commissioned a clinical reviewer to review the clinical care the man received at The Verne. He and the investigator visited the prison together in June and carried out joint interviews with members of healthcare staff.

4. HM Coroner for Western Dorset district was notified of the investigation and provided the results of the post mortem. The Coroner will receive a copy of the report to assist with his enquiries.

5. The senior family liaison officer contacted a close friend of the man, who was his listed next of kin, to explain the purpose of my investigation and to invite her to raise any questions or concerns to be considered. She said that she noticed his mood deteriorate when he was at HMP Lewes and that he attempted suicide there. She wrote to the governor of Lewes, outlining her concerns, and wanted to know whether they had been passed to staff at The Verne when he transferred there. I can confirm that the letter was placed in his prison file and that staff at The Verne were aware of its contents.

6. The man's friend said that, after he transferred to The Verne, he began asking her for money and other items, and that she was concerned he was involved in gambling or drugs. She said that the day before he died, he wrote to her and sent a visiting order (which gives the authority for named individuals to visit the prisoner). She wondered why he had done so if he was intending to kill himself and was worried that something had happened to him the night before he was found dead. I have found no evidence to suggest this was the case and the police investigation found no evidence of third party involvement in his death. Finally, his friend raised concerns about the manner in which the news of his death was broken to her. However, she praised the two prison family liaison officers who offered support following his death. I hope this report helps to answer her questions.

7. The man was the fifth prisoner to die at The Verne since the Ombudsman began investigating all deaths in prisons in 2004, but only the second to apparently take his own life. Since his death, another prisoner has died there.

## HMP THE VERNE

8. HMP The Verne is a category C training prison for adult men on the Isle of Portland, Dorset. It holds up to 607 prisoners who are mainly life sentence prisoners or those who have received a determinate sentence (where the number of years imprisonment to be served is decided by the sentencing judge). Foreign national prisoners form a large part of the population.

9. Inside the secure perimeter walls of the prison, there is minimal physical security and prisoners are able to move freely around the prison. For this reason, only those prisoners who meet the strict reception criteria are accepted. Suitable prisoners, among other factors, must:

    - Be 25 years of age or older
    - Have at least nine months of their sentence left to serve
    - Have no history of escape or attempted escape
    - Have no history of racism
    - Have no significant history of prison drug trafficking or dealing
    - Not require intensive psychiatric intervention
    - Not be assessed as posing a high risk to other prisoners

10. The National Offender Management Service (NOMS) publishes quarterly performance ratings for all prisons in England and Wales. The ratings are based on a set framework and prisons can be rated from one to four (with four indicating 'exceptional' performance). The Verne has achieved a rating of three ('good' performance) for the last four published quarters.

## HM Chief Inspector of Prisons (HMCIP)

11. The most recent available inspection report by HMCIP relates to a full announced inspection of the prison conducted in August 2007. (HMCIP inspected The Verne again in 2010 but the report is not yet available.) The then Chief Inspector noted the good relationships between staff and prisoners and reported that earlier concerns about safety had been "largely addressed". However, violence reduction and safer custody policies were not sufficiently robust.

12. The violence reduction strategy did not meet the needs of the population and there were no interventions to encourage bullies to confront their behaviour. However, the inspection found little evidence of violence at The Verne, and prisoners said they felt safe there.

13. There were few indications that drug misuse was a problem and prisoners said that it was not easy to get hold of drugs. Mental health support for prisoners was "excellent". The Chief Inspector reported that segregation was used rarely and that the segregation unit accommodation was appropriate. Prisoners spending time there were treated appropriately, although the regime was limited.

## Independent Monitoring Board (IMB)

14. Each prison in England and Wales is monitored by an independent board of volunteers drawn from the local community. Members of the Board have access to every part of the prison and all prisoners held there. The Board must produce an annual report, the latest available for The Verne covering the period May 2008 to May 2009.

15. The IMB reported on "great improvements" in safer custody since the previous year. However, they recognised continuing problems with the completion of safer custody and violence reduction paperwork.

16. The Board noted that the increased proportion of British prisoners (as opposed to foreign national prisoners) in the preceding year had led to led to a "very active drug culture" in the prison. While the Board commended segregation staff for their respectful treatment of segregated prisoners, they noted their concerns about the length of time prisoners were held in segregation awaiting transfers to other prisons. They recognised, however, that delays were often due to external factors.

## Categorisation

17. All adult male prisoners are classified on reception into prison and put into one of four security categories based on the likelihood of escape and the risk to the public if they did escape. Category A prisoners would be highly dangerous to the public, police or national security if they were to escape. Category B prisoners are those for whom the highest security conditions are not necessary, but for whom escape needs to be made very difficult. Category C prisoners cannot be trusted in open conditions but are unlikely to make a determined escape attempt. Category D prisons operate open conditions and hold prisoners who can be trusted not to try and escape.

## Assessment, Care in Custody and Teamwork (ACCT)

18. ACCT, the Prison Service-wide process for supporting and monitoring those prisoners thought to be at risk of harming themselves, was introduced in 2007. An ACCT plan can be opened by anyone working in the prison if they have any concerns that a prisoner might have tried, or, in the future, might try to harm himself. The purpose of ACCT is to try to determine the level of risk posed, the steps that might be taken to reduce this and the extent to which staff need to monitor and supervise the prisoner. Levels of observations (where staff must check the prisoner) and interactions (where staff must have a conversation with the prisoner) are flexible and can be set according to the perceived risk of harm. If staff perceive the risk of harm to be very high, the prisoner may be constantly observed, with a member of staff positioned outside their cell at all times. Where the perceived risk is lower, the level of observations may be several times an hour or day. Observations also take place during the night. Prior to the introduction of the ACCT system, prisoners at risk of harming themselves were monitored under the F2052SH process.

## Prison Service Orders

19. The Prison Service is governed by a number of rules, regulations and guidelines contained in Prison Service Instructions (PSIs) and Prison Service Orders (PSOs). They contain mandatory instructions which all prison staff must adhere to.

## KEY EVENTS

20. The man was remanded into the custody of HMP Liverpool, charged with murder, on 9 October 1990. Not long after he arrived in prison, he showed signs that he was struggling to cope, including scratching his wrists and cutting his arms. He said that he felt suicidal at times.

21. He was found guilty and sentenced to life imprisonment on 28 October 1991. He was told that he must serve a minimum of ten years in prison before he was eligible for release. After receiving his sentence, he complained of depression and was given medication, which he continued to take until 1992.

22. Between 1992 and 2009, he moved prison 22 times. Some of the moves were a result of sentence progression but he was also moved for other reasons, including because he broke prison rules. (Every sentenced prisoner will have a sentence plan, which outlines the actions they and the prisons holding them need to complete to reduce the risk of future offending and prepare them for their eventual release. Such actions might include undertaking specific courses, some of which may only be available at certain prisons. Part of a prisoner's sentence progression will normally include moving to lower category prisons, with increasingly more open conditions.)

23. The man was often moved to the segregation units of the various prisons he stayed in. Sometimes this was at his request as he said he preferred the isolation of segregation to the pressures of relationships and life on the wing. At other times, however, he was moved there for his own protection (because staff thought he was being bullied) or because he had broken prison rules.

24. In 1993, he complained of trouble sleeping and was prescribed mirtazapine (an antidepressant). In May 1997, while in the segregation unit at HMP Garth, he was found unconscious on his cell floor with a ligature made from bed sheets around his neck. Staff who responded began cardiopulmonary resuscitation (CPR) and managed to revive him.

25. The following year, he was back in the segregation unit at Garth. He told staff that he had recently been thinking of hanging himself because he "felt he had hit a wall" in his sentence. He was assessed by medical staff who concluded that he was not suffering with a mental illness and had no symptoms of depression.

26. In May 2001, the man moved to HMP Swaleside. In July of the following year, again in the segregation unit, he cut his left arm. He refused to talk to staff about why he had harmed himself. Healthcare staff were unable to assess his mental state because he would not speak to them. An F2052SH document (the system that predated ACCT) was opened and he was moved to the healthcare centre where he was constantly monitored. He remained in healthcare for two weeks, during which time he began to speak to staff. He told them that he was feeling "remorseful and guilty".

27. The man transferred to HMP Leyhill, a category D open prison, in April 2007. Leyhill's function is to assess and prepare life sentence prisoners for release.

However, he stayed there for only five months, after he was alleged to have developed an inappropriate relationship with a female member of staff. As this is against prison rules, he was moved initially to HMP Gloucester (a category B prison) and then to three other establishments, before arriving at HMP Ashwell (a category C prison) in February 2008. The Prison Service began an investigation into the allegations against him. (Twelve months later, the investigators concluded that there was no evidence of improper behaviour.)

28. In July 2008, the man complained of feeling stressed. During conversations with healthcare staff he said that having been recalled from category D conditions, he was unclear about his sentence progression. He said that he was feeling despondent and wanted to "get on with his life and have some sort of direction". He explained that he had not been complying with prison rules because he was feeling low. He said he had felt depressed in the past, but preferred not to take medication, asking for information on managing stress instead. He said that he had harmed himself in the past, as a "young lad", but that he would not do it again. He said that he drew strength from his Christian faith.

29. At the end of October 2008, he transferred to HMP Ford, a category D open prison. However, less than a month later, he was caught outside the prison's perimeter fence. (Prisoners held in open prisons may be allowed out of the prison for specific reasons and only with authorisation, however they are expected to remain within the perimeter fences at all other times.) He told staff that he had left the prison to buy take away food for himself and a few other prisoners. Initially he said that he was being bullied by the other prisoners, but later denied this. As a result, he was re-categorised and moved to HMP Lewes, a closed category B prison, on 24 November 2008.

30. On 9 January 2009, the man had an appointment with the doctor because he was losing weight, had no appetite and felt stressed. He said that he had used heroin and cannabis in the past while in prison, but had never injected drugs. In June, he asked to move to the segregation unit. He denied having any thoughts of harming himself. However, later that day, staff received information from prisoners that he was planning to hang himself in the segregation unit. Staff carried out checks and concluded there was no reason to be overly concerned about him.

31. The man's friend, who visited him frequently in prison, wrote to the Governor of Lewes on 23 June, expressing her concerns about him. She was worried that he had served much longer than the ten year tariff set at court and still did not know when he might be released. His friend said that he had recently tried to kill himself (there is no information suggesting staff were aware of this in his prison file). The Deputy Governor responded, writing that he would pass her concerns to the appropriate manager. The lifer manager at Lewes also replied to the man's friend. He said that the man had told him that he had recently been feeling "very low" and could not see any positives in his future. He said he had reassured him and offered his support in helping him progress towards release. The letters from the man's friend were placed in his prison file.

32. In September and October, the man got into trouble on several occasions. He was reported to have made “inappropriate comments” to a female member of staff, was believed to have been using drugs with other prisoners and was found with medication prescribed to another prisoner. Some of these matters resulted in adjudication and he received various punishments. (When a prisoner has been accused of breaking a prison rule, they must appear in front of a governor grade member of staff who listens to the evidence and decides whether the prisoner is guilty of the charge. If the prisoner is found guilty, the governor may impose a punishment, such as loss of earnings or cellular confinement for a period of time. This process is known as adjudication.)

33. On 3 December, he moved to The Verne. Normally, when a prisoner arrives at a new prison, he is assessed by a member of healthcare staff. The purpose of the assessment is to identify any immediate mental or physical health needs. He did not undergo such an assessment until 18 January 2010. (Healthcare staff were unable to clarify why the delay had occurred or what had triggered the review on 18 January.)

34. Senior Officer (SO) A carried out the Wing Manager’s Reception Interview with the man later on 3 December. He recorded that he had been monitored under F2052SH procedures about ten years earlier. He wrote that he had no drug or alcohol problems but, over the course of his sentence, had received 14 adjudications.

35. The man began attending education classes and, on 8 December, was seen rolling a cigarette during a lesson, which is against the rules. As a result he was given an Incentives and Earned Privileges (IEP) warning. (Through the IEP scheme prisoners can earn additional privileges, such as extra visits or having a television in their cell, by behaving responsibly and complying with the prison’s rules. There are three IEP levels: basic, standard and enhanced. Behaviour that does not meet expectations might result in the prisoner’s IEP level being reduced and them losing privileges.) At the time of the warning, he was a standard level prisoner.

36. On 3 January 2010, having moved to a single cell on C wing, he met his personal officer. (Personal officer schemes operate in most prisons in England and Wales. Officers working on the wings are allocated a number of prisoners for whom they act as the first port of call if the prisoner has any questions or concerns.) She made an entry in his prison file noting that he was “polite and respectful, open and honest, remorseful”. The officer told him that his offender supervisor was from the Offender Management Unit (OMU), and that he had an appointment with her on 8 January. (Offender supervisors are responsible for the day to day implementation of the individual’s sentence plan. They can be based in the community or in prison and play a large part in encouraging and motivating the individual. In prison, they write parole reports, attend parole hearings, complete risk assessments and answer the prisoner’s questions and concerns.)

37. In interview, the offender manager explained that she carries a caseload of about 75 prisoners. She has to prioritise her caseload by individual needs, risk of

serious harm and what stage each prisoner's sentence has reached. She said that she spends more time with prisoners who have important dates, such as parole hearings or release, approaching. However, she said that a prisoner on her caseload can request an appointment or make a written application and she will arrange to see them or deal with their enquiry.

38. It appears that the man went to see her some time before 8 January, although no date is recorded in the file. She told the investigator that, on their first meeting, he seemed "bouncy, full of life and bubbly". He told her that he was concerned about his parole process because he had not heard anything since transferring to The Verne. She said that the OMU did not yet have any information for him, but that she would contact him as soon as she did. He went to the OMU again on 8 January and she told him that she still had no news for him. She thought he was settling in to life at the prison well.

39. As noted earlier, the man did not undergo a medical assessment until 18 January, when he had an appointment with Nurse A. She recorded that he appeared to be fit and well, was not being prescribed any medication and had no outstanding medical appointments. However, he told her that he would like an appointment with the doctor because he had lost a lot of muscle over the past year and wanted to be prescribed dietary supplements. He said that he had used heroin in the past, but had not done so for the last ten years.

40. The nurse wrote that he seemed "slightly low" but did not want to be prescribed medication. She recorded that he had tried to hang himself in 1997 and cut his arms in 1999 but had not tried to harm himself since. He told her that he had been seen by the mental health team at Lewes. The nurse referred him to the doctor as requested.

41. At 5.05am on 22 January, an Operational Support Grade (OSG) working on C wing went to the man's cell because the television was playing loudly. When he opened the cell door, he was not in the room. (At The Verne, prisoners are not locked in their cells at any time, although they are supposed to stay in their room after 11.00pm on weeknights and 11.30pm at the weekend. Cell doors are fitted with "privacy locks" and each prisoner has a key to their own room. Staff also carry a key to override the lock, meaning that they can enter the rooms if necessary.) The OSG wrote in the man's wing file that he had checked the toilets and he was not there. He notified the duty night manager and other staff arrived on the wing to carry out a roll check (when every prisoner is checked and counted). When the room was checked again at 5.20am, he had returned. The OSG recorded that he thought he had been in another prisoner's cell. Staff issued him with an IEP warning.

42. The man had an appointment with the prison doctor on 25 January following the nurse's referral. He is a locum doctor but has been working at The Verne on a full time basis for about 18 months. The man told the doctor he had lost weight over the past two years, possibly due to stress. He complained of not sleeping well and feeling low. He wanted to avoid being prescribed medication but asked to be prescribed nutritional drinks. (In interview, the doctor explained that, at The Verne, he is able to prescribe Fortisips, a brand of nutritional supplement. He

said that such drinks are generally prescribed to patients who, due to serious illness, are unable to gain nourishment from food. The doctor said that Fortisips drinks are often traded with prisoners who enjoy body building and as such, have some "currency" in the prison. Because of this, he is reluctant to prescribe them unless absolutely necessary.) The doctor asked him to complete a food diary, recording what he ate and drank, and gave him another appointment for the following week.

43. The doctor told the investigator that the man said he was stressed because he was still relatively new at The Verne. However, he also told him that he had suffered with "long term chronic depression" since 1997, when he had first attempted suicide. Because his primary concern that day seemed to be his weight and body image issues, they did not discuss his depression in great depth.

44. On 29 January, the man went to the OMU and met his offender supervisor. She recorded in her contact sheet that he "clearly looks as though he has lost his spark". In interview, she explained that he was very quiet and not his usual self. He told her he was worried because he had not heard anything from the Parole Board. She said that he talked about having returned to a closed prison from open conditions and the stress of moving to several different prisons. He also talked about his "stupid" decision to leave Ford to get a takeaway. She explained:

> "I suppose I thought to myself … [that] he was very immature in that he didn't really think about the consequences, he acted for the here and now. He didn't really consider long term consequences of anything really … I got the impression that he was kind of easily led, you know, you could talk him into things and he wouldn't really see the bigger picture. As long as everybody was having a nice time then everything was fine."

45. He said that he had been to see healthcare staff but did not want to take medication. She noted that they had discussed whether he would benefit from counselling. He told her that he had been playing cards with other prisoners on C wing and she warned him about the company he mixed with, writing that "gambling card games are played on the wing". He assured her that the prisoners he played with were not involved in gambling. He told her that he wanted to do a plastering course and she agreed to contact the education department about this.

46. The investigator asked her whether she had ever been concerned that he might harm himself. She explained that although he had seemed quiet that day, nothing that he said that day, or on any other occasion, alarmed her or gave her reason to worry about him.

47. The man received another IEP warning on 31 January because he was not in his room during a roll check at 1.30am. He had also recently received a warning for twice being late for work and so staff began the process of downgrading his IEP status to basic. Two days later, staff decided that he should remain standard level for a 14 day trial period.

48. The doctor assessed him again, as planned, on 2 February. In interview, the doctor said that he seemed "very low compared to the week before". During the appointment he "threatened suicide". He told the doctor he was feeling low having been re-categorised from category D. He said he thought of suicide twice a day. The doctor explained that they discussed him being monitored on an ACCT plan, but he said that if the doctor opened an ACCT, he would deny ever having mentioned suicide and "will find the first opportunity to hang himself".

49. In interview, the doctor explained that he had never received ACCT training but had gained knowledge of the process during his time at the prison. The doctor said that he was concerned about the man and that, had he agreed, "I would have put him on [an ACCT plan] there and then". He explained that he became more concerned when he refused to be monitored under the ACCT process.

50. The man refused a prescription for antidepressants but agreed to talk to a mental health nurse. The doctor accordingly referred him to Nurse B, a primary mental health nurse. The doctor also prescribed one bottle of Fortisips per day because, he said, he hoped this would help calm his anxiety. In interview, the doctor explained that he discussed the man with Nurse B immediately following the appointment.

51. The doctor was asked whether he had considered letting staff on the man's wing know that he needed closer monitoring, without breaching patient confidentiality. (Medical information is confidential between the patient and medical staff and is not normally shared with non-medical staff. However, in certain circumstances, medical information may be shared with others.) He said that this was something he would have discussed with Nurse B. The doctor thought they probably had agreed to ask wing staff to keep an eye on him. However, there is no record of any such contact with wing staff in the man's file. In her interview, the nurse said that no decision to contact wing staff had been made.

52. Two days later, the man had an appointment with Nurse B. The nurse recorded that he seemed to be "settled" and made good eye contact. He told her that he had suffered depression in the past and had tried to kill himself twice before. He said that he felt as low in mood now as he had done when he first began his sentence. He admitted that he had been "silly" to have broken the rules at Ford. She advised him to see his experiences as a learning curve. She arranged to see him in two weeks.

53. The nurse said that, during the appointment, she asked him if he was thinking of killing himself and he said that he was not. She said that she urged him to be honest with her and he replied "I'm not thinking about suicide, it's just I'm low and upset". She said she would have opened an ACCT had she been worried about him.

54. On 7 February, he received another IEP warning for hosting a games party in his room after midnight. As a result, he was moved to basic level. At their next appointment a few days later, his offender manager told him that at his stage of a life sentence she did not expect him to be on a basic regime. In interview, she

explained that in order for him to move to category D conditions, he needed to be at least standard level. She said that his IEP level was something the Parole Board would consider and so it was important that he showed he could be trusted and comply with the regime. He "made light" of the situation and told her she was worrying for no reason.

55. The man did not attend his appointment with Nurse B on 17 February. (Prisoners are responsible for keeping their medical appointments in prison much as they would be in the community.) She said she was surprised that he did not turn up, but two days later they met by chance in the prison grounds. She asked him why he had not kept the appointment and he told her that he had overslept. She described him as seeming more cheerful. He saw a nursing assistant a week later because he wanted to be prescribed more Fortisips. She agreed to refer him to the doctor who continued the prescription for another week.

56. The man's personal officer made an entry in his wing file reviewing his recent behaviour. She wrote that he had a job in the wood mill but did all he could to avoid work. The officer noted that his behaviour had gradually deteriorated over the past few months and that he did not behave as a "lifer at this stage" should. She concluded by noting that he was enrolled on the Thinking Skills Programme (an offending behaviour programme) and might gain some insight into his behaviour as a result.

57. Nurse B recorded that he missed a second appointment with her on 3 March, but they did meet on 16 March. On that occasion, he said he had been coping well until the previous night when he had watched a television programme that made him think about his past and had left him feeling low. She gave him advice on "snapping out of thoughts" and suggested that he try and make contact with his mother. She gave him another appointment in four weeks' time.

58. The same day, a female member of staff complained that the man had made inappropriate comments to her. He denied this, but agreed to be careful how he talked to female staff in future. Two days later, his IEP status was reviewed but staff decided that he should remain at basic level.

59. On 19 March, he received a pair of trainers in the post. Generally, prisoners at The Verne are not allowed to receive shoes in this way. However, the security manager told the investigator that prisoners can make an application to the Governor. In certain circumstances they will be allowed the shoes, or may be given them if they move to a different prison. Staff became suspicious when he repeatedly asked for the shoes. As a result, staff checked them and found a quantity of drugs hidden in the heels. Another pair of trainers sent to him previously was then checked and the heels were also found to contain wraps of drugs. A Security Information Report (SIR) was completed and staff noted that the drugs might have been sent in for another prisoner, or so that he could settle gambling debts.

60. The security manager wrote that the large amount of drugs found suggested that the man was involved in drug dealing at The Verne. He concluded that he might need to be moved from the prison as he would no longer meet the criteria. He

directed that he be moved to the segregation unit. The information was passed to the prison's police liaison officer (a police officer who is based at the prison and can investigate alleged criminal offences).

61. The man was taken to the segregation unit that afternoon. The paperwork completed that day indicates that he was segregated under both Rule 53 (awaiting adjudication) and Rule 45 (removal from association for the maintenance of Good Order or Discipline, known as GOoD). The Security Governor noted that he was "happy" to be segregated and there were no concerns about him. However, staff were instructed to check him every hour. At 4.20pm, Nurse B visited him in segregation and completed the algorithm (an assessment that checks the prisoner is mentally and physically well enough to be segregated), recording that she had no concerns about him being segregated. In interview, she said that she was disappointed to learn that he had been segregated because she thought his mood was improving and he was beginning to live more healthily.

62. The following day, 20 March, Prisoner A approached staff and told them that he thought another prisoner had pressured the man into having the drugs sent in. The prisoner, who had been transferred to another prison, was interviewed by the Ombudsman's investigators. He said that the man had been using heroin from time to time at The Verne, but that because he did not have very much money, he did not use often. He thought that the man had some debts. He did not think that he had run them up through gambling, but said that they had never really discussed them.

63. Prisoner B, who had been transferred from The Verne, was interviewed during the investigation. He had been held in the segregation unit at the same time as the man and spoke to him regularly. He said that the man used heroin every day and had sold his Playstation to fund his habit. He said that another prisoner, who was dealing drugs in the prison, offered the man heroin if he agreed to have drugs posted to him. He did not think that the man had been in debt prior to the drugs being sent to him. However, he explained that because the drugs were confiscated by staff, the dealer would have considered the man to be in his debt.

64. At about 4.30pm on 20 March, the man spoke to a Listener (a prisoner trained and supported by the Samaritans to offer a confidential listening service to other prisoners). (At The Verne, Listeners visit the segregation unit every day between 4.15pm and 4.50pm and any prisoner held there can ask to speak to them. If a prisoner wants to speak to a Listener outside of their allotted visit to the unit, for example during the night, one is brought to the unit.) Segregation staff recorded in his segregation file that he was "in good spirits". However, three hours later, he asked for the Samaritans' telephone. (Many prisons have a dedicated telephone, sometimes a cordless or mobile telephone, which allows prisoners free access to the Samaritans' helpline. Prisoners are given the telephone to use in their cell, in private.) Officer A, one of the segregation unit officers, noted that his mood seemed to have changed and he wanted someone to talk to. The officer wrote that he was not thinking of harming himself but that he would monitor him anyway. He informed the duty manager and wrote that he would

speak to night staff about him when they began their duty. He returned the Samaritans' telephone at 8.50pm and "seemed a lot happier".

65. The officer was interviewed during the investigation. He said that during his time in the segregation unit, the man came across as a "happy go lucky, cheeky chappie" who was "lively, in a good, positive sense". He said that the two of them had built up a good rapport. The officer said that, at times, he seemed to get a bit frustrated and wanted someone to talk to. The officer said that from reading his file, he knew that he sometimes had periods of feeling low. He saw that staff at other prisons, for example at Lewes, had supported him by talking to him and so he did the same. Their conversations were of a general nature, and certainly he never told the officer that he was feeling depressed or suicidal. If he had, the officer said he would have begun ACCT procedures. The officer recalled that he seemed "annoyed" about the drug find and said that he had nothing to do with it. However, he did not tell the officer that he had been bullied or pressured by any other prisoner.

66. According to Prison Service Order (PSO) 1700 Management of segregation units, segregated prisoners must be visited every day by a governor grade member of staff, a doctor or nurse and a member of the chaplaincy team. The duty member of the IMB should visit as often as possible. Visiting staff must sign the segregation file to indicate that they have visited. For eight of the 19 full days the man was segregated it is not possible to tell whether all those with a mandatory duty to visit did so, because they have not signed the visitor sheet.

67. Shortly after he arrived in the segregation unit one of the prison chaplains visited him. The chaplain was interviewed as part of the investigation. He said that the man frequently attended chapel at The Verne and that they had had several long conversations since he arrived. The chaplain knew that he had experienced difficult periods during his sentence and had harmed himself in the past. However, he said that he never gave him, or any other member of the chaplaincy team, any indication that he might be thinking of harming himself. While talking about the reasons for his segregation, he told the chaplain that he had not arranged for the drugs to be sent to him. He said he was doing it as a "favour" for another prisoner. Despite the chaplain's encouragement, he refused to say anymore about the situation and would not name the other prisoner involved.

68. On 22 March, the Security Governor, Officer B, Nurse B and the man met to review his segregation status. The officer reported that he was well behaved, compliant and polite. The Governor told him that he would be transferred to another prison because he no longer fitted The Verne's criteria, and that he would remain segregated until his transfer. Nurse B recorded that he appeared "settled". She noted that he raised no concerns during the review and that she had no concerns about his mental state. He was no longer being checked every hour.

69. During her interview, the nurse explained that it is sometimes hard to properly assess the mental state of a segregated prisoner. She said that each segregated prisoner must be unlocked by two officers and there is little opportunity to talk privately with a prisoner. She thought that prisoners found it

hard to open up and admit to problems because of this. The nurse said that healthcare staff use their experience to judge whether a prisoner is coping in the unit or not. She told him that she would make an appointment for 12 April so she could assess him properly. However, she was clear that during her visits to the segregation unit, she never had any reason to worry that his mood was deteriorating.

70. The lifer manager visited the man in the segregation unit that day. He advised him that he would be transferred once a place at another prison had been found. He noted that he was "fully expecting this". Officer A agreed that the man knew he would be transferred and did not seem overly anxious or upset about this.

71. During the investigation, the lifer manager was interviewed by telephone. He said that trying to transfer prisoners from The Verne to other prisons is an "awful process" that generally relies on the goodwill of prison governors. He explained that it is particularly difficult to arrange transfers of prisoners who are being segregated.

72. According to him, the man had become "institutionalised" having spent so many years in prison. He had also been held in a number of establishments, many of whom did not want to take him back again. He said that he had been trying to get him transferred to Ashwell (where he had been before), but they were reluctant. At the time of his death, he was awaiting their decision. He explained that arranging the transfer of a "normal" prisoner could take a number of weeks but that it usually took even longer when they were a life sentence prisoner and segregated.

73. The lifer manager said that he visits segregated prisoners to discuss their transfer. He saw the man a couple of times while he was in the segregation unit and thought that he "seemed to quite like" being segregated. He said that he saw no signs that he was finding the wait for a transfer stressful. He knew that he was going to be moved from The Verne and gave the impression that he had no objections where he moved to. He said that it seemed that the man understood the situation and was "upbeat".

74. On 23 March, Prisoner C approached staff and told them that another prisoner had pressured the man into accepting the drugs in the post. He suggested that the man was in debt. The member of staff completed an SIR detailing the information. The prisoner was interviewed as part of the investigation. He said that he got to know the man through a mutual friend and often talked to him by shouting from the windows of one of the residential units while he was in the segregation unit exercise yard. He told the prisoner that he had been "stitched up" by another prisoner, who had the drugs sent to him. The prisoner said that the man was not expecting the drugs and so was upset. He thought he might have been in debt, perhaps through playing poker with other prisoners.

75. Prisoner D, the man's friend, was interviewed. He said that he and the man met while at Ashwell. While the man was segregated, the two men spoke every day. The prisoner said that on his arrival at The Verne, the man said he was fed up with being in prison and felt he was not getting any closer to release.

76. According to the prisoner, not long after arriving at The Verne, the man began using heroin “every now and again” to “get his mind out of prison”. He said that although it was harder to get hold of drugs at The Verne than some other prisons, it was still possible. He did not seek help for his drug use because he worried that admitting to using heroin would further delay his release. (All prisons in England and Wales have a substance misuse team who provide support and interventions to prisoners. Engagement is on a voluntary basis.)

77. The prisoner said he did not think that the man was the “sort of person” who could be pressured into trafficking drugs. He said that he had stood up to bullies throughout his sentence. However, he thought that he might have been offered “a deal” or an opportunity to earn money and he might have agreed to have the drugs sent to him. The prisoner said that wages at The Verne were very low and this was a particular worry for life sentence prisoners who were trying to save money for their release.

78. During their daily conversations, the man never gave him any reason to worry about him and “seemed happy enough”. However, the prisoner said that spending a long time in segregation could be very difficult for prisoners as it gave them too much time to think and this could “affect your mind”. He thought that The Verne needed to transfer prisoners more quickly.

79. On 25 March, the man cut his finger while in the segregation exercise yard. The wound was treated by Nurse A. Prisoner B told the investigator that he was also in the segregation unit at the time. He explained that, when he was segregated, the man began withdrawing from heroin and this made him feel very depressed and consider harming himself. A number of other prisoners thought that it was unfair that he had got into trouble but the prisoner who had arranged the sending of the drugs had not. The prisoner said that they put pressure on the other prisoner, who then threw a few packets of heroin over the segregation exercise yard fence. He said that the man cut himself trying to retrieve one that had got caught on the barbed wire. He said that the other prisoner considered that the man had now been “paid” and so he did not throw over any more packets. As a result, he said that the man began withdrawing again. He described the man’s life as “revolving around drugs”. Officer A said that segregation staff never had any suspicions that he was using drugs in the unit.

80. At 9.30pm on 27 March, the man asked for and was given the Samaritans’ telephone again. Over the following days, he was visited by the duty governor, chaplaincy and healthcare staff and all noted that there were no concerns. On 2 April, he asked Security Governor and a prison Governor about his transfer. He was told that the lifer manager was trying to arrange this.

81. A second segregation review took place on 4 April with the man, the Security Governor, the Head of Healthcare and Officer A present. The staff noted that he was polite and compliant and had a “good attitude”. No issues were raised and so the next review was scheduled to take place on 17 April.

82. During the investigation, the Security Governor said that he offered the man the chance to return to normal location on the wings while he waited for his transfer to be arranged. He said that he did not want to return to the wings because he might encounter problems there and preferred to remain in the segregation unit. None of this information is recorded in the segregation paperwork.

83. Prisoner E was held in the segregation unit at the same time as the man. He was interviewed as part of the investigation. He explained that the two men had known each other at a previous prison. He described him as a bubbly person, who was "always having a good laugh". The prisoner said that he had been upset about family problems and being in the segregation unit. The man had offered support and had also talked about his own family situation and having lost touch with his son. He said that the man was "pissed off about how the justice system was treating him", particularly because he had served nearly ten years more than his original tariff.

84. The prisoner saw that the man had scars on his arms and asked him about them. He told him that he had cut himself in the past but that "next time … that'll be it". However, the prisoner said that he never imagined that he might be thinking of harming himself again. He explained that the man had helped him through a very difficult time.

85. The chaplain told the investigator that a prisoner (who wished to remain anonymous but provided information through him) had been asked to go the segregation unit to support Prisoner E, who was struggling to cope. The prisoner also spoke to the man and found him to be "despondent". He was worried that, although the drugs find had not led to any disciplinary charges being laid against him, it would impede his sentence progression. The prisoner told the chaplain that the man said "they'll not get another Christmas out of me". The prisoner offered his support and encouragement. He did not pass any concerns to staff.

86. Officer C, segregation officer at The Verne since 2008, was interviewed as part of the investigation. He said that the man had been very helpful by supporting Prisoner E. The officer said that he and the man had got on well and described him as polite and funny. He said that he never gave staff any indication that he was struggling to cope or was thinking of harming himself. However, the officer was critical of the decision to hold him in segregation for such a long period of time. He explained that, although accused of being involved in drug dealing and trafficking, he had never faced an adjudication for this. He said that segregation staff understood that he was being segregated "pending an investigation", but he was not aware of the outcome of the investigation, or if one had been carried out.

87. The officer said that prisoners at The Verne sometimes spend long periods in segregation, particularly when they are being transferred to another prison. He said that it seemed to be very difficult to transfer life sentence prisoners. The officer thought that the man was getting frustrated about how long he had been kept in the segregation unit. He did not think that he would have taken his life had he been on normal location on one of the residential wings, because he would have been with his friends.

88. The prison doctor, who had been on leave since shortly after he saw the man in February, carried out the healthcare review of segregated prisoners on 6 April. He had no concerns about him and said that he saw no obvious deterioration in his mood or appearance since their last meeting. In interview, he explained:

> " … When I saw him in the segregation unit that day, I'll be perfectly honest, I'd forgotten that he was the guy that had told me all of these things because he was so different."

The doctor said that some prisoners held in segregation seemed to enjoy the "seclusion and quietness" of segregation, however, others struggled to cope in the unit. He said that he seemed to "actually improve and settle" during his time in the segregation unit.

89. The man continued to eat his meals, take exercise and socialise with other prisoners in the segregation unit. On 7 April, his IEP status was upgraded to standard due to his ongoing good behaviour. His friend, Prisoner E, was transferred to HMP Dorchester that day. In interview, he said that the man asked him to stay for another week. At the time, he was not concerned by this request.

90. The Verne's Listener Co-ordinator (and also a prisoner), was interviewed as part of the investigation. He said that two Listeners spoke to the man on 7 April and were concerned about him. (Information shared with a Listener is confidential, even after death. This means that Listeners who have information that a prisoner is thinking of harming himself must not pass that information to staff, although they can discuss it with other Listeners and the Samaritans, who support them. Similarly, they are not able to share confidential information with the Ombudsman's investigators. For that reason, there is no further information about the nature of their concerns.)

91. At about 8.45pm on 7 April, two Operational Support Grades (OSG) began their night shift. (OSG staff are not required to undertake the same duties as officers and receive less intensive training.) OSG A explained that the segregation unit is patrolled by one OSG at night and that the local policy directs that two OSG grade staff take turns to patrol the unit and the perimeter fence. He took the first shift in the segregation unit and received a handover of information from the evening staff. In interview, he said that night staff must familiarise themselves with any prisoner being monitored on an ACCT plan and carry out checks as directed on the ACCT booklet. In addition, he explained that more informal checks might be carried out if staff identify that a prisoner is upset or there are other concerns. Evening staff did not mention having any concerns about the man during the handover.

92. The OSG explained that night staff must undertake "pegging" patrols of the segregation unit. (Pegging is a method for recording that staff have patrolled an area of a prison. Normally it involves either pressing buttons or touching electronic devices located in around the area being patrolled. In the segregation unit at The Verne, staff must press a button located outside each cell.) However, he said that, at the time, there were conflicting instructions about what pegging involved and how often it should be done. He said that one policy instructed staff

to peg outside each occupied cell once every half an hour, but did not specify that staff should check the prisoner inside the cell. Another policy instructed staff to peg outside each cell once an hour and visibly check the prisoner in the cell. He said that he took the latter approach. He explained that, in order to check the prisoners, he looked through the observation hatch in each cell door, turning on the cell light if necessary.

93. At some point between 12.40am and 1.10am, he carried out his last pegging round before swapping roles with OSG B. He remembered checking the man and saw "the glowing ember of a cigarette". He explained that he was satisfied that there was nothing amiss and so he did not disturb him any more or switch on the cell light.

94. OSG B was also interviewed during the investigation. He explained that he usually works day shifts and had received no formal training to undertake night shifts. He understood the instructions to be that staff carry out pegging patrols once every half an hour. However he did not think staff need to visibly check the prisoners in the unit during the night (unless there is a reason to do so). As a result, he did not visibly check the man between 1.10am and 6.00am. He described his time in the unit that night as quiet. He was not aware of any problems and the man did not press his cell bell at any point. (Each cell in the segregation unit is fitted with an emergency bell which prisoners can use to alert staff attention. The bell can only be silenced by a member of staff pressing a button outside the cell.)

95. OSG A took over in the unit at about 6.00am. He explained that on returning to the unit, he always carries out a pegging round whether one is due or not. On checking the man, he saw him sitting up in bed and thought no more of it. Although staff need only carry out pegging duties until 6.00am, he said that he checked the prisoners again at 7.15am. He looked into the man's cell and saw that he was still sitting up in bed. As he moved away to check the next cell, he realised that "something wasn't right". He looked carefully into his cell and realised that he had a ligature tied around his neck.

96. At 7.17am, he used his radio to inform staff of an "urgent message" (a special use of words which indicates an emergency situation). SO A was the night orderly officer (in charge of the prison) that night. She was interviewed during the investigation and explained that, as the night shift ends at 7.45am, she and two officers who had been working that night, were in the gate house returning their keys. On hearing the urgent message, the three staff members went straight to the segregation unit.

97. On entering the unit, they met the OSG who directed them to the man's cell and told them that he had hanged himself. The SO explained that, according to the local policy, it was up to OSGs whether they were comfortable going into a cell alone in an emergency situation. The OSG understood that he was not allowed to do so until other staff had arrived.

98. The SO said that she was fumbling with her keys, trying to unlock the door (it transpired she had picked up the wrong set of keys as she left the gate house).

She asked Officer D to get the cell key from the OSG's sealed pouch. (During the night, only the night orderly officer carries a cell key. In an emergency, other staff use a cell key contained in a sealed pouch. If a sealed pouch has been opened, paperwork must be completed explaining why.) As they went into the cell, the SO instructed staff to call for an ambulance. The prison log records that this was done at 7.22am.

99. The officer used his anti-ligature knife (a knife specially designed to safely cut ligatures from around the neck) to cut the ligature. In interview he explained that the ligature (made from a torn piece of bedsheet) was tied to the cell window bars. The staff checked for a pulse and signs of breathing but found none. During the night, there are no healthcare staff on duty at The Verne. The SO, officer and OSG said that they had not recently received any emergency first aid training, although they all said that they were prepared to attempt cardiopulmonary resuscitation (CPR). The SO and officer tried to lay the man on the cell floor. As they did so, they realised that his body was stiff and cold and thought that he had died.

100. The ambulance crew arrived at the cell at 7.38am. They quickly established that nothing could be done to resuscitate the man and pronounced his death at 7.40am.

**Post mortem**

101. The post mortem report concluded that the man died as a result of hanging. Toxicology screening revealed no drugs or alcohol in his body at the time of his death.

**Contact with the man's next of kin**

102. When he arrived at the prison the man did not provide any next of kin contact details to reception staff. However, during his induction interview, he gave the name and address of his close friend, who visited him regularly. Prison staff searching for next of kin details were unsure whether his friend was in fact his nominated next of kin or not. At 11.00am, they telephoned her to clarify the position and to ask if she had any contact details for members of his family. However, she had already been telephoned by a visiting chaplain (who was not permanently attached to The Verne but sometimes carried out pastoral work there). He told her of the man's death. She was upset that someone not employed by the prison had learnt of his death before she had.

103. Two family liaison officers were appointed, a governor and an officer. They made contact with the man's friend that day. She praised the support she received from the two appointed prison family liaison officers. In line with PSO 2710, follow up to a death in custody, the prison offered to make a financial contribution to the cost of the funeral.

## Support for prisoners

104. On 9 April, the Safer Custody Governor held a drop in "surgery" for prisoners on the man's former wing. A member of healthcare staff and a residential manager were also present to offer support to prisoners. The Safer Custody Governor also held a meeting for Listeners, to check their wellbeing and offer support.

105. A memorial service was organised by the chaplaincy team. The man's friend was invited to attend along with prisoners at The Verne.

## Support for staff

106. All staff interviewed as part of the investigation were asked whether they had received sufficient support from the prison in the follow up to the man's death. Generally, they agreed that they had been well supported, although several said that they had sought support from family, partners or close colleagues, rather than from the prison Care and Welfare Team.

107. Shortly after the man's death, a hot debrief was held. (Holding a hot debrief is a requirement of PSO 2710, Follow up to a death in custody. Its purpose is to allow staff involved in responding to a death in custody to talk about what has happened and how they are feeling.) However, the SO explained that she and the other staff who had found the man, were allowed to go home before the hot debrief took place. A critical incident debrief was held on 5 May.

108. Members of healthcare staff felt they had been less well supported by their managers or the PCT. They did not attend any debriefs and said that the first opportunity they had to talk about their contact with the man came when they were interviewed as part of this investigation.

## ISSUES

### Clinical care

109. NHS Dorset commissioned a clinical reviewer to review the clinical care the man received at The Verne. According to PSO 3050, Continuity of healthcare for prisoners, an initial assessment of the healthcare needs of newly arrived prisoners must take place within 24 hours of their first reception. The PSO advises that "there are good reasons … to ensure that [transferred prisoners] are seen by a member of the health care team before the prisoner's first night … ". However, the PSO does not direct that a full assessment must be undertaken. He did not undergo a full medical assessment until he had been at The Verne for some six weeks. Healthcare staff spoken to as part of this investigation were unable to explain why this was the case or what eventually triggered the assessment. Following the assessment in January, he asked to be referred to the doctor. Thus, had he been assessed on his arrival, he might have been referred to the doctor six weeks earlier than he eventually was.

110. There are clearly good reasons for prison healthcare teams to undertake their own assessment of a transferred prisoner's health needs as soon as possible. The PSO is somewhat unclear about the obligations on receiving prisoners. However, I made a recommendation to The Verne about this in relation to a death that occurred in 2008.

    **The Head of Healthcare should devise a local protocol outlining the health assessment process for newly transferred prisoners.**

111. The clinical reviewer highlights that, having initially resisted prescribing the man nutritional build-up drinks, the prison doctor eventually did so. In interview, the doctor explained that such drinks are popular with body builders and, as such, have a certain currency in the prison. Prisoners might request them in order to trade them with other prisoners. Although apparently worried about his weight loss and body image, there was no medical reason for prescribing the drinks to him. The reviewer concludes that the use of such drinks should be limited to those who require them on medical grounds. He makes the following recommendation to NHS Dorset:

    **NHS Dorset should monitor the prescribing of build-up drinks in its prisons and have guidelines for their use.**

### The failure to instigate ACCT procedures

112. On 2 February, the man had an appointment with the prison doctor during which he said that he thought of suicide twice a day. When the doctor suggested that he be monitored under ACCT procedures, he refused. He threatened to kill himself at the "earliest opportunity" if the doctor opened an ACCT plan. The doctor agreed not to begin ACCT procedures if he met one of the prison's mental health nurses. The doctor discussed him with Nurse B, who assessed him two days later.

113. The doctor told the clinical reviewer that he had been acting as the prison doctor on a locum basis for 18 months. During that time he had received no formal training (other than security training) to equip him for the position, including training in the ACCT process. According to the mandatory instruction contained in paragraph 1.2.1 of PSO 2700, Suicide prevention and self harm management, "*all staff in contact with prisoners must be trained to at least ACCT Foundation level … and when caring for at-risk prisoners follow the ACCT procedures …".* (All mandatory actions in PSOs are written in italics.) Paragraph 1.2.2 directs that "[w]*henever any member of staff believes a prisoner is at risk of suicide or self-harm they must open an ACCT Plan"*. This instruction covers all members of staff who have contact with prisoners, no matter their employer or function.

114. The doctor said that he had picked up a working knowledge of the ACCT system and had used it with other prisoners he considered at risk. Clearly, given that the man told him he was thinking of killing himself, he should have opened an ACCT plan immediately. However, it would be manifestly unfair to criticise a member of staff who has not received the requisite training to allow them confidence in their decision making. The investigator highlighted the doctor's lack of training to the Deputy Governor in person, immediately following the interview and in writing to the Governor. In addition, I make the following recommendation:

    **The Governor and Head of Healthcare should:**
    **a) carry out an immediate audit to identify any staff who have not received mandatory training,**
    **b) ensure that any staff who have not yet received ACCT training do so as a matter of urgency, and**
    **c) repeat the audits on a regular basis to ensure that all staff, including new and temporary members, receive mandatory training.**

115. Despite the initial failure to place the man on an ACCT plan, all staff who came in to contact with him after 2 February agreed that he showed no signs of feeling suicidal or vulnerable. Nurse B assessed him on 4 February, just two days after his appointment with the doctor. She was not sufficiently concerned about him to consider opening an ACCT on that occasion. He told her that while he felt low, he was not thinking of harming himself. Over the following weeks, she met him several times, including while he was in segregation, and thought that his mood had improved. All staff spoken to as part of the investigation expressed their astonishment on hearing that he had taken his life. Staff working in or visiting the segregation unit agreed that he appeared, outwardly at least, upbeat and cheerful. Those staff who are trained in ACCT procedures were clear that they would have opened an ACCT had they had any concerns about him.

**The use of Segregation**

116. On 19 March, two pairs of shoes which had been sent to the man were searched and found to contain a large quantity of cannabis. Because prisoners are not allowed to receive shoes through the post, they had been kept in the reception area. At no time had he had access to the shoes, or the drugs hidden in them.

117. Segregated prisoners are usually subject to a restricted regime and so the limited grounds on which they may be segregated are clearly set out in national policies. Under Rule 45 of the Prison Rules, a prisoner may be removed from association (segregated) "where it appears desirable for the maintenance of good order or discipline or in his own interests … " (GOoD). Rule 53 states that "a prisoner who is to be charged with an offence against discipline may be kept apart from other prisoners pending the governor's first inquiry".

118. As soon as the drugs were found, the man was moved to the segregation unit. The paperwork notes that he was initially being segregated under both Rule 45 and Rule 53. The security manager explained that it would be difficult, if not impossible, to prove that he had anything to do with the drugs being sent in, or even that he knew of their existence. (Some of the prisoners interviewed during the investigation thought that he was involved in the drugs being sent to him, others thought he knew nothing about it. The security manager mentioned other circumstantial evidence suggesting that he was at least aware of them.) As a result, he was not charged with a disciplinary offence and so never faced adjudication for the matter. The drugs find was referred to the police, who decided not to investigate.

119. Given that the man did not face adjudication, the only grounds to hold him in Segregation were under Rule 45. According to PSO 1700:

> "Prisoners are only segregated for reasons of Good Order or Discipline when there are reasonable grounds for believing that the prisoner's behaviour is likely to be so disruptive or cause disruption that keeping the prisoner on ordinary location is unsafe."

The policy goes on to say that the person authorising segregation should assess whether the situation could be "better addressed by adopting alternative arrangements".

120. I am not convinced that the decision to segregate the man was in accordance with PSO 1700. It is my view that a more proportionate response would have been to allow him to remain on normal location, monitored more closely by staff, and subject his incoming and outgoing post to rigorous searching. The lifer manager explained that transferring a life sentence prisoner was very difficult but even more so if they were segregated. He said that he was struggling to find a prison willing to accept him. It is possible that he would have been transferred more quickly had he not been segregated.

121. Staff who had contact with the man over the last two weeks of his life said that there were no signs that he was struggling to cope with segregation. Nevertheless, there is evidence that segregation can negatively impact on a prisoner's mental health. The Ombudsman noted in his 2005-2006 Annual Report that segregation units are "places of isolation, with little means of occupation or distraction". Furthermore, PSO 1700 notes that segregation has a "negative impact" on the mental health of most segregated prisoners. I am pleased that, while segregated, he was provided with a television and allowed to attend a course. He mixed with other segregated prisoners and even made

friends there. His physical and mental health was reviewed by healthcare staff and they also had no concerns about him. I accept that staff had no reason to suspect he might be a risk to himself. Although it seems that some prisoners did have concerns about him, these concerns were not passed to staff.

122. During the course of the investigation several people expressed their concerns about the use of segregation at The Verne, particularly the reasons for segregation and the time spent segregated. The prison provided the investigator with segregation statistics covering the period January to May 2010. During that period, prisoners were segregated on 49 occasions (some prisoners were segregated more than once). On 27 occasions, the reason for the segregation was GOoD and 13 prisoners (including the man) spent more than seven days in segregation. Six prisoners spent more than 20 days in segregation during that period.

123. The security manager and Security Governor confirmed that the man was being segregated on the basis that he no longer fitted the criteria for The Verne. (As noted earlier, one of the acceptance criteria stipulates that the prisoner must not have any significant history of prison drug trafficking or dealing.) Other interviewees mentioned that prisoners who did not meet the criteria were routinely segregated until they could be transferred to another establishment.

124. The investigator raised the issue with the Deputy Governor, who confirmed that this was the case. He said that senior NOMS staff had instructed the management team to segregate any prisoner who does not meet the acceptance criteria while they await transfer. I am deeply concerned that prisoners who do not meet the criteria (sometimes through no fault of their own) may find themselves segregated for lengthy periods. It is my view that the use of segregation at The Verne requires a thorough review, and that the management team will need support from NOMS to do this. I make the following recommendation:

**The Governor, with support from NOMS headquarters, should conduct a thorough review of the use of segregation at The Verne and ensure that it is compatible with national policies.**

125. The Security Governor told the investigator that, when offered the chance to move back to the wing, the man declined, stating that he might encounter problems there. This important information is not recorded in any of the segregation paperwork, and should have been. Furthermore, his concerns should have been referred to the safer prisons team – of which I write more below.

**The Governor should remind staff to record all relevant information in the prisoner's segregation file.**

126. Under PSO 1700, while a prisoner is segregated, specific members of staff must visit on a daily basis and sign the necessary paperwork. While on most occasions the visits were undertaken in accordance with the PSO, this was not always the case, or at least the paperwork was not signed. PSO 1700 highlights that the purpose of such visits is, amongst other things, to ensure that prisoners are being held safely and fairly. This is an important safeguard in the segregation process and can help to mitigate against the negative effects of segregation. I make the following recommendation:

**The Governor should ensure that daily visits to the segregation unit are carried out and recorded in accordance with PSO 1700.**

**Whether the man was subject to bullying by prisoners or staff**

127. The man's friends were divided on whether they thought he had been a willing participant in the attempt to smuggle drugs, or whether he had been put under pressure by another prisoner (or prisoners). Several knew that he had begun using heroin again, and some said that he was involved in gambling. It appears that he had got into debt while at The Verne. The fact that the drugs had been found and confiscated by staff might well have left him in even more debt – even if he had nothing to do with their trafficking.

128. Shortly after the drugs had been found and he had been segregated, two prisoners approached staff telling them that he had been pressured into receiving the drugs. On each occasion, an SIR was completed. The SIR includes a list of actions that might be taken as a result of the information. One such option is to inform the "anti-bullying co-ordinator" and/or the "suicide prevention co-ordinator". In many prisons, violence reduction and suicide and self harm prevention functions are fulfilled by the same team. At The Verne, the safer prisons team is responsible for both. It appears that the information provided by the two prisoners was not passed to the safer prisons team. Certainly the Safer Custody Governor said that she was not aware of the allegations. It appears that there was no further investigation of the allegations.

129. While in the segregation unit, the man was offered the opportunity to return to normal location. He told the Security Governor that he did not want to because he might encounter problems there. I think this warranted further investigation to see if he was worried about being bullied. Again no further action was taken to investigate the nature of his concerns and the Security Governor was not informed. I make the following recommendation:

**The Governor should remind all staff that any allegation or suggestion of bullying or intimidation should be referred to the safer prisons team and investigated.**

130. Early on in the investigation, the investigator was told that a prisoner had made a complaint alleging that the man had been bullied by segregation staff. Prisoner B had been segregated at The Verne at the same time as the man, but had since

transferred to HMP Dorchester. During his interview with the investigator, he clarified that he did not think that the man had been bullied by segregation staff. The man himself made no complaints while he was segregated. Other prisoners interviewed said that he had never mentioned being bullied by staff and thought it unlikely that this would have happened. Generally, prisoners were positive about staff.

131. Staff interviewed during the investigation, including the chaplain whose role includes monitoring the segregation unit, said they had no concerns about the behaviour of staff in the unit. None had received any information suggesting that the man was bullied by staff while segregated.

**Overnight checks on prisoners in the segregation unit**

132. In interview, OSG A, OSG B and the SO highlighted that there were conflicting policies relating to the overnight checking of segregated prisoners. OSG A said that he chose to follow the policy that directed that night staff carry out pegging rounds and visibly check each segregated prisoner once an hour. OSG B, who was less used to working the night shift, thought that he needed to carry out pegging rounds every half an hour. He did not think he needed to check the prisoners as he did so.

133. The SO said that she had noted the contradictory instructions and, since the man's death, had written a new "aide memoir" to staff. The aide memoir instructs night staff in the segregation unit to carry out pegging rounds and check each prisoner twice an hour. The instructions contained in the document provide clarity to night staff.

134. Had OSG B followed the pegging instructions set out in the SO's document, it is possible that the man might have been found much earlier than he was. The following recommendation is made with that in mind.

**The Governor should devise a single policy for night patrol staff working in the segregation unit, drawing on the SO's aide memoir.**

**The emergency response**

135. OSG A realised that the man had a ligature around his neck at 7.17am and used his radio to communicate an "urgent message". The OSG said that he was not happy to enter the cell until other staff had arrived. The SO's instructions outline that the preservation of life takes precedence, but that night staff should not take action that they feel would put themselves or others in unnecessary danger. On that basis, I believe the OSG's decision to wait for other staff was reasonable.

136. However, staff responding to the urgent message had no idea what situation they were facing when they arrived in the segregation unit. They brought no emergency first aid equipment with them in preparation. Additionally, given the severity of the situation and the relative geographical isolation of the prison, an ambulance should have been called immediately. While I do not think the

introduction of a code system would have altered the outcome for the man, it may do in a future incident.

**The Governor should consider introducing a code system which provides information about the nature of the emergency and allows for appropriate action to be taken swiftly.**

137. Sadly, when staff reached the man, they realised that nothing could be done to resuscitate him. This was confirmed by the paramedics who arrived shortly after. While staff who responded said that they would have been prepared to attempt CPR, none had received any recent training. Given that The Verne does not have 24 hour healthcare I think it is imperative that staff on duty at night are equipped to deal with first aid emergencies while waiting for health professionals to arrive. As a night orderly officer (senior officer grade staff) is always on duty at night, it might be sensible to begin by ensuring that all those who might be expected to fill this position receive the relevant training.

**The Governor should establish the number of emergency first aid trained members of staff in the prison and assess whether this provides adequate cover for when healthcare staff are not on duty.**

138. Members of staff involved in the immediate response said that they did not attend a hot debrief on 8 April because they had been allowed to go home before it took place. I appreciate that the decision to allow them to leave was made with the very best of intentions. However, the hot debrief provides an opportunity to reassure staff and this is likely to be particularly important for those who were involved in the response. I make no recommendation but highlight it as a learning point for managers.

139. Healthcare staff who had contact with the man while at The Verne felt that they had been less well supported. They had not had an opportunity to talk about their contact with him or the decisions they had made in relation to him until interviewed as part of this investigation. Again, I make no formal recommendation, but suggest that the head of healthcare considers the support available to her staff should a similar incident occur.

**Contact with the man's next of kin**

140. On his arrival at The Verne the man did not provide any next of kin details, but during an induction interview he gave the name and address of his close friend. After his death, prison staff searched his file for family contact details. They found his friend's details and also saw that she had visited him regularly. However, staff remained confused about whether she was in fact his next of kin.

141. Prison staff telephoned the man's friend at 11.00am on 8 April. During the conversation she was asked if she had any contact information for his family. She confirmed that she was his listed next of kin. Under PSO 2710, news of the death should not be broken to the next of kin by telephone, unless there are exceptional reasons for doing so. I appreciate that, on this occasion, confusion about his next of kin affected the manner in which the news was delivered. I am

pleased to report that The Verne has introduced a system for checking prisoners' listed next of kin on a yearly basis. I hope this will avoid a similar situation occurring in future.

142. However, the man's friend said that she received a telephone call from a visiting chaplain at about 8.45am on the morning of 8 April informing her of his death. His friend was upset that people from outside the prison had found out about his death before she had. I accept that it is very difficult to prevent news of a death in custody from spreading quickly beyond the prison walls. It is most unfortunate that the chaplain took it upon himself to break the news himself, seemingly without discussing this with anyone at the prison. I am sure he did so with the best of intentions and I appreciate that it occurred on this occasion because of a very specific set of circumstances. It is not possible to legislate for every eventuality and I do not think there is any recommendation I could make which would ensure it did not happen again.

## CONCLUSION

143. By the time he arrived at The Verne in December 2009, the man had already served 18 years of a life sentence – eight years beyond the tariff set at court. He had spent time at a large number of prisons and had twice failed in category D conditions. At times over the course of his sentence, he had complained of depression and suicidal thoughts and on at least two occasions, he had harmed himself. While at The Verne, he again admitted to feeling suicidal but he was not placed under ACCT monitoring procedures.

144. On 19 March, a large amount of cannabis was found in two pairs of shoes sent to him. He was segregated as a result and the process of transferring him to another prison began. In April, during a routine check at 7.15am, he was found in his cell in the segregation unit with a ligature around his neck. His death was pronounced by paramedics shortly after.

145. I have made ten recommendations as a result of this investigation. Several centre on my concerns about the use of segregation at the prison. I am not convinced that the decision to segregate him was reasonable or proportionate. However, this is an issue which may well go beyond the prison management team. I have also made recommendations in relation to mandatory training and investigating allegations of bullying, and two concerning healthcare.

146. I accept that, outwardly, he generally appeared to be cheerful and "happy go lucky". Staff who had contact with him in the weeks and days before his death saw no indications that he was vulnerable or posed a risk to himself. The prisoners who had concerns about him either could not or chose not to tell staff of their worries. In that sense, I do not think that his death was foreseeable. However, it is my view, and one that is shared by some of those interviewed as part of the investigation, that he was affected by his segregation.

## RECOMMENDATIONS

NOMS has responded to the recommendations made. The response is included in italics beneath each recommendation.

1. The Head of Healthcare should devise a local protocol outlining the health assessment process for newly transferred prisoners.

*This recommendation has been accepted*. *"Prisoners are initially screened on Reception by Health Care but a prioritisation protocol for full assessments will now be devised."*

2. NHS Dorset should monitor the prescribing of build-up drinks in its prisons and have guidelines for their use.

*This recommendation has been accepted. "PCT and Healthcare Managers to discuss and implement guidelines area wide."*

3. The Governor and Head of Healthcare should:
    a) carry out an immediate audit to identify any staff who have not received mandatory training,
    b) ensure that any staff who have not yet received ACCT training do so as a matter of urgency, and
    c) repeat the audits on a regular basis to ensure that all staff, including new and temporary members, receive mandatory training.

*This recommendation has been accepted. "ACCT training has been provided to existing health care staff during Sept/Oct 2010. The Health Care Manager should review this and ensure that a list of staff still requiring training is passed to the Training Manager urgently. Thereafter ACCT training should be detailed on any new member of staff's induction programme and must be signed off as completed within a month of their appointment."*

4. The Governor, with support from NOMS headquarters, should conduct a thorough review of the use of segregation at The Verne and ensure that it is compatible with national policies.

*This recommendation has been accepted. "Initial talks between the Area Manager and Governor have taken place. Arrangements to move any prisoners who are 'out of criteria' have been made with HMP Dorchester to reduce the numbers of segregated prisoners and the time they spend in the unit. A detailed review should now be conducted by the Segregation Manager to identify further issues which need to be addressed or improved."*

5. The Governor should remind staff to record all relevant information in the prisoner's segregation file.

*This recommendation has been accepted. "A reminder has already been issued and duty governor daily checks now include ensuring health care visits have been made and recorded daily."*

6. The Governor should ensure that daily visits to the segregation unit are carried out and recorded in accordance with PSO 1700.

*This recommendation has been accepted. "A Notice to Staff is to be issued to reinforce this. Duty Governor routine checks to ensure compliance are now in place as detailed above."*

7. The Governor should remind all staff that any allegation or suggestion of bullying or intimidation should be referred to the safer prisons team and investigated.

*This recommendation has been accepted. "Staff are routinely reminded through the monthly Safer Custody Committee meeting minutes which are available to all staff and publicity around the prison, staff guides etc. An information sharing meeting takes place monthly between the Interventions dept, Security dept, REO and Head of Safer Custody to ensure any potential bullying issues are raised, discussed and resolved where possible. A 'live' anti bullying log detailing all suspicions, allegations and proven incidents of bullying is held on the Z drive for all staff to access. A notice to staff has been issued by the Head of Safer Custody in October 2010 reminding staff of these systems."*

8. The Governor should devise a single policy for night patrol staff working in the segregation unit, drawing on the SO's aide memoir.

*This recommendation has been accepted. "Segregation Unit Manager to produce and publish an agreed protocol."*

9. The Governor should consider introducing a code system which provides information about the nature of the emergency and allows for appropriate action to be taken swiftly.

*This recommendation has been partially accepted. "A code system is already in place. Staff will be reminded of its purpose and when to use it."*

10. The Governor should establish the number of emergency first aid trained members of staff in the prison and assess whether this provides adequate cover for when healthcare staff are not on duty.

*This recommendation has been accepted. "Training Manager to review and advise the Governor accordingly."*