A Report by the Prisons and Probation Ombudsman Nigel Newcomen CBE

Investigation into the death of a man in July 2014 at HMP Wandsworth

Our Vision

To be a leading, independent investigatory body,
a model to others, that makes a significant contribution to
safer, fairer custody and offender supervision.

This is the investigation report into the death of a man who was found dead in his cell at HMP Wandsworth on 28 July 2014. The man was 41 years old. I offer my condolences to the man's family and friends.

An investigator was appointed. A clinical reviewer reviewed the man's clinical care in prison. The prison cooperated fully with the investigation. The investigation was suspended for some time because of the need to wait for a post-mortem report giving the cause of death. I am sorry for the consequent delay in issuing this report.

The man was remanded to HMP Belmarsh on 4 March 2014 and was transferred to Wandsworth on 7 May. He had a history of drug use, particularly cocaine, although he said that he was not dependent on drugs.

On 27 July, closed circuit television footage showed the man apparently secreting an item passed by a visitor, although he denied this. He was segregated in line with the prison's policy for dealing with prisoners suspected of concealing drugs. However, staff did not follow the instructions in the policy: they did not regularly check the man and a nurse did not take baseline clinical observations.

At 8.30am on 28 July, officers unlocked the man's cell and found him unresponsive on the floor. Attempts to resuscitate him were unsuccessful. The post-mortem examination found that the man died from acute heroin intoxication and pneumonia.

The investigation found a number of deficiencies in the management of segregated prisoners at Wandsworth, particularly those segregated on suspicion of concealing items internally. I am also concerned about the apparently lax attitudes of night staff who did not observe prisoners in the segregation unit throughout the night as they are expected to do.

The 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.

Nigel Newcomen CBE
Prisons and Probation Ombudsman **August 2015**

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SUMMARY

1. On 4 March 2014, the man was remanded to HMP Belmarsh, charged with drug offences. A nurse recorded at his first health assessment that he had some substance misuse issues. Later that month, the man was sentenced to two years eight months in prison. He was transferred to HMP Wandsworth on 7 May.

2. On the afternoon of 27 July, during a visit, supervising staff suspected that a friend of the man's had passed something to the man, which he had hidden in his anal passage. In line with Wandsworth's policy for dealing with such incidents, staff took the man to the segregation unit. Although no one recorded what they suspected the man had hidden, the implication was that they considered it was illicit drugs.

3. The duty nurse, who assessed whether the man could be segregated, said that she did not know he had secreted an item and so she did not carry out any clinical baseline observations or comply with the instructions set out in the policy. Contrary to the policy, the duty governor who authorised the man's segregation did not set a level of observations. Although the expected practice in the segregation unit was to check all prisoners at least once an hour, the night duty officer did not conduct regular checks during his shift. No one checked the man between 12.30am and 8.30am on 28 July.

4. At around 8.05am on 28 July, an officer knocked on the man's cell door to wake him but he did not respond. The officer saw that he was lying on the floor but did not regard this unusual and assumed he was asleep. At about 8.30am, officers went to unlock the man's cell to take his meal orders and allow him to collect hot water. The man could not be roused. An officer established that he was unconscious and tried to resuscitate him while other officers raised the alarm. Nurses arrived at the cell very quickly and took over the resuscitation attempt. Paramedics arrived at around 8.45am. They could not resuscitate the man and an emergency doctor pronounced his death at 8.57am.

5. We are concerned that the man's care in the segregation unit fell below an acceptable standard. Staff involved in his initial segregation did not follow the local policy to take clinical observations and set an appropriate level of checks. Staff did not comply with standard segregation practice of checking prisoners once an hour during the night; had they done so, they might have realised that he was unwell. The investigation also identified inappropriate practice by night staff at Wandsworth and a need to ensure appropriately resourced family liaison. We have made three recommendations.

THE INVESTIGATION PROCESS

6. The investigator issued notices to staff and prisoners at HMP Wandsworth informing them of the investigation and asking anyone with information to contact him. No one responded.

7. The investigator visited Wandsworth on 29 July and met the Governor, Head of Healthcare and a representative from the Independent Monitoring Board. He visited the segregation unit and obtained copies of relevant extracts from the man's prison and healthcare records.

8. NHS England commissioned a clinical reviewer to review the man's clinical care in prison. The investigator and clinical reviewer interviewed 14 members of staff and three prisoners during the investigation, some jointly. The investigator informed the deputy governor about his preliminary findings.

9. We informed HM Coroner for Inner West London District of the investigation. Our investigation could not proceed until the post-mortem and toxicology results were available. We regret that this delayed the publication of this report. We have sent the coroner a copy of this report. At the draft report stage, the National Offender Management Service (NOMS) responded to the recommendations. That response is included below the recommendations at the end of this report.

10. One of the Ombudsman's family liaison officers contacted the man's partner to explain our investigation and to ask if she had any matters she wanted the investigation to consider. The man's partner had the following concerns:

    - When she saw the man two days after his death, his face looked bruised and he had a cut on his head. She wanted to know if had been assaulted after he was segregated and asked if there was any closed circuit television (CCTV) footage of the man being taken to the segregation unit on 27 July.
    - She wanted to know more about what had happened to the man on 27 and 28 July, as she had been given conflicting information about the sequence of events.
    - She believed the man would have asked staff to help him if he felt unwell and wanted to know if the segregation unit had an electronic cell bell system, and whether the man had pressed his bell after he was segregated on 27 July.
    - She complained of receiving inadequate support from the prison's family liaison officer and said she had eventually had to ask a senior prison manager.

    The man's partner received a copy of this report. She did not make any comments.

HMP WANDSWORTH

11. HMP Wandsworth is a local prison in London which holds up to 1,656 men in eight residential wings and primarily serves the courts in south London. St George's University Hospitals NHS Trust and its partners provide healthcare services at the prison.

HM Inspectorate of Prisons

12. The report of the most recent inspection of Wandsworth in February/March 2015 has yet to be published. However, we understand from initial feedback that inspectors had concerns about safety at the prison. In 2013, inspectors noted that the management of the segregation unit was good, with a published strategy, setting expected working practices.

Independent Monitoring Board

13. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help ensure that prisoners are treated fairly and decently. In its 2013-14 annual report, the IMB highlighted that there had been an increase in the number of segregated prisoners (509 spells of detention compared to 328 the previous year) but were impressed with the professionalism of the staff in dealing with difficult prisoners.

Previous deaths at Wandsworth

14. There were ten deaths at Wandsworth in 2014. The man's was the only one to have occurred in the segregation unit. There are no similarities between the circumstances or the findings of this investigation and those conducted into the other deaths in 2014.

Segregation unit

15. Segregation units (sometimes known as care and separation units, as is the case at Wandsworth) are used to keep some prisoners apart from others. This can be because they feel vulnerable or under threat from other prisoners or if they behave in a way that prison staff think would put people in danger or cause problems for the rest of the prison. They also hold prisoners serving punishments of cellular confinement after disciplinary hearings. Segregation is authorised by a prison operational manager who has to be satisfied that the prisoner is fit for segregation after an assessment by a member of healthcare staff. Segregation unit regimes are restricted and prisoners are usually permitted to leave their cells only to collect meals, wash, make phone calls and have a daily period in the open air. The segregation unit at Wandsworth comprises 13 cells. Each cell has an emergency call button and when this is pressed a light flashes outside the cell and it activates a buzzer which can be heard throughout the unit.

KEY EVENTS

16. On 2 March 2014, the man was arrested for possession of class A drugs with intent to supply, and driving offences. At the police station, the man said that he had taken cocaine that day, but was not dependent on drugs or alcohol. A doctor examined him and noted that the man was a long-term cocaine user. The doctor wrote that the man was agitated and tense and had delusional parasitosis, or ‘cocaine bugs’ (the feeling of bugs crawling under the skin) which made his skin itchy and irritated. The doctor prescribed skin cream, an antihistamine and a dose of diazepam.

17. The man appeared in court on 4 March and was remanded to HMP Belmarsh. It was not his first time in prison. A nurse recorded in the man’s medical record that he suffered with migraines and was addicted to drugs (but did not record any further information about the nature of his drug use). A prison doctor prescribed a hydrocortisone cream and an antihistamine.

18. On 25 March, the man was sentenced to two years and eight months in prison. The man did not settle well at Belmarsh and, in April, spent 20 days in the segregation unit. On 7 May, the man transferred to Wandsworth. Despite the previous information, the nurse recorded that the man did not use drugs. A doctor noted the man’s history of acne and headaches and prescribed medication. He also prescribed one dose of zopiclone, to help the man sleep.

19. On 8 May, the doctor prescribed aqueous cream for the man’s skin condition and prescribed zopiclone for another two nights.

20. There were very few entries in the man’s prison record. On 19 July, he was noted to be threatening and abusive to an officer, but then apologised and no further action was taken. This was the last entry in the man’s prison record. The man did not have any contact with substance misuse services at Wandsworth.

Sunday 27 July

21. On the afternoon of 27 July, the man’s partner, children and a friend visited him. The visits hall was monitored by CCTV and the CCTV operator saw the man’s friend take something from his mouth and pass it to the man, who appeared to take the item and then put his hand down his trousers. The CCTV operator suspected that the man had secreted the item internally and alerted the Supervising Officer (SO).

22. The SO told the investigator that she viewed the CCTV footage and was sure that the man had hidden an item in his anal passage. The SO instructed officers in the visits hall to end the man’s visit and take him to the designated search room. The SO called the police who interviewed the man’s friend. After initially denying that he had passed the man anything, he then said that he had passed him money. The SO said that she told the man’s friend that she did not believe he had passed money. As officers did not find any prohibited items on the man, the police took no further action against his friend.

23. Two officers strip searched the man, but did not find anything. The SO instructed officers to take the man to the segregation unit in line with the prison's 'Swallowing items through visits and secreted items policy' (which also forms part of the local segregation policy). The officers did not need to use force and CCTV footage showed the man looking relaxed when he arrived at the segregation unit at around 3.10pm.

24. Officers used a body orifice security scanner (BOSS) chair (which detects metal inside the body) to scan the man and it did not detect any metal item. Officers then strip searched the man again, but did not find any unauthorised items. The man then moved to a holding cell.

25. The duty governor was in the segregation unit when the man arrived and asked him what had happened. In an internal statement after the man died, the duty governor wrote that the man told her that he had put his hand down his trousers to rearrange himself after being aroused when he hugged his partner. The duty governor told the man that she would view the CCTV footage from the visits hall before deciding whether he needed to remain in the segregation unit.

26. The duty governor viewed the footage from the visits hall and agreed that the man had secreted something passed by his visitor. She concluded that the man should remain in the segregation unit. The duty governor did not speak to the man again. An officer and the duty governor completed the segregation documentation. They did not record any details of what they suspected the man had concealed.

27. At 4.15pm, the duty nurse completed the Initial Segregation Health Screen (which must be completed within two hours of the prisoner being segregated). The nurse found no medical reasons to advise against segregating the man.

28. When interviewed, the nurse described the man as approachable and cooperative and said that he had no visible injuries. She said that she asked segregation unit staff whether the man had swallowed or secreted an item and they said he had not, but that he had hidden something in his trousers.

29. According to Wandsworth's swallowed/secreted items policy, healthcare staff are expected to explain to the prisoner that holding items internally is highly dangerous and might result in serious illness or death. They are instructed to ask the prisoner if he is willing to hand over the item and to advise him that he will be regularly checked while in the segregation unit. Healthcare staff are expected to offer a confidential drug test and to take the prisoner's blood pressure, pulse, respiratory rate and pupil reaction at least every four hours. The nurse said that she understood her responsibilities under the policy, but because she was told that the man had not swallowed or secreted anything, she did not take any of the actions prescribed in the policy.

30. The nurse said that she was unable to update the man's clinical record until the next day (after the man's death) because, at the time, there was no computer access to medical records in the segregation unit. The nurse said that the

pressure of work that day meant that she had forgotten to update the man's record when she returned to the healthcare centre. In her retrospective entry, she described the man as alert, orientated and cheerful when she saw him and had told her he did not need to see a nurse.

31. Wandsworth's swallowed/secreted items policy states that when a prisoner is located in the segregation unit, the duty governor, healthcare representative and the segregation unit SO must decide on a formal level of observations. This did not happen. The segregation unit manager that day told the investigator that, although formal observation levels were not set, all prisoners in the segregation unit were automatically checked once an hour (unless there was reason to check them more often). When interviewed as part of an internal prison investigation, the duty governor said she did not know that the policy required specific observation levels to be set.

32. At about 4.20pm, officers moved the man into a standard segregation unit cell, E1-12. All 13 cells in the segregation unit were in use that day. At around 5.30pm, the SO took some food to the man. The SO said that he told the man that it was in his best interests to hand over anything he had concealed internally, but the man said he did not have anything. At 5.45pm, staff recorded that the man was eating his dinner.

33. The officer's shift ended at around 6.00pm, and he handed over responsibility to another officer. The officer told the investigator that all prisoners in the segregation unit are checked at least once an hour. At 7.00pm, the officer recorded that the man was on his bed asleep. At 8.00pm, the officer wrote that the man was lying on his bed awake. There were no further entries in the man's observation record after that.

34. At around 8.30pm, the officer handed over to a third officer, the night duty officer. The officer told the investigator that he told the night duty officer that the man had secreted an item. The night duty officer said in his statement to the police that he had spoken to the man when he was doing his first checks in the unit and the man had told him that he was fine. (The night duty officer did not record the details of any checks in the man's segregation file. According to the CCTV footage, the night duty officer looked through the observation panel in the man's door at 8.46pm and again at 9.18pm.)

35. The night duty officer said that he helped a prisoner in the unit write two letters and complete two complaint forms. The CCTV footage shows the night duty officer at the prisoner's cell door from 9.58pm until 11.04pm. The officer said that, about this time, he heard the man shouting to other prisoners, but he did not hear what he was saying.

36. The prisoner in the cell opposite the man (E1-04) told the investigator that he knew the man a little from around the prison and in the community. The prisoner said that, between 9.30pm and 10.00pm, he heard the man use prison slang to ask other prisoners for some tin foil because he had some heroin. When no one was able to give him any foil, the man said he would have to

‘snort it’. Several people who were in the segregation unit that night reported that the man seemed in good spirits and was singing.

37. The night duty officer said that, at some point, he left the segregation unit to go to the prison’s centre office. He also telephoned his girlfriend. The night duty officer said that he had no memory of several hours of his shift.

38. According to cell bell records, the man did not use his emergency cell bell at all during the night of 27-28 July. CCTV footage showed that, at around 1.30am, the night duty officer checked either the man or his neighbour. (As the segregation unit was in darkness, the footage is not very clear.) The footage showed that the man’s neighbour pressed his cell bell at 2.30am, and the night duty officer responded.

39. CCTV footage showed that at 3.00am, the night duty officer and an officer arranged chairs so they could lie down to watch television in the segregation unit staff room. (The officer was responsible for assisting the night orderly officer.) At around 3.24am, the night duty officer checked either the man or his neighbour. (The CCTV is not clear but it is possible that the prisoner in the cell next to the man’s was being observed under ACCT suicide and self-harm prevention procedures. The prison was unable to provide us with the segregation daily log which would include this information.)

40. The custodial manager, who was the orderly officer in charge of the prison that night, visited the segregation unit at 12.33am, 2.15am, 5.01am and 6.00am. He told the investigator that the night duty officer did not raise any concerns with him during his visits. The custodial manager did not talk to any prisoners or check segregation unit prisoner records during his visits. He said that he did not know that prisoners in the segregation unit should be checked hourly.

Monday 28 July

41. At 6.00am on 28 July, the night duty officer recorded on the Night Patrol Officer’s Report Form that he had checked all of the prisoners in the segregation unit. However, the night duty officer said in his police statement that he had not done this check or any other checks of prisoners during the night. After the man’s death, the night duty officer refused to cooperate with an internal prison investigation and resigned from the Prison Service.

42. Another officer took over from the night duty officer in the segregation unit at around 7.15am and said the night duty officer did not mention any concerns from during the night. The officer did not check the prisoners at the beginning of his shift, but, at 7.15am, he recorded in the segregation unit observation book: “All residents and area checked. No issues”.

43. At around 8.05am, an officer started knocking on cell doors in the segregation unit to wake the prisoners. The man did not respond and she looked through the observation hatch and saw that he was lying on the floor with his feet facing the window. The officer told the investigator that she had assumed the man was asleep and so she continued to the next cell. She said that it was not

unusual for prisoners to prefer to sleep on the floor and so she thought nothing of it.

44. After knocking on each cell door, three officers began unlocking prisoners, one at a time to collect their meal orders and to allow them to get hot water from the servery. They reached the man's cell at about 8.30am. The man was still lying on the floor and did not respond when one of the officers called to him so he unlocked the door and went in. He could only open the door slightly as the man was lying with his head against the door.

45. The officer said the man was lying on his back and there was what looked like bile and blood on the floor near his head. The man had dried blood on his left cheek, but no other visible injuries. The officer checked the man for a pulse but could not find one and so he started chest compressions. Another officer asked staff to radio a code one emergency (which indicates someone is unconscious, not breathing or is having breathing difficulties). In response, staff in the control room requested an ambulance at 8.33am.

46. The emergency response nurse and two other nurses were already on their way to the segregation unit to examine a member of staff who was unwell when they heard the code one message. When they arrived at the segregation unit, staff told them that they suspected the man was dead. An officer continued with chest compressions while a nurse administered oxygen. Two other nurses, who had also responded to the code one message, attached a defibrillator (a life saving device that gives the heart an electric shock to restart the heart rhythm in some cases of cardiac arrest). The defibrillator delivered one shock to the man, but there was still no sign of life.

47. At around 8.45am, paramedics arrived at the cell and took over emergency treatment. At 8.57am, a doctor from the Helicopter Emergency Medical Service pronounced the man's death.

48. After his death, the police searched the man's cell and found a piece of rolled up paper, which tested positive for heroin.

Contact with the man's family

49. At 12.25pm, one of the prison's family liaison officers, the Head of Operations and a prison chaplain, went to the man's partner's home and informed her of his death. In line with national policy, the prison offered financial assistance towards the cost of the man's funeral, which took place in December 2014.

50. The man's partner said that she had found it difficult to contact the prison's family liaison officer and so she had dealt mostly with the Head of Operations. He told us that the prison's family liaison officer was not relieved of any of his normal duties when he was given the family liaison role. His shift pattern meant that he was not in the prison every day in the weeks following the man's death so he had helped with the family liaison role.

Support for staff and prisoners

51. Later on 28 July, the Head of Safety at the prison debriefed the staff involved in the emergency response, and the prison's care team offered support. The Governor issued notices to staff and prisoners informing them of the man's death. Officers and members of the chaplaincy team supported prisoners. Staff reviewed prisoners who had been assessed as at risk of suicide and self-harm in case they had been adversely affected by the man's death.

Post-mortem report

52. The post-mortem examination recorded the man's cause of death as acute heroin intoxication with pneumonia. The pathologist concluded that the heroin the man took caused severe respiratory depression. There was no evidence that the man had been assaulted before his death.

ISSUES

Segregation under Wandsworth's 'Swallowing items through visits and secreted items policy'

Checking the man

53. On 27 July, the duty governor authorised the man's segregation because, during a visit, he was suspected of secreting an item in his anal passage. The man and his visitor denied passing anything between them. The supervising officer in the visits hall and the duty governor both viewed CCTV footage and concluded that the man's visitor passed an item from his mouth, which the man then concealed. No one recorded details of what they believed had been passed, but the implication was that they suspected it was drugs. Officers strip-searched the man twice, including asking him to squat, but found nothing. It is unlikely that such searches will detect if a prisoner has drugs concealed internally and prisons are not permitted to conduct intimate internal searches of prisoners.

54. Wandsworth's swallowed/secreted items policy sets out how prisoners suspected of secreting an item internally should be managed. It directs that those authorising segregation under the policy must give consideration to levels of observation, a strategy for retrieving the item, briefings at handovers and arrangements for exercise and association with others.

55. The duty governor told the investigator that she was not aware that she had to set a level of observation under the secreted items policy and none was set for the man. The man's segregation papers make no mention of a retrieval strategy, or special arrangements for exercise and association.

56. Prison Service Order (PSO) 1700 gives instructions for managing segregated prisoners. It is mandatory that all segregated prisoners are checked at an agreed frequency relevant to their individual circumstances. The level of observations should be set by the person authorising segregation, although prisoners serving punishments of cellular confinement have to be observed at least hourly. Wandsworth's local segregation policy does not contain any mandatory instructions on how often staff should check segregated prisoners. However, officers and managers we interviewed during the investigation agreed that the standard practice and expectation was to check all the prisoners in the segregation unit at least hourly, both day and night.

57. Staff checked the man hourly until 8.00pm but the night duty officer did not conduct hourly observations that night and did not do an early morning roll check at 6.00am. Other prisoners in the segregation unit told us that they heard the man talking and singing into the early hours of the morning. We have viewed CCTV footage and, while it is possible that the night duty officer observed the man at 12.30am on 28 July, it seems more likely that he was checking the prisoner in the cell next door. There is no evidence of any checks throughout the night and no one observed the man again until he was found unresponsive at 8.30am.

58. The lack of checks is a serious concern. Staff should observe all segregated prisoners at agreed intervals but this is particularly important when prisoners are suspected of concealing drugs internally. The swallowed/secreted items policy explains that part of the purpose of carrying out checks is to look out for symptoms of drug overdose, such as drowsiness, vomiting, agitated state, bizarre behaviour and breathing difficulties. Although managers did not set a specific level of checks for the man, he should have been checked at least hourly. Had the night duty officer checked the man hourly during the night, he might have realised that he was unwell and got medical help.

Healthcare assessment

59. A nurse completed the healthcare assessment of suitability to segregate, and concluded that there was no clinical reason against the man's segregation. The second page of the assessment form states the registered nurse or doctor must:

- Have a discussion with the prisoner.
- Look at their medical records and any other relevant documents.
- Gather information from other staff, including discipline staff.
- Review the nature of the incident which has led to segregation being necessary.

60. According to the local swallowed/secreted items policy, healthcare staff must explain to the segregated prisoner that holding items internally is highly dangerous and may result in serious illness/death. They must ask the prisoner whether he is willing to hand over the item, inform him that staff will check him and take his blood pressure, pulse and respiratory rate every four hours.

61. The nurse said that segregation unit staff did not tell her that they suspected The man had concealed an item internally, but had told her only that he had hidden something in his trousers. Segregation unit officers told the investigator that they had told the nurse the reason for the man's segregation. However, as we have already noted, no one recorded details of what they suspected the man might have hidden. In the circumstances, it would have been sensible for the nurse to have clarified the exact reasons for his segregation.

62. Because the nurse did not think the man had something concealed internally, she did not follow the instructions in the policy and take any clinical observations and none were taken at any time during the night. There was therefore no opportunity to identify the man's respiratory depression and take any action. The clinical reviewer, considered there was a lapse in the man's clinical care after he moved to the segregation unit and has made recommendations, which the Head of Healthcare will need to address.

63. The man had been segregated because he was suspected of having concealed an item in his body, likely to have been drugs. Subsequent events suggest that he had hidden some heroin, which he used some time during the night in his cell. We are concerned that managers and staff showed a lack of awareness of the local policy and procedures for prisoners suspected of swallowing or

concealing items internally and the associated risks. This meant that staff did not properly identify those risks and manage the man appropriately. We make the following recommendation:

The Governor and Head of Healthcare should ensure that all managers authorising segregation, healthcare staff assessing suitability for segregation, and all staff working in the segregation unit are aware of and follow the local procedures for managing prisoners suspected of swallowing or concealing items internally.

Operation of the segregation unit

64. We have identified that the night duty officer did not check prisoners in the segregation unit every hour as he was expected to do or carry out the morning roll check on 28 July. However, he signed to indicate that he had done a check. The night duty officer told the police that, during his shift, he made a personal telephone call and left the unit for some time. During the night, he and another officer lay on chairs in the staff rest room and watched a film.

65. Prisoners held in segregation units are at greater risk of harm than prisoners elsewhere in prisons and we do not consider that leaving the unit unstaffed or watching television in this way, meant that the staff were able to meet their duty of care towards prisoners. It is important that staff in segregation units are vigilant at all times.

66. It is also concerning that the custodial manager in charge of the prison that night visited four times yet did not establish that none of the segregated prisoners had been checked during the night and professed ignorance of the requirement for such checks. In the morning, when an officer took over responsibility from the night duty officer he also did not check the welfare of the prisoners in the segregation unit, yet made a false entry in the unit observation book to say he had done so.

67. We understand that after the man’s death, the prison held an internal disciplinary investigation and the night duty officer resigned. Managers told the investigator that they had taken action to review the procedures for segregated prisoners. However, we are concerned that this investigation identified a number of lax procedures in the operation of the segregation unit, particularly at night, and an apparent lack of understanding of some basic procedures designed to safeguard prisoners. We make the following recommendation:

The Governor should ensure that the segregation unit operates fully in accordance with mandatory Prison Service requirements designed to safeguard prisoners and that staff understand their duty of care towards the prisoners held there.

Contact with the man’s family

68. The man’s partner said that she had found it difficult to contact the nominated family liaison officer and had therefore had to get information and support from

the Head of Operations instead. He said that the prison's family liaison officer had been expected to complete his normal duties as an officer, at the same time as fulfilling the family liaison role. His shift pattern meant that he was not in the prison every day and did not have his own office from which to make or take sensitive phone calls. The Head of Operations said that he had been happy to speak to the man's family when the prison's family liaison officer was not available.

69. Prison Service Instruction 64/2011 contains guidance on the role of the family liaison officer. It notes that the grade of the member of staff acting as the family liaison officer is less important than appointing someone with the right qualities. We agree, but it is important that the family liaison officer is available and accessible to bereaved families, particularly in the days immediately after a death. We accept that the Head of Operations gave the man's family help and advice when they needed it, but as the prison's family liaison officer had not been given time to fulfil family liaison duties properly and was not easily contactable it was unhelpful to have expected him to act as the primary family liaison officer. The Head of Operations should have given his own details as first point of contact, which would have saved the man's partner some difficulty after his death. We make the following recommendation:

The Governor should ensure that family liaison officers have the time and resources needed to give bereaved families prompt and effective support.

RECOMMENDATIONS

1. The Governor and Head of Healthcare should ensure that all managers authorising segregation, healthcare staff assessing suitability for segregation, and all staff working in the segregation unit are aware of and follow the local procedures for managing prisoners suspected of swallowing or concealing items internally.

2. The Governor should ensure that the segregation unit operates fully in accordance with mandatory Prison Service requirements designed to safeguard prisoners and that staff understand their duty of care towards the prisoners held there.

3. The Governor should ensure that family liaison officers have the time and resources needed to give bereaved families prompt and effective support.

Action Plan					
No	**Recommendation**	**Accepted/Not Accepted**	**Response**	**Target date for completion and function responsible**	**Progress (to be updated after 6 months)**
1	The Governor and Head of Healthcare should ensure that all managers authorising segregation, healthcare staff assessing suitability for segregation, and all staff working in the segregation unit are aware of and follow the local procedures for managing prisoners suspected of swallowing or concealing items internally.	Accepted	A review of the existing Swallowed or Concealed Items policy has been conducted and significant changes have been made to take in to account the learning points which have identified following the tragic death of The man. The revised policy instructs that prisoners who are suspected of swallowing or internally concealing items are no longer placed in segregation but are located in a Constant Supervision cell on D Wing, are subject to healthcare professional supervision for 24hrs and have physical observations taken and recorded hourly. This policy will be personally issued to all managers conducting Duty Governor and Orderly Officer duties and all Healthcare professionals undertaking emergency/incident response duties and published via the establishment Intranet for the understanding of the entire staff group.	Head of Safety and Head of Healthcare	July 2015
2	The Governor should ensure that the segregation unit operates fully in accordance with mandatory Prison Service requirements designed to safeguard prisoners and that staff understand their duty of care towards	Accepted	A review will be undertaken of existing processes within the Segregation Unit to identify area of non-compliance in relation to PSO 1700 – Segregation and other mandatory instructions relating to the management and observation of prisoners located within Segregation Units.	Head of Safety and Safety Custodial manager	August 2015

Action Plan					
No	**Recommendation**	**Accepted/Not Accepted**	**Response**	**Target date for completion and function responsible**	**Progress (to be updated after 6 months)**
	the prisoners held there.		A further review of the briefing and handover processes which exist within this unit will be undertaken to ensure that staff are fully conversant with the risks and issues associated with each prisoner located there, and therefore have an increased understanding of their duty of care towards each prisoner.		
3	The Governor should ensure that family liaison officers have the time and resources needed to give bereaved families prompt and effective support.	Accepted	The Head of Safety now monitors the time allocated to Family Liaison Officers (FLOs) to ensure they have sufficient time to support the bereaved families appropriately. The Head of Safety has introduced a system whereby each FLO meets with them either monthly or when an issue arises which needs to be considered, whichever is the soonest. These meetings provide further opportunity to monitor the amount of time allocated to each FLO and where concern are raised over this, the matter is brought to the attention of the Head of Corporate Services where it can be addressed.	Head of Safety	Completed