

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Thomas Bielby, a prisoner at HMP Hull, on 8 August 2015

**A report by the Prisons and Probation Ombudsman
Nigel Newcomen CBE**

Our Vision

To carry out independent investigations to make custody and community supervision safer and fairer.

Our Values

We are:

Impartial: *we do not take sides*

Respectful: *we are considerate and courteous*

Inclusive: *we value diversity*

Dedicated: *we are determined and focused*

Fair: *we are honest and act with integrity*



© Crown copyright 2015

This publication is licensed under the terms of the Open Government Licence v3.0 except where otherwise stated. To view this licence, visit nationalarchives.gov.uk/doc/open-government-licence/version/3 or write to the Information Policy Team, The National Archives, Kew, London TW9 4DU, or email: psi@nationalarchives.gsi.gov.uk.

Where we have identified any third party copyright information you will need to obtain permission from the copyright holders concerned.

The Prisons and Probation Ombudsman aims to make a significant contribution to safer, fairer custody and community supervision. One of the most important ways in which we work towards that aim is by carrying out **independent** investigations into deaths, due to any cause, of prisoners, young people in detention, residents of approved premises and detainees in immigration centres.

My office carries out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

Mr Bielby was found hanged in his cell in the segregation unit at HMP Hull on 7 August 2015, and died in hospital the next day. He was 26 years old. I offer my condolences to Mr Bielby's family and friends.

Mr Bielby was subject to an apparently disproportionate disciplinary punishment of cellular confinement. He was subsequently segregated, but without a mandatory mental health assessment.

Mr Bielby had a difficult telephone call with his partner a few hours before his death, although an officer identified that Mr Bielby was upset and spent time talking with him. The officer believed that he had helped Mr Bielby address his issues and, although the final outcome proved otherwise, I consider that his decision not to begin suicide and self-harm prevention procedures was reasonable at the time.

Finally, I am concerned that there were weaknesses in the emergency response procedures, an issue I have highlighted in previous reports following deaths at Hull.

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.

Nigel Newcomen CBE
Prisons and Probation Ombudsman

March 2016

Contents

Summary	1
The Investigation Process	3
Background Information	4
Background Information	4
Key Events	6
Findings.....	11

Summary

Events

1. Mr Thomas Bielby was sentenced to 16 weeks' imprisonment on 29 June 2015. Mr Bielby had been in prison a number of times previously and has been monitored on suicide and self-harm prevention procedures (known as ACCT) several times. When he arrived at HMP Hull, reception staff did not identify any risk of suicide and self-harm.
2. On 31 July, Mr Bielby pleaded guilty to two disciplinary charges; he had a television in his cell, which he was not permitted to have, and he had damaged the television. The adjudicating manager punished him with two weeks' cellular confinement in the segregation unit. Local guidelines state that adjudicators should only impose cellular confinement for serious offences. The adjudicating manager said that he imposed this punishment because Mr Bielby had little regard for prison rules.
3. No one completed an Initial Segregation Health Screen for Mr Bielby within two hours, as they should have done. The adjudicating manager signed the form to say the health screen had been completed and he had considered it, and said that he did so in the expectation that someone would complete it later.
4. Mr Bielby had a difficult telephone conversation with his partner on the afternoon of 7 August. A segregation unit officer acknowledged this, spoke to Mr Bielby for some time about the call and allowed him a second call to his mother (although Mr Bielby then called his partner again). The officer thought that their conversation had helped Mr Bielby resolve his issues and he did not identify that Mr Bielby was at risk of suicide and self-harm.
5. That evening, the night patrol officer found Mr Bielby sitting in the corner of the cell. Mr Bielby did not respond when the night patrol officer tried to rouse him. He radioed for emergency assistance, but did not open the cell as he was unsure what had happened. The first officer to respond also did not open the cell. When another officer arrived, they opened the cell and found Mr Bielby had hanged himself. Paramedics took him to hospital, but he died the next afternoon.

Findings

6. Mr Bielby evidently struggled to deal with the outcome of his phone conversation on 7 August. Nevertheless, we are satisfied that the segregation unit officer considered the issues raised by this conversation and helped Mr Bielby to address them, and that it was reasonable at the time for him not to open suicide and self-harm prevention procedures. However, we are concerned that the decision a week earlier to punish Mr Bielby with cellular confinement was not in line with local guidelines. It is also worrying that Mr Bielby was segregated without consideration to the effect this might have on his health. We also found that it took too long to go into Mr Bielby's cell when the night patrol officer raised concerns, and there was a delay to calling an emergency ambulance.

Recommendations

- The Governor should ensure that managers conducting adjudications impose punishments in line with local adjudication tariff guidelines.
- The Governor should ensure that managers imposing punishments at adjudications fully consider the likely impact on the health and welfare of the prisoner and that an initial segregation health screen is completed before a punishment of cellular confinement is imposed.
- The Governor should ensure that all prison staff are made aware of PSI 24/2011 and Local Instruction 1.3 and that they understand that, subject to a personal risk assessment, they should enter a cell at night when there is potentially a risk to life.

The Investigation Process

7. The investigator issued notices to staff and prisoners at HMP Hull informing them of the investigation and asking anyone with relevant information to contact him. One prisoner contacted him as a result.
8. The investigator visited Hull on 14 August 2015. He obtained copies of relevant extracts from Mr Bielby's prison and medical records, and spoke to two prisoners who knew Mr Bielby.
9. NHS England commissioned a clinical reviewer to review Mr Bielby's clinical care at the prison.
10. The investigator interviewed 14 prison staff, and the prisoner who had made contact, from 9-11 September. The clinical reviewer joined the investigator for interviews with clinical staff on 11 September.
11. We informed HM Coroner for East Riding and Kingston upon Hull of the investigation who sent the results of the post-mortem examination. We have given the coroner a copy of this report.
12. One of the Ombudsman's family liaison officers contacted Mr Bielby's mother to explain the investigation. She said that her son had harmed himself during a previous prison sentence and asked us to consider how frequently he was checked and whether prison staff should have checked him more frequently.
13. Mr Bielby's mother received a copy of the initial report. She did not make any comments.

Background Information

HMP Hull

14. HMP Hull is a local prison, which holds approximately 1,000 unconvicted and sentenced men in ten residential wings.

HM Inspectorate of Prisons

15. The most recent inspection of HMP Hull was in October 2014. Inspectors found that the number of adjudications was low and hearings were conducted fairly. However, they found that the use of segregation was relatively high. Monitoring and management of the segregation unit was not sufficient and the regime for prisoners was poor. Inspectors also found that there were fewer incidents of self-harm than at similar prisons.

Previous deaths at HMP Hull

16. Mr Bielby was the sixth prisoner to die at Hull since July 2014, the third self-inflicted death in that time. None of the other deaths occurred in the segregation unit. In the two most recent investigations, we found that there was a significant delay to calling an ambulance.

Assessment, Care in Custody and Teamwork (ACCT)

17. Assessment, Care in Custody and Teamwork, known as ACCT, is the Prison Service care-planning system used to support prisoners at risk of suicide or self-harm. The purpose of ACCT is to try to determine the level of risk, how to reduce the risk and how best to monitor and supervise the prisoner. After an initial assessment of the prisoner's main concerns, levels of supervision and interactions are set according to the perceived risk of harm. Checks should be irregular to prevent the prisoner anticipating when they will occur. There should be regular multi-disciplinary review meetings involving the prisoner. As part of the process, a caremap (plan of care, support and intervention) is put in place. The ACCT plan should not be closed until all the actions of the caremap have been completed. All decisions made as part of the ACCT process and any relevant observations about the prisoner should be written in the ACCT booklet, which accompanies the prisoner as they move around the prison. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011.

Segregation units

18. Segregation units are used to keep prisoners apart from other prisoners. 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 an operational manager at the prison 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 usually restricted and prisoners are permitted to leave their cells only to collect meals, wash, make phone calls and have a

daily period in the open air. The unit at Hull is known as the Separation and Care Unit (SACU) and comprises ten cells.

19. In a PPO learning lessons bulletin about segregation, published in June 2015, we highlighted seven lessons to be learned from investigations into the self-inflicted deaths of prisoners being held in segregation conditions at the time of death:
- Special accommodation and protective clothing should only be used if absolutely necessary and after all other options have been exhausted.
 - Staff responsible for the care of prisoners in segregation units should fully understand and follow the mandatory procedures for safeguarding segregated prisoners set out in Prison Service Order (PSO) 1700, Segregation, and PSI 64/2011.
 - Segregated prisoners should be provided with the means to occupy themselves, at minimum reading material and a radio.
 - During an Initial Segregation Health Screen and ensuing Segregation Review Boards, staff should base decisions about fitness for segregation on the prisoner's full mental health history and other relevant factors that could potentially compromise their ability to cope, not on current demeanour alone.
 - Lengthy periods of segregation are to be avoided.
 - Exceptional circumstances to justify the segregation of a prisoner subject to ACCT procedures should actually be exceptional.
 - When there are exceptional reasons to justify a prisoner at risk of suicide and self-harm being held in segregation, the additional required safeguards in PSO 1700 should be followed, including holding a mental health assessment and an ACCT review within 24 hours.

Key Events

20. Mr Thomas Bielby spent several periods in prison from 2006, the longest of which was a five and a half year sentence for robbery, from which he was released in March 2014. Mr Bielby spent a lot of time in segregation units during these periods of custody, including at HMP Hull in 2011. Prison staff also monitored him under ACCT procedures several times, most recently in 2013, usually because he had cut his arms or chest. Mr Bielby once said that he had made a “noose” when he was 12 years old, but there is no indication that he had tied a ligature during any of his previous times in prison.
21. On 29 June 2015, Mr Bielby was convicted of assault and sentenced to 16 weeks imprisonment. This was the first time he had been in prison since March 2014. Mr Bielby arrived at Hull that afternoon. His Person Escort Record (PER, a form that accompanies prisoners on all journeys to communicate information including about risk factors) stated that Mr Bielby had cut himself in 2009 and 2011.
22. A nurse assessed Mr Bielby and noted that he said he had last cut himself 17 months ago and currently had no thoughts of self-harm. Mr Bielby said he was annoyed and frustrated about being in prison as he had not been in prison for over a year and had now got a job and a girlfriend. He said that he smoked cannabis every day, but did not say that he used any other drugs. She said that Mr Bielby was a well-mannered and pleasant man who, despite his frustration at imprisonment, was positive about the future. She did not consider it necessary to begin ACCT procedures. She said that she asks all new prisoners if they would like to see the mental health in-reach team. Mr Bielby declined. She did not refer him for an assessment herself.
23. An officer completed a first night interview that evening. Mr Bielby said he did not feel like harming himself, but he asked for vulnerable prisoner status because of a previous offence (a robbery against a female pensioner) which had received negative publicity in the local press. (Vulnerable prisoners are those who might need to be kept separate from the general prison population for their own protection due to the nature of their offence.) The officer said that Mr Bielby seemed happy when they met. He said that he has access to a prisoner’s electronic prison record (known as NOMIS), but did not remember if he spoke to Mr Bielby about the risk markers for self-harm that were highlighted on there from previous imprisonment. He thought that Mr Bielby seemed well and did not think it necessary to begin ACCT procedures.
24. Mr Bielby completed his application for vulnerable prisoner status that evening. He explained why he wanted to be a vulnerable prisoner, and he also provided information on local drug dealers who had associates, who he named, in the prison.
25. On 30 June, the manager of the first night and induction wings met Mr Bielby to consider his application. He said that he knew Mr Bielby had taken vulnerable prisoner status at times during previous sentences, but he had to consider whether prison staff could manage any risks to Mr Bielby without him taking a place on the vulnerable prisoner unit. He told us that he did not grant Mr Bielby vulnerable prisoner status for two reasons: the men named by Mr Bielby were not

currently at Hull and the offence he mentioned was historic and there was no evidence of any current threat to him because of it. He said that Mr Bielby accepted this. He had the right to appeal the decision to the Head of Residence, but it does not appear that he did so.

26. On the same day, a healthcare assistant completed a secondary health screen. Mr Bielby told her that he had cut his arms and put a bag around his neck to try to strangle himself when in prison two years previously, because of personal issues which he had now resolved. He said that he had a short sentence to serve and had a job and girlfriend outside prison. The healthcare assistant said that the factors that prompted Mr Bielby's previous self-harm were no longer present. She told us that she did not therefore think it was necessary to open ACCT procedures.
27. No significant entries were made in Mr Bielby's prison records over the next three weeks. A prisoner shared a cell with Mr Bielby for much of this time. He said that Mr Bielby was pretty quiet and kept himself to himself. The prisoner said that Mr Bielby used subutex (a medication used as a substitute for heroin), which he bought from someone else on the wing. He did not think Mr Bielby used any other drugs.
28. On 25 July, Mr Bielby was one of four prisoners who allegedly assaulted another prisoner. Mr Bielby was charged with a disciplinary offence and moved to D Wing. Prison staff also reduced his incentives and earned privileges level (IEP, a scheme designed to encourage and reward good behaviour in prisons). The adjudication hearing was due to be held on 27 July, but was adjourned as the police were investigating the incident.
29. A prisoner who knew Mr Bielby from his previous time at Hull saw him in the gymnasium on 30 July. He told us that Mr Bielby seemed more comfortable and mature compared to when he had previously known him. He said that Mr Bielby was worried that his application for vulnerable prisoner status had been rejected, and thought this would bring him problems.
30. Later on 30 July, an officer charged Mr Bielby with the disciplinary offence of possessing of an unauthorised article, when he found a television in his cell. Mr Bielby was not allowed a television as he was on the lowest tier of the IEP scheme. The television was damaged, so the officer charged Mr Bielby with a second offence of destroying or damaging prison property. The prisoner, who had also moved wings following the alleged assault on 25 July and who shared the cell on D Wing with Mr Bielby, told us that they were both culpable for obtaining the television but Mr Bielby said he would take the charge as he only had a few weeks left on his sentence.
31. The Head of Offender Management was the adjudicator at Mr Bielby's disciplinary hearing on 31 July. Mr Bielby pleaded guilty to both charges, and said that he had damaged the television while trying to hide it. He punished him with 14 days' cellular confinement in the segregation unit. Local adjudication tariff guidelines state that cellular confinement should be awarded for serious offences. For possession of an unauthorised item, local guidelines define a serious offence as involving items such as mobile phones, drugs or weapons. For damaging prison property, local guidelines highlight the seriousness of the

damage, whether there was disruption to the regime and whether others were put at risk as consideration to determine the seriousness of the offence. He told us that he invoked the more serious punishment because Mr Bielby had a disregard for prison rules and thought he could take matters into his own hands.

32. When a prisoner is segregated, a qualified healthcare professional (doctor or nurse) should complete an Initial Segregation Health Screen within two hours of the prisoner being segregated. The purpose is to take a snap shot assessment of the prisoner's mental health, so that very mentally unwell or suicidal prisoners from are not segregated in all but the most exceptional of circumstances. No one completed this health screen when Mr Bielby was segregated. An operational manager should sign the bottom of the form to show they have acknowledged and considered the health screen. The Head of Offender Management signed the form, and told us that he did so in the belief that a member of healthcare staff would subsequently complete it.
33. An officer then completed the opening pages of Mr Bielby's segregation unit booklet. This contains an overview of the reasons for segregation, any issues the prisoner has, and includes a checklist to confirm that the required paperwork, including the Initial Segregation Health Screen, has been completed. He circled the relevant boxes to say that the health screen had been completed within two hours of segregation and signed by a doctor or nurse. He told us that this was an oversight and he circled the boxes without properly checking the form.
34. Mr Bielby's first week in the segregation unit passed quietly and without incident. An officer told us that Mr Bielby was polite and did not cause any problems. He said that Mr Bielby got on with his punishment and looked forward to returning to his wing.
35. On 6 August, the adjudication hearing from 27 July was reconvened, as the police were taking no further action. The Head of Offender Management dismissed the charge, as the alleged victim was not willing to make a statement.
36. At around 8.45am on 7 August, a nurse saw Mr Bielby as part of a routine healthcare segregation round. She said that Mr Bielby did not mention any problems and seemed well. At around 9.45am, Mr Bielby went out for exercise. The duty governor saw Mr Bielby at around 12.00pm, as part of a routine segregation round, and noted that he said he had no problems.
37. At around 2.00pm, Mr Bielby phoned his partner. Prisoners' telephone calls are recorded and we listened to recordings of Mr Bielby's calls. Unless there are security grounds to target calls, prison staff listen to a random sample of telephone calls, but they had not listened to Mr Bielby's. Mr Bielby's partner told him that Social Services had said he was not allowed into her house under any circumstances. Mr Bielby's partner said that her son was at risk of being taken from her and Mr Bielby would be arrested if he went to her house, and asked him what he had done to lead to this. Mr Bielby did not directly answer this question and we do not know the specific reasons why Social Services issued this warning to Mr Bielby's partner. Mr Bielby said that they should end the relationship, and finished the call by saying he would not phone or write again.

38. When a prisoner in the segregation unit makes a telephone call, a prison officer is required to observe them at a distance. The officer should stand in a position where they can watch the prisoner but are not close enough to listen to the conversation. An officer watched Mr Bielby, realised that he had had a difficult phone call, and went to his cell afterwards to speak to him. Mr Bielby told him about the phone call. The officer advised Mr Bielby to engage with Social Services and work with them to reach a solution that would, in time, allow him to have full access to his partner and her son. He said that Mr Bielby seemed to appreciate this and that he had calmed down during the conversation. Mr Bielby said he would write to his partner to apologise, and said he was due for release soon and would deal with things then. He asked if he could use the phone again to call his mother. Local policy is that prisoners in the segregation unit are allowed just one phone call a day, but as he thought it would help Mr Bielby to speak to his mother, the officer allowed him to make an additional call.
39. Mr Bielby made a phone call at 2.50pm, but he called his partner again rather than his mother. He told her that an officer had helped him put things into perspective and that they should listen to Social Services and deal with the problem. Mr Bielby's partner said she was scared of what Social Services might do and that her son had to come first. The conversation ended when Mr Bielby's credit expired. The officer watched Mr Bielby during the call and said that it appeared to be a normal conversation and Mr Bielby was not angry or tearful. He asked Mr Bielby how he was after the call, and Mr Bielby said that everything was fine.
40. Prison officers are required to check prisoners serving punishments of cellular confinement at least hourly. The officer recorded that he completed these checks at 3.30pm and 4.30pm. He did not speak to Mr Bielby during the checks. At 5.30pm, Mr Bielby came out of his cell to collect his evening meal. The officer asked him if he was all right, to which Mr Bielby replied "yes, no problems".
41. At around 6.25pm, another officer checked Mr Bielby and recorded that he was sitting on the bed reading. He did not speak to Mr Bielby. The officer left the unit at around 6.45pm when he was relieved by the night patrol, an operational support grade (OSG).
42. At around 6.50pm, the OSG began a check of the prisoners in the unit. When he got to Mr Bielby's cell, he found him sitting on the floor in the corner near the door. He shouted to Mr Bielby and kicked the door, but Mr Bielby did not respond. The OSG said that he did not know what Mr Bielby was doing and was uncertain whether this was a ploy or whether Mr Bielby was unwell. He said that he could not see the ligature because of the position in which Mr Bielby was sitting. He radioed a 'code blue' medical emergency, indicating a life threatening situation in which the prisoner has difficulty breathing. The control room operator recorded this call at 6.52pm. The OSG did not open the cell at this stage due to his uncertainty about what had happened.
43. An officer was working on the floor above the segregation unit and went downstairs when he heard the emergency call. He went to Mr Bielby's cell, looked through the flap and saw Mr Bielby sitting in the corner with his head down. He said that his initial thought was that Mr Bielby had taken drugs and

was unconscious. He also could not see the ligature. The officer telephoned the control room and said that they needed support as a prisoner was unconscious. He said he did not open the cell as he was the only prison officer present. (Operational support grade is the grade below prison officer.) Local instructions state that a cell would normally only be unlocked at night when there are a minimum of three members of staff present. However when there is, or appears to be, danger to life, an individual member of staff may enter the cell if they assess it is safe to do so. The policy does not distinguish between the different grades of staff who might be involved in opening a cell.

44. A custodial manager arrived around a minute later and instructed the officer to open the cell. They found Mr Bielby hanged from a ligature made from a bed sheet which he had attached to a tap on the sink in the corner of the cell. The officer cut the ligature and they laid Mr Bielby on the floor. The response nurse arrived and applied oxygen and began chest compressions. A custodial manager radioed for an emergency ambulance. The control room officer recorded this at 6.55pm. She told us that she did not telephone for an ambulance after the code blue, as national instructions require, as local practice is to wait for a specific request for an ambulance.
45. The first paramedics arrived at the cell at around 7.05pm and took over life support. They were able to re-establish a pulse and, at around 7.45pm, took Mr Bielby to the Intensive Care Unit at hospital. Mr Bielby was managed on a life support machine but died at 4.55pm on 8 August.

Contact with Mr Bielby's family

46. The duty governor phoned Mr Bielby's mother at around 8.10pm on 7 August and told her what had happened. Mr Bielby's mother visited the hospital that night and, with her daughters, was present when he died. Mr Bielby's funeral was held on 26 August and Hull contributed to the costs in line with national instructions.

Support for prisoners and staff

47. After Mr Bielby's death, the duty governor debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.
48. The prison posted notices informing other prisoners of Mr Bielby's death, and offering support. Staff reviewed all prisoners subject to suicide and self-harm prevention procedures in case they had been adversely affected by Mr Bielby's death.

Post-mortem report

49. A post-mortem examination established the cause of death as hanging.

Findings

Identification of risk of suicide and self-harm

50. Prison Service Instruction (PSI) 64/2011, which governs ACCT suicide and self-harm prevention procedures, requires all staff who have contact with prisoners to be aware of the risk factors and triggers that might increase the risk of suicide and self-harm and take appropriate action. Any prisoner identified as at risk of suicide or self-harm must be managed under ACCT procedures. We have considered whether staff at Hull should have recognised Mr Bielby as at risk and opened an ACCT.
51. When he arrived at Hull, some of these risk factors applied to Mr Bielby. He had harmed himself a number of times previously in prison, usually by cutting his arms or chest, and he was charged with a violent offence. At the reception health screen, a nurse identified that Mr Bielby had previously harmed himself and discussed this with him. She identified that he was serving a short sentence and had a job and partner in the community, and that for these reasons Mr Bielby was positive about the future. She was satisfied that she did not need to open an ACCT.
52. Prison staff must consider all risk factors to ensure a prisoner's level of risk is holistically judged. While this can be a finely balanced decision, the nurse took into account Mr Bielby's risk factors and discussed them with him. We are satisfied that it was reasonable for her to conclude that Mr Bielby did not need to be monitored under ACCT procedures when he arrived at Hull.
53. Mr Bielby had a difficult phone call with his partner on the afternoon of 7 August. An officer acknowledged this and spent some time speaking with Mr Bielby afterwards. He said he thought this was a good, constructive, conversation and helped Mr Bielby to calm down, and Mr Bielby told him of his future plan to address the issues raised in the phone call. Mr Bielby himself said that the officer had helped him to put things into perspective. When Mr Bielby asked for another phone call, the officer thought this would be helpful and permitted it. Although he thought Mr Bielby had called his mother, when in reality he phoned his partner, the officer watched Mr Bielby during the call and thought that he was not upset or angry during the conversation. After the call, he said that everything was fine afterwards. The officer told us that it is not unusual for prisoners to have a bad phone call, and he was aware that Mr Bielby did not have long until his release from prison. He was satisfied that Mr Bielby had thought about how to deal with the issues raised during the call. He did not therefore think that Mr Bielby was at increased risk of suicide and self-harm.
54. PSI 64/2011 lists relationship problems as a risk factor and trigger for suicide and self-harm. Segregation is also listed as a trigger that might increase risk. Staff judgement is fundamental to the ACCT system. The system relies on staff using their experience and skills, as well as local and national assessment tools, to determine risk. Although Mr Bielby had a difficult phone call on 7 August, the officer acknowledged this and thought that he had been able to help Mr Bielby address the problem. While hindsight suggests that this was not the case, we

are satisfied that it was not unreasonable for him to have concluded that Mr Bielby did not need to be monitored under ACCT procedures.

Adjudication hearing

55. PSI 47/2011 sets out the process and procedures that must be followed when a prisoner is charged with a breach of prison rules. It states that any punishment the adjudicator may impose must be proportionate and in accordance with the Prison Rules. The adjudicator must take into account the seriousness of the offence, local punishment guidelines, the prisoner's previous disciplinary record, the likely effect of the punishment on the prisoner, and any mitigation the prisoner may offer. The punishment and any reasons for departure from local guidelines must be recorded on the record of hearing and explained to the prisoner. Hull's local adjudication tariff guidelines state that adjudicators should always consider alternative punishments to cellular confinement, such as removing a prisoner's gym access or reducing their earnings or the amount of money they can spend in the prison shop.
56. Mr Bielby was charged with two offences; possessing an unauthorised article, and destroying or damaging prison property. For the first charge, the local adjudication tariff guidelines state that adjudicators should only impose cellular confinement for serious offences, which it defines as involving items such as mobile phones, drugs or weapons. Less serious offences involve property and other (unspecified) items.
57. For the second charge, local guidelines also state that adjudicators should only impose cellular confinement for serious offences. The guidelines are less prescriptive about what is deemed serious, but lists various questions for the adjudicator to consider. These include consideration for the cost of the damage caused, whether there was disruption to the regime, whether others were put at risk and whether the prisoner had a history of that type of offence.
58. We do not believe that Mr Bielby's offences should have been considered as 'serious' as defined by local guidelines. The unauthorised property he had was a television, which is not an item listed as constituting a 'serious' offence. The adjudication papers do not detail the extent of the damage to the television, just that Mr Bielby damaged it when trying to conceal it. We have seen nothing to suggest that the offence caused disruption to the regime or put anyone at risk. Although Mr Bielby had been guilty of several disciplinary offences during previous periods in custody, this was his first proven adjudication during this period of imprisonment. The adjudicator told us that the suspended hearing relating to an alleged assault did not count against Mr Bielby.
59. The adjudicator said that he invoked the more serious punishment of cellular confinement because Mr Bielby had an attitude of disregard for prison rules and thought he could take matters into his own hands. However, punishments should be based on the actual charge proved and not on the adjudicator's view of the prisoner's conduct during the hearing.
60. We are not satisfied that the decision to punish Mr Bielby with cellular confinement was in line with local guidelines, although it is not clear whether this

would have made any difference to the final outcome. We make the following recommendation:

The Governor should ensure that managers conducting adjudications impose punishments in line with local adjudication tariff guidelines.

Initial segregation health screen

61. Prison Service Order (PSO) 1700 sets out mandatory requirements and guidance to ensure the security and safety of those living and working in segregation units. It states that a doctor or registered nurse must complete the initial segregation health screen within two hours of a prisoner being segregated. PSO 1700 states that the health screen will normally be completed before a punishment of cellular confinement is imposed. Hull's local segregation policy takes this further and states that the initial health screen must be carried out before a prisoner receives a punishment of cellular confinement.
62. No one completed an initial segregation health screen for Mr Bielby. The adjudicator, who signed the manager's section of the form to say it had been completed, said that he did so in the belief that someone would subsequently carry out the screen. However, as the guidance states, he should not have given Mr Bielby a punishment of cellular confinement until he was satisfied that the health screen had been completed and there were no medical reasons not to segregate. A second opportunity to identify that the health screen had not gone ahead was missed when an officer circled the relevant box in Mr Bielby's segregation unit booklet to say that the screen had been completed without first checking the form.
63. The purpose of the initial screen is to determine whether there are any healthcare reasons against holding a prisoner in segregation and to provide a 'snapshot' of the prisoner's mental well-being at the time of the screen. As such, it is an important safeguard to ensure that very mentally unwell or suicidal prisoners are excluded from segregation in all but the most exceptional circumstances. While there is no obvious reason why a doctor or nurse would have identified reasons not to segregate Mr Bielby, who was not under the care of the mental health team at Hull, we are concerned that no one carried out this vital assessment. We make the following recommendation:

The Governor should ensure that managers imposing punishments at adjudications fully consider the likely impact on the health and welfare of the prisoner and that an initial segregation health screen is completed before a punishment of cellular confinement is imposed.

Emergency response

64. At night, officers have a cell key in a sealed pouch for use in an emergency. PSI 24/2011, which covers management and security at nights, states that staff have a duty of care to prisoners, to themselves, and to other staff. The preservation of life must take precedence over usual arrangements for opening cells and where there is, or appears to be, immediate danger to life, then cells may be unlocked without the authority of the night orderly officer and an individual member of staff can enter the cell on their own. Staff are not expected to take action that they

feel would put themselves or others in unnecessary danger. What they observe and any knowledge of the prisoner should be used to make a rapid dynamic risk assessment. Hull's Local Instruction 1.3 provides instructions on the procedures to follow when opening a cell at night and contains similar information to the PSI.

65. The OSG said he could see Mr Bielby sitting in the corner of the cell near the door when he completed his roll check on 7 August. Mr Bielby did not respond when he called his name and kicked the door. He said he could not see the ligature at this time and was uncertain whether Mr Bielby was unwell or whether he was feigning illness. He radioed a code blue emergency but decided to wait for support before opening the cell. Given that he was unsure about what had happened, we are satisfied that it was reasonable for him to wait for support.
66. An officer responded and arrived quickly. He could not see Mr Bielby better than the OSG, and he said he thought that Mr Bielby had taken drugs and was unconscious. He also waited for support, which he said was because he was the only officer present. However the OSG, while not a prison officer, is required to open cells at night when circumstances dictate and was therefore qualified to assist the officer at the time. The officer said he thought Mr Bielby was unconscious. While we understand that it is difficult for staff in such situations to make immediate decisions, when someone is in a potentially life threatening situation it is essential to act quickly. In such circumstances we would normally expect prison staff to go into a cell as soon as possible, in case there is a chance of saving someone's life. As there were two members of staff present, we consider that they should have immediately gone in to Mr Bielby's cell to assist rather than wait for support. We make the following recommendation:

The Governor should ensure that all prison staff are made aware of PSI 24/2011 and Local Instruction 1.3 and that they understand that, subject to a personal risk assessment, they should enter a cell at night when there is potentially a risk to life.

67. We are concerned that there was a three minute delay after the OSG radioed code blue before the control room called an ambulance. The officer who was working in the control room said that local practice is to wait for a specific request for an ambulance in addition to the emergency call.
68. PSI 03/2013 requires that governors must have a medical emergency response code protocol to ensure that an ambulance is called immediately in a life-threatening medical emergency. The PSI explicitly states that all prison staff must be aware of and understand their responsibilities during medical emergencies. It states that control room staff should automatically call an ambulance whenever an emergency code is used. Governor's Order 09/2015 incorporates this into local policy.
69. We highlighted this issue in our report into the death of a man in February 2015, and recommended that the Governor ensure that prison staff call an ambulance without delay whenever there is a medical emergency. This recommendation was issued and accepted after Mr Bielby's death and we do not therefore repeat it.

**Prisons &
Probation**

Ombudsman
Independent Investigations