

**Investigation into the circumstances surrounding  
the death of a man in January 2011  
whilst he was a serving prisoner  
at HMP & YOI Hollesley Bay**

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

**January 2012**

The man was 22 years old when he died at 5.40pm in January 2011 after he was hit by a heavy goods vehicle. He had been released from HMP & YOI Hollesley Bay for the day on temporary licence. Witness statements indicate that he deliberately placed himself in the path of the vehicle. The post mortem report determined that he died from multiple injuries as a result of the collision.

I would like to extend my sincere condolences to the man's family. The circumstances of his death have undoubtedly proved to be extremely traumatic for them. I hope that my report provides them with a better understanding of what happened to him in prison.

The investigation was completed by three investigators. They interviewed staff and prisoners. A Family Liaison Officer contacted the man's family to tell them more about the investigation and to find out what concerns and questions they had about his death. I am very grateful to them for their involvement.

A clinical review of the treatment which the man received in prison was undertaken by a clinical reviewer who was appointed by the local PCT. He assessed whether the care that the man received in custody was comparable to that he could have expected in the community.

This has been a somewhat unusual investigation. Although the man was a serving prisoner and apparently chose to end his own life, he did so not in prison but in the local community. The investigation has deliberately examined the entirety of his time in custody because, although he did not report any mental health problems or suicidal thoughts at Hollesley Bay, he experienced a significant period of crisis in 2009. He was subject to self harm monitoring for over three months and underwent a number of psychiatric assessments. Yet for the last 16 months of his life, he did not show any similar signs of distress.

The investigation has also considered allegations of racial discrimination by officers on the residential unit the man lived on for four months. These allegations were made independently by two different prisoners who have since left Hollesley Bay. Their claims prompted my investigators to return to the prison and interview the staff concerned. Because the claims were only made several months after he died, the necessary additional investigation has slightly delayed publication of the report. I apologise for the delay, but this was an issue worth covering in some depth so as to achieve the most accurate possible picture. I am satisfied from the evidence available that race equality is an issue taken extremely seriously by staff at Hollesley Bay, however, do make recommendations for continual improvement in this area.

I make five recommendations as a result of the investigation.

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 Ombudsman**

**January 2012**

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## SUMMARY

1. The man committed four driving offences in August 2007, including causing death by dangerous driving. However, he was not arrested and remanded into custody for these offences until February 2009. He had a number of previous convictions and had previously spent time in prison. Prior to his remand into custody for the new offences, had had no involvement with mental health services in the community. He was initially taken to HMP & YOI Chelmsford, before moving to HMP & YOI Norwich in March, where he was briefly subject to self harm monitoring for two days after he refused to eat.
2. In April, the man transferred to HMP Pentonville. His mental health seemed to deteriorate and he was referred to a doctor, who prescribed antidepressant medication. Staff began a second, much longer period of self harm monitoring in late May. In early June, however, before he could undergo further assessment, he moved to HMP Belmarsh.
3. After the move, the man remained subject to self harm monitoring. He spent periods in the healthcare centre because staff were concerned that he might try to harm himself. He was assessed by another doctor who considered that he did not have a mental illness but might be suffering from post traumatic stress disorder (PTSD). The doctor requested a further psychiatric assessment. In late July, he was found with a ligature and placed under constant supervision in a safer cell in the healthcare centre (this type of cell has a gate rather than a door and allows fewer opportunities for a prisoner to form a ligature). Four days later, he attended a court appearance and was taken back to Pentonville.
4. The man moved back to Pentonville whilst still subject to constant supervision in a healthcare setting. He was assessed by doctors, but again tried to harm himself and seemed to be experiencing visual and auditory hallucinations. Constant supervision continued until early August. However, staff began to suspect that he might be exaggerating some of his symptoms in front of them, as he was observed laughing and joking with the prisoners.
5. Another doctor assessed the man and decided that he did not have a mental illness or PTSD. She thought that he was exaggerating his symptoms. He was discharged from the healthcare centre at Pentonville in late August and staff stopped self harm monitoring in mid September. Around this time, he received a prison sentence of more than five years. He was discharged by the mental health team in October.
6. The man transferred to HMP The Mount in January 2010. Healthcare staff checked his records and assessed his mental health, but he did not give staff the kind of serious concerns he had done the previous summer and no further interventions were planned.
7. On 23 August, the man moved to open conditions at HMP & YOI Hollesley Bay. His mood seemed stable during the next few months and he did not come to the attention of mental health services. He was unhappy about his

risk assessment by his community probation officer and complained about this. It meant that he could not work in the nearby community. Instead, he started a plastering course.

8. From October, the man was granted periods of temporary release on licence. At weekends, he spent days in the community in the company of a named friend or family member. He had to leave and return to the prison at specified times and remain within a thirty mile radius of Hollesley Bay. He left the prison under this scheme on numerous occasions and returned without incident. He complied with the rules and was also granted two longer periods of leave with his family back in London.
9. The man was granted resettlement day release as usual on 15 January 2011. He left the prison accompanied by his partner. He spent the day at a local hotel. Later that day, he seemed to become distressed and argue with his partner. They left the hotel in her car and drove around the local area before eventually parking in a lay-by on a busy A road. He had been voicing suicidal thoughts to his partner and on the telephone to family members. His partner told the police that he got out of the car and deliberately moved into the path of a heavy goods vehicle, which collided with him and killed him instantly.
10. The investigation has explored the problems which the man seemed to experience in 2009. These seem to contrast with his settled behaviour throughout 2010. There is no record of him experiencing any mental health problems at Hollesley Bay. His death came as a shock to staff and I have not found any evidence that they could reasonably have predicted or prevented his actions, particularly since he was in the community when he died.
11. Two prisoners who lived on Wilford Unit when the man was there have made separate allegations about racial discrimination against black and minority ethnic prisoners by officers at Hollesley Bay. The investigators have sought as much information as possible to place the allegations in context and have spoken to the staff involved. It is difficult to draw definitive conclusions, but on balance I am satisfied that race equality is promoted and prioritised by the management team at Hollesley Bay.

## THE INVESTIGATION PROCESS

12. The investigator was informed of the man's death on 17 January 2011. Notices were issued to staff and prisoners at HMP & YOI Hollesley Bay telling them about the investigation process and inviting them to contact my investigator.
13. The investigator liaised with the Principal Officer (PO) during the investigation. He visited Hollesley Bay on 25 January to speak to staff and collect paperwork relating to the man's time in custody. He interviewed a prisoner who spent time with the man on temporary day release on the day he died. He also met the Coroner's officer and went to visit the police responsible for investigating the road traffic incident.
14. The investigator contacted the local PCT to ask that a clinical review be carried out with regard to the medical treatment which the man received in custody. The purpose of the review is to establish whether the care which he was offered in prison was comparable with that he could have expected in the community. A clinical reviewer completed the review.
15. The investigator returned to Hollesley Bay on 3 March to interview five members of staff. On 10 March, he wrote to the Governor to provide initial feedback about the investigation.
16. The investigator had not planned to interview any other members of staff until another prisoner wrote to him making further allegations on 16 April. The investigator's colleague interviewed him about his allegations at HMP & YOI Norwich on 10 May. The investigator spoke to the Chair of the Independent Monitoring Board on the telephone. His colleague interviewed another prisoner at HMP & YOI Chelmsford. The investigator also asked the Governor of Hollesley Bay to arrange a further day of interviews. On 12 July, two investigators interviewed the race equality officer and two officers. Before they left the prison, they provided feedback about the progress of the investigation.
17. The investigator wrote to the local Coroner's office at the start of the investigation to inform them of its nature and scope. HM Coroner will be provided with a copy of this report.
18. One of the Ombudsman's Family Liaison Officers spoke with the man's mother (his listed next of kin) on 22 February. She explained the purpose of my investigation and provided an opportunity for her to raise any concerns she had about the care her son received.
19. She thought that moving to an open prison had helped calm her son down. She said that he had enjoyed his recent periods of temporary release at home, and in recent weeks had appeared positive about completing his sentence and ultimately being released. She mentioned that her son had been unhappy about risk assessments made by his probation officer.

20. The family received a copy of the draft report of my investigation. His mother provided a very thoughtful and considered response to our findings. We have reflected her opinions on pages 43 and 44. We are grateful for her contribution.

## **HMP & YOI HOLLESLEY BAY**

21. Hollesley Bay is an open prison located in Suffolk. There are five residential units holding more than 300 adult and young adult men. Prisoners who move to Hollesley Bay are trusted to live in open conditions. Many of the prisoners are temporarily released on licence to work in the local community in preparation for their eventual release from custody. If a prisoner misbehaves to an unacceptable degree (for instance, they are found with class A drugs such as heroin), they can be returned to a more secure, closed prison.

### **Town visits and home leave**

22. Prisoners can be granted town visits on Saturdays and Sundays. They are released on temporary licence for the day but must return to the prison in the evening. This form of resettlement day release requires that a named friend or family member accompanies the prisoner during the day. They have to stay within 30 miles of the prison
23. Prisoners can also apply for periods of home leave. They are temporarily released on licence and can return to stay at a given address with their family. This period of release may last for several days, after which time they are trusted to return to Hollesley Bay. Over the Christmas period, 181 prisoners (more than half the population) were allowed to go home to see their friends and families.

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

24. Assessment, Care in Custody and Teamwork (ACCT) monitoring is started if a prisoner is thought to be at risk of harming himself. The prisoner is interviewed and a plan for his care is drawn up in response to his needs and concerns. The process is ongoing and the document remains open whilst the risk remains. ACCT reviews should be held at intervals commensurate with the risk that the prisoner presents to himself. Any staff who have contact with a prisoner can make entries in the document. The frequency of observations by staff is set out on the front cover, for example, 'hourly'. Staff must check the prisoner at least this often, they should conduct their observations at random intervals and write down all the checks in the ongoing record. Some of the scheduled checks must be 'quality observations', meaning that the member of staff speaks to the prisoner at some length and has meaningful interaction with him in order to gauge his mood and the risk he may present to himself.

### **Her Majesty's Chief Inspector of Prisons**

25. The then HM Chief Inspector of Prisons inspected Hollesley Bay in February 2009. She made the following comments:

'The prison provided a very safe, well controlled and respectful environment. Prisoners were kept purposefully occupied...

'Early days [in custody] were well managed and there was very little bullying or self-harm. Prisoners were largely well behaved and motivated.

'Incidents of self-harm were rare... Only three ACCTs had been opened to date in 2009 and then only for a very short time. Twenty had been opened in 2008 and nine in 2007. None of the prisoners involved had been returned to closed conditions because they needed more intensive supervision. Assessments and care plans demonstrated a good level of care, and quality and procedures were checked by managers.'

### **Independent Monitoring Board**

26. The most recent annual report published by the Independent Monitoring Board (IMB) at Hollesley Bay covers the year from January to December 2010. (The IMB at each prison is made up of members of the public who are both independent and unpaid. They monitor the day-to-day life in their local prison and ensure that proper standards of care and decency are maintained.) The IMB reported that:

'...Hollesley Bay continues to be a well managed prison providing a safe and decent environment...'

### **Previous deaths at Hollesley Bay**

27. The Prisons and Probation Ombudsman has investigated deaths in custody since 2004. Since then, the death of one prisoner at Hollesley Bay, in 2007, has been investigated. That prisoner had absconded from the prison and died in the community after drinking an excess quantity of alcohol. I found that the staff could not have predicted or prevented the man's actions.

## KEY EVENTS

28. The man had misused drugs and alcohol for a number of years. He left school in his early teens and had nine previous convictions for a total of 21 offences. He had previously spent time in custody.
29. The man committed offences of causing death by dangerous driving, driving whilst disqualified, failing to stop at the scene of an accident and having no insurance on 31 August 2007. The consequences of his offending behaviour later seemed to affect his mood. His partner recalled in her statement to the police that he 'went very quiet' after his arrest and had nightmares about his offence.
30. On 26 February 2009 (a year and a half after he committed the offences), the man was remanded into custody at Crown Court and taken to HMP & YOI Chelmsford. Whilst he was held at Chelmsford, a member of staff recorded that he had a mild form of Asperger's Syndrome (a form of autism). (This is not alluded to again in any of the other clinical records.)
31. The man moved to HMP & YOI Norwich on 20 March. A nurse assessed him during the reception process and did not identify any mental health problems. He was briefly subject to ACCT self harm monitoring between 19 and 20 April. He refused to eat because he said that he thought that he could catch a disease from the food. He subsequently agreed to eat and staff stopped ACCT monitoring with his consent.

### HMP Pentonville

32. The man transferred to HMP Pentonville on 21 April. The nursing staff did not identify any mental health issues during the reception process. However, on 13 May, a wing officer referred him to the mental health in-reach team for an assessment.
33. Nursing staff performed this assessment on 19 May. The man said that he had never been treated for mental health problems before and that there was no associated history in his family. He said that he was hearing voices and thinking about harming himself, but would not act on these thoughts. Staff referred him to a psychiatrist and started ACCT self harm monitoring again on 29 May after he said that he could not cope and would harm himself unless he was assessed by a doctor.
34. During this period, the man appeared in court to plead guilty to three of his offences. He was found guilty after a trial of the fourth and most serious offence, causing death by dangerous driving. A probation officer was asked to interview him to complete a pre-sentence report.
35. In her report, dated 2 June, the probation officer noted that the man was still trying to come to terms with his actions. He found it extremely difficult to talk about his offences and when he did, it made him depressed. He said that he had trouble eating and sleeping and experienced bad dreams. She thought

that he might have learning difficulties. She noted that there were already concerns about his mental health.

36. She spoke to a psychiatric nurse, who thought that the man might either be experiencing post traumatic stress disorder (PTSD, when an individual experiences severe anxiety following psychological trauma) or be showing signs of the onset of a psychotic illness. He said that he had thought about cutting his wrists. She assessed him as presenting a high risk of harm to himself. She proposed that the court request a full psychiatric report before sentencing him.
37. A doctor assessed the man on 3 June. He said that he was sleeping poorly and having flashbacks to his offence. He described putting tissues in his ears to try to stop auditory hallucinations. The doctor decided to continue ACCT monitoring and prescribed fluoxetine (an antidepressant) and zopiclone (a sleeping tablet). She referred him to a counsellor and the forensic therapies team. However, he transferred to HMP Belmarsh the following day, 4 June, so these referrals were not completed.

### **HMP Belmarsh**

38. The man appeared in court on 4 June, from where he transferred to HMP Belmarsh rather than returning to Pentonville. Although staff at Pentonville had begun ACCT monitoring on 29 May, it was Belmarsh staff who actually carried out the initial assessment interview and filled in the action following assessment documents on 5 June. (These documents are supposed to be completed within 24 hours of the start of ACCT monitoring.)
39. After he moved to Belmarsh, healthcare staff referred him for a mental health assessment. He said that he heard voices, specifically a person called 'Tom' who was encouraging him to harm himself. On 15 June, he attended his assessment and received a preliminary diagnosis of PTSD. He was prescribed fluoxetine and diazepam (also known as Valium, a benzodiazepine used to treat anxiety).
40. On 18 June, staff became more concerned that the man might harm himself and moved him to the healthcare centre for observation. His mood was low and wing staff worried what he might do. However, he asked to return to the wing the next day.
41. He received a second diagnosis of PTSD on 24 June. He told a psychiatrist that he was experiencing flashbacks and having bad dreams. He thought about his offence constantly. The psychiatrist diagnosed possible depression with psychotic features. His antidepressant medication was increased and he was also prescribed a low dose of an antipsychotic drug.
42. The next day, an officer made an entry in his wing history sheet about his low mood and the resulting ACCT monitoring. She described him as 'very manipulative'.

43. The man was readmitted to the healthcare centre on 6 July, because he was having suicidal thoughts. He expressed remorse and guilt about his offences and said that he had no hope for the future. He explained that he was hearing different voices in his head and having flashbacks and hallucinations. During this period, he handwrote a number of notes to staff in large capital letters. One of these read, 'YOU'RE DRIVING ME INSANE, YOU WANT ME TO DIE.'
44. On 17 July, a locum consultant forensic psychiatrist prepared a psychiatric report for the court about the man. He told her that he had heard voices from the age of 16, but had not told anybody because he was afraid of being taken to hospital. However, his partner and cousin both told the psychiatrist that he had never previously mentioned hearing voices or demonstrated any signs of a mental disorder before his period on remand.
45. The psychiatrist concluded that stress was likely to be aggravating his probable personality disorder. She concluded that he did not have a psychotic or mental illness, but that he probably did suffer from PTSD. She thought that he did not require admission to a psychiatric hospital but that he could benefit from psychological assessment and treatment after he was sentenced.
46. On 23 July, staff found him with a ligature made out of a bed sheet. They recorded that he had made clear plans to take his own life. He was moved to a safer cell (a dedicated gated cell designed to have fewer ligature points) in the healthcare centre and kept under constant supervision. He was provided with special anti-tear bedding and clothing. Any items that he might have been able to use to harm himself were removed from his person.
47. The psychiatrist prepared an addendum psychiatric report on 23 July. She wrote that he had become more distressed since she prepared her original report and that he had needed a significant amount of intervention from the mental health team in the prison. His probation officer had expressed concerns about his ability to cope with a lengthy prison sentence. The psychiatrist considered the possibility of him being transferred to hospital under the terms of the Mental Health Act for further assessment. However, she first of all requested that the court commission another psychiatric assessment in order to obtain a second opinion.
48. On 25 July, the man made a superficial cut to his wrist and told staff that he had swallowed a razor blade. Staff confirmed that he had not had access to a blade and he remained under observation in the healthcare centre.

### **HMP Pentonville**

49. The man appeared at court again on 27 July. When he left Belmarsh that morning, he was still under constant supervision in a gated cell in the healthcare centre. ACCT monitoring continued as he travelled to Crown Court. His case was adjourned to allow for another psychiatric report and he returned to Pentonville from court.

50. A doctor assessed the man in the reception area and wrote in the clinical record that he was 'frankly psychotic' and was hearing 'Tom' (an auditory and visual hallucination) 'constantly'. The doctor recorded a probable diagnosis of paranoid schizophrenia and referred him for further mental health assessment.
51. He stayed in the healthcare centre after he returned to Pentonville. He was prescribed olanzapine (an antipsychotic medication) and remained under constant supervision as part of the ACCT process. A nurse observed him talking to 'Tom' and recorded that he was 'very psychotic'.
52. A doctor spoke to the psychiatrist at Belmarsh the next day. She told him that the man did not in fact have a psychotic illness but probably had a personality disorder. The doctor said that he had had a bad reaction to fluoxetine and did not benefit from olanzapine.
53. He remained under constant supervision in the healthcare centre after he tried to cut himself with a razor blade the same day, 28 July. On 31 July, staff recorded that he was having constant visual and auditory hallucinations and was talking to 'Tom' all the time. He asked staff if he could be taken under section to a secure psychiatric hospital.
54. However, a couple of days later, staff suspected that he might be manipulating them when they observed him laughing and joking with other prisoners. As soon as he noticed that staff were watching him, he reverted to quiet and withdrawn behaviour.
55. Staff ended the period of constant supervision on 5 August and gradually reduced the frequency of ACCT observations. The man asked again about the possibility of being taken to hospital under section on 9 August.
56. A psychiatrist assessed the man and prepared a psychiatric report for the court dated 1 September. He told her about his visual and auditory hallucinations. He said that 'Tom' encouraged him to harm himself and would instruct him to take his own life if he was discharged from the healthcare centre. Although the other psychiatrist had thought that he might have PTSD or a personality disorder, she disagreed. She also thought it unclear that he had a psychotic illness such as schizophrenia.
57. Although the man's behaviour was unusual, the psychiatrist found him unconvincing and she suspected that he was exaggerating his condition. She thought that 'Tom' was a coping mechanism rather than an actual hallucination. She wrote that he was immature and behaved impulsively. She did not think he needed to be transferred to hospital.
58. She asked a consultant forensic psychiatrist to provide a second opinion. He also interviewed the man and spoke to his family. The man's partner told the psychiatrist that he had not experienced mental health problems before. She mentioned that he had a friend called Tom who had apparently taken his own

life. However, she also said that he had experienced nightmares since he committed his offence. She thought that his mood had worsened in prison and that he was not exaggerating his mental health problems.

59. The psychiatrist agreed with the other psychiatrist that the man did not have a psychotic illness. He was not convinced by his symptoms and did not think that he should be admitted to hospital. The man's probation officer agreed with both doctors.
60. With the approval of the psychiatrist and the agreement of the man, he was discharged from the healthcare centre on 28 August. He appeared in court again on 3 September and received a custodial sentence of five years and 140 days. Subject to good behaviour, his first possible release date was set at 5 November 2011. His partner recalled in her police statement that he reacted well to his sentence because he had thought that it might be longer.
61. Staff ended ACCT self harm monitoring on 10 September with the man's agreement. A week later, on 17 September, they conducted an ACCT post-closure review and recorded that all of the issues on the care plan had been addressed.
62. On 14 October, he was discharged from the care of the mental health team. However, he did report hearing voices on one more occasion, on 30 November. He was assessed by a mental health nurse again in January 2010. The nurse recorded that he was not experiencing any auditory or visual hallucinations and that his mood was stable. The nurse planned monthly check ups to keep an eye on him.

### **HMP The Mount**

63. The man transferred from Pentonville from HMP The Mount on 29 January. During the reception process, nursing staff read the psychiatric report. They recorded his history of self harm, recent mental health concerns and contact with mental health services.
64. On 9 February, he was discussed at a mental health in-reach referral meeting. The team decided that he should be screened by a nurse. He underwent an assessment with a mental health nurse two weeks later. He said that 'Tom' was a real person who had now died. He did not raise any new concerns and therefore no further treatment was planned.
65. Whilst at The Mount, he impressed staff with his politeness and compliance. One officer described him as the 'hardest working cleaner on the wing'. On 4 March, he wrote to his probation officer because he was unhappy with his OASys risk assessment. (OASys is an electronic risk assessment tool used by the National Offender Management Service to determine an offender's risk of reoffending and the risk he presents to the public.) A prison officer checked his letter for him and commented that it was 'logical, clear [and] constructive'.

66. In May, the man told the nursing staff that he felt stressed and worried. They advised him to use the gym more often, mix with other prisoners during the association period and come for weekly healthcare checks.

### **HMP & YOI Hollesley Bay**

67. The man was given permission to move to an open prison and transferred to Hollesley Bay on 23 August. His partner remembered in her police statement that he had reacted well to the move. During his first night reception health screening, he told a nurse that he had never tried to harm himself, that he was not thinking of doing so presently and that he had no mental health problems. (When a prisoner arrives at a new prison, the healthcare staff rely to a large extent on him self-reporting any problems, as they do not have time to read his complete clinical record.) The next day, he attended an induction interview with an officer.

#### *Mental health*

68. The man did not receive or request treatment from the mental health team whilst he was held at Hollesley Bay. He was not subject to ACCT monitoring and there is no record that he ever asked for help with mental health problems or reported problems such as depression. He was not prescribed any medication. A probation officer based at Hollesley Bay and the man's offender supervisor looked at previous psychiatric assessments, including the psychiatrist's report, and talked to him. He told her that he had manipulated staff in the past by exaggerating his symptoms. She told the investigator that she discussed the matter with the mental health team.

#### *Location*

69. The man moved onto Wilford Unit (one of five residential units) when he arrived at Hollesley Bay. In mid-October, an officer noticed that he seemed rather lost and unhappy, and that he had asked to move to a different unit. Other staff had already recorded that he seemed to be struggling to settle in and that he had misbehaved on a couple of occasions.
70. On 16 December, the man moved to room 55 on D wing on Stow Unit. He was one of four prisoners on Wilford Unit who were 'giving cause for concern'. Staff made the decision to separate the group and move them to different units 'both for their own benefit, and for the stability of Wilford Unit'.
71. During October and November, the prison's race equality team investigated allegations of racially discriminatory behaviour by staff on Wilford Unit. I have detailed the progress and findings of their investigation in the 'Issues' section of the report. The man gave evidence during that investigation, and I have included the text of his interview.

### *Substance misuse rehabilitation work*

72. A Counselling, Assessment, Referral, Advice and Throughcare Services (CARATS) worker assessed the man in late August. (There is a CARATS team in each prison working with prisoners who misuse either drugs or a combination of drugs and alcohol.) He said that he did not have any drug or alcohol misuse problems and the CARATS worker did not identify any current treatment needs. His notes were kept on file and he was told that he could access help from the CARATS team at any time. However, he asked if he could attend the Short Duration Programme (SDP) to address his previous substance misuse.
73. The man completed the four week SDP programme on 1 October. Staff reviewed his progress on 8 October and recorded that he was '100 percent clear minded', that he had successfully completed the course and that he had taken a lot from it. He talked about possibly going to university. Staff closed his CARATS file on 22 October because he had achieved all of his objectives. He was told how to contact the CARATS service in future.

### *OASys assessment*

74. At about the same time the man moved to Hollesley Bay, a probation officer in his home area in east London reassessed the risk he presented to members of the public if he returned to the community. The Probation Service uses a risk assessment tool called OASys. This is an electronic document which uses information about the offender to determine the likelihood that he will reoffend and the risk of harm that he presents to others.
75. The last probation officer to use the OASys risk assessment tool had decided that the man presented a medium risk of harm to the public. However, another officer completed a new assessment and assessed the risk of harm as high. (The author of the original pre-sentence report in 2009 had actually made the same assessment.) Although she completed the OASys assessment another probation officer took over as his offender manager in the community.
76. On 10 September, his probation officer informed him that his OASys risk assessment had been increased. He was unhappy about this news and she agreed that they would speak to his offender manager.
77. He submitted four Prisoner's Formal Complaints about his OASys assessment. On 13 September, an officer replied to the first complaint, assuring him that she would ask his probation officer to look into the matter.
78. On 28 September, an officer spoke to him and noted that he was 'rather upset' by his OASys risk assessment and that the problem was 'all-consuming' for him. On 14 October, he took part in a telephone conference call with his probation officer and offender manager to discuss his increased risk assessment.

79. An officer replied to the man's second complaint on 21 October, confirming that he would need to liaise with his offender manager in the community because prison staff could not alter the assessment. In the meantime, she informed him that his high risk assessment meant that he would not be able to perform paid or voluntary work in the community.
80. Another officer replied to his third complaint on 10 November. He provided him with contact details for the Prisons and Probation Ombudsman (PPO). (As well as investigating deaths in custody, the Ombudsman's office also considers complaints from prisoners.) He also provided a complaint form for London Probation Trust and reminded him that his offender manager in east London was responsible for the risk assessment.
81. On 17 November, the officer replied to the man's fourth complaint, agreeing to forward his details to the PPO. He complained to the Independent Monitoring Board at Hollesley Bay and wrote to London Probation Trust. He received a reply from the PPO on 2 December. He was told that, before the Ombudsman could help him, he would need to exhaust London Probation Trust's complaint procedures.
82. On 6 January 2011, the man told his probation officer that he was still upset by his increased OASys risk assessment. The matter had not been resolved to his satisfaction. They discussed a possible move to HMP Latchmere House (an open prison in south west London). He was keen to pursue this transfer and was told in early January that it was likely to happen.

*Release on temporary licence*

83. On 9 October, as part of the resettlement day release scheme, the man spent his first day in the community on temporary licence. He could leave the prison in the company of an approved person at 9.00am and had to return by 7.30pm. He was required to remain within a 30 mile radius of the prison. He was also released on resettlement temporary licence on 16 and 23 October, 6, 13 and 20 November, 4, 11, 18 and 19 December and 1, 8 and 15 January 2011.
84. To help him resettle into the community, he was granted periods of prearranged temporary release at his family's home address in London. Whilst released on temporary licence, he was told that he could neither use drugs nor alcohol, nor could he contact the family of the victim of his offence. His offender manager in east London supported the decision to allow him day release in the local area and overnight release with his family.
85. He was released from the prison on a resettlement overnight temporary licence at 8.30am on 1 November. He returned to the prison at 3.30pm on 3 November. He was also granted a period of home leave in east London over Christmas. He was away from Hollesley Bay for three nights from 8.30am on 24 December until 3.30pm on 27 December.

### *City & Guilds course*

86. On 22 November, the man began studying for a Level One City & Guilds Certificate in Basic Construction Skills. (He was still studying for the qualification when he died.) This plastering course usually lasts for 12 weeks. The course is full time and runs for four and a half days a week. The course consists of three weeks of induction and nine subsequent units, each lasting for a week.

### **Saturday 15 January 2011**

87. As was becoming habitual, the man was granted resettlement day release on 15 January. His partner was due to collect him. He made a series of telephone calls to her from about 7.40am until she arrived to collect him at about 10.30am. These were short telephone calls concerning the delays she was experiencing because her car would not start. The investigator has listened to these telephone calls, which were made from a prison telephone. There does not seem to be anything remarkable about them which would indicate that he was thinking of harming himself or was distressed.
88. His partner arrived during the morning with one of his friends. His sister's partner was already waiting in another car outside the prison. Once his partner collected him and they left the prison, he chose to travel in the other car with his sister's partner. They drove to a local McDonalds restaurant and then onto the Holiday Inn in Ipswich, where he and his partner had reserved a room.
89. Another prisoner had also been granted temporary day release. He and his partner and child had booked the adjoining room in the hotel. He recalled during interview that the man checked into the hotel at about 11.00am. He saw him from time to time throughout the day. He told the investigator that he never seemed particularly upset. The man's partner also told the police that, for the first part of the day, he 'seemed his usual self'.
90. His partner told the police that his friend and his sister's partner both left Ipswich at about 4.00pm. After they left, he became upset and fell into a negative mood. He and his partner argued and were both shouting. The prisoner remembered overhearing him and his partner having an argument later in the afternoon.
91. Before 5.00pm, the man telephoned his sister. They had a fairly long conversation, during which he asked her to telephone his father in the USA. He said that he wanted to go and stay with his father. He said that if this didn't happen he was going to 'find the tallest building and jump off it'.
92. The prisoner told the investigator that he spoke to the man at about 5.00pm. He said that the man had asked for a lift back to the prison because he didn't want to travel back with his partner. The prisoner replied that he and his partner wanted to order and eat a Chinese takeaway first, but that after that they were happy to drive him back to Hollesley Bay.

93. The prisoner remembered suggesting that he could collect the man at about 6.30pm. They agreed to arrange a meeting place using mobile telephones. He told the investigator that he then saw the man's partner in her car and the man approaching it before walking away. He said that he saw him walking off and his partner pulling away in her car. He did not see him again.
94. The man's partner told the police that he had wanted to get his day release licence out of the car. He got in and she then drove away from the hotel. He would not talk to her. Eventually they arrived at a multi-storey car park and he told her to drive to the top of the building. They reached the eighth floor and he got out of the car. He looked for access to the roof but could not find an open door. His partner was crying but he was silent. They got back in the car and drove away. As they left, he told his partner that he had wanted to throw himself off the roof.
95. A female friend of the man's who lives in Ipswich received a call from him shortly before he died. He told her that he hated his life and no longer wanted to live. He also telephoned his mother between 5.10pm and 5.20pm. She could hear shouting in the background.
96. The man's partner recalled in her police statement that she was worried about his behaviour by this stage but that he would not talk to her. He instructed her to drive them back to the prison along the A14. He smoked a cannabis cigarette in the car.
97. The man's partner was very agitated. She told the police that he instructed her to pull over into a lay-by in order to calm down. He then telephoned his sister and told her that his partner was alone and upset in a lay-by and needed to be collected. He opened the passenger door and got out. He leant against the car and took out a cigarette. His partner got out and approached him, but he would not look at her. He kept his eyes on the ground.
98. She tried to put her arms around his neck, but he pushed her away. She tried to grab his clothing but could not hold onto it. She told the police that he suddenly took 'two big jumps' and then 'made a leap like a star jump' into the path of an oncoming heavy goods vehicle (HGV). She confirmed to the police that there was nothing that the driver of the HGV could have done to avoid him. She also stated that the HGV would not have hit him if he had not deliberately moved away from the safety of the lay-by.
99. The man died at about 5.40pm. The collision took place on the eastbound side of the A14 (a dual carriageway road) near Bucklesham and Stratton Hall. At the time it was dark but the weather was good. The traffic was typical for that time on a Saturday. The car was parked up on the grass verge. There was a distance of some metres between the car and the lane the lorry travelled down, which was the one nearest the lay-by.

100. Paramedics took the man to hospital where he was pronounced dead. His sister and mother arrived at the hospital. His mother identified his body at 7.50pm.
101. The prisoner told the investigator that he and his partner collected a Chinese takeaway and ate it back at the hotel. He then telephoned the man and did not get an answer. Eventually, the man's partner answered his calls and told him what had happened. At first, he did not believe her. He telephoned the prison and told them what had happened. He travelled to the hospital. He was permitted to remain away from Hollesley Bay until 8.30pm.
102. Because the man died in the community whilst on temporary release on licence, it was initially difficult for staff at Hollesley Bay to obtain information from the police about exactly what had happened. The Principal Officer (PO), duty governor, came into the prison at about 8.30pm. At that stage, staff only knew that the man had been collected by his partner that morning, that he had not returned by his 7.30pm curfew and that he had been involved in a road traffic collision.
103. After the PO confirmed that the man had died, he arranged for Listeners to be briefed so that they could offer support to any prisoners who might be upset by the news. (Listeners are prisoners who have been specially trained by the Samaritans to sit with and listen to other prisoners who are in distress. Their support is confidential and is not disclosed to staff or others.) He then gathered the prisoners together in each of the five residential units in order to personally let them know what had happened. He made sure to speak to the prisoner individually. He also confirmed that the man's next of kin had arrived at the hospital and had been told about his death.
104. That evening, only one prisoner in Hollesley Bay was already subject to ACCT self harm monitoring. Another prisoner's ACCT document had been closed the day before. The next morning, 16 January, staff reviewed the needs of both men in view of the news about the man. Prayers were said for him at the Church of England Sunday service. There was a higher than usual attendance at the service.
105. The PO is the prison's trained family liaison officer (FLO). He waited until Monday 17 January to contact the man's family. His named next of kin was his mother, but he could not reach her by telephone. Instead, he managed to speak with the man's sister. She agreed to pass on the condolences of the prison staff to her mother. He subsequently spoke to the man's mother on Thursday 20 January.
106. Because the man died in the community and his family had already spoken to the police and hospital staff, the Governor of Hollesley Bay initially told The PO not to offer to visit the family home. (When a prisoner dies in custody, it is normally expected that the FLO and chaplain from the prison will visit in person to convey condolences and offer to answer any questions the family might have.) The prison made a contribution towards the cost of the funeral after the Governor spoke to my investigator and consulted his area manager.

The PO and a SO subsequently drove to the family home to return the man's property on 25 February.

107. Before he died, the man had booked another day's release on temporary licence on Saturday 22 January. He had also been granted another period of home leave from 31 January until 4 February. This leave had been approved at the end of December.
108. The post mortem report showed that the man died from multiple injuries as a result of the collision with the HGV. The toxicology results showed no traces of either alcohol or drugs in his body.

## ISSUES

### ACCT monitoring in 2009

109. In the first six months after the man was admitted to custody in 2009, he was subject to two periods of ACCT monitoring. Staff briefly opened an ACCT document in April, but decided that monitoring was not required the following day. However, a much longer period of ACCT monitoring began on 29 May at Pentonville. I am concerned that an ACCT assessment interview does not seem to have been completed until 4 June and the first case review not until 5 June. Both only took place after he moved to Belmarsh. Prison Service Order (PSO) 2700 states that an assessment interview is supposed to take place within 24 hours of ACCT monitoring beginning. I have provided the Governor of Pentonville with a copy of this report.
110. The second period of ACCT monitoring was prolonged, lasting over three months until September 2009. The ACCT document was regularly reviewed. After the man was found with a ligature and moved to a special safer cell in the healthcare centre on 23 July, staff at Belmarsh conducted an ACCT case review. I consider that this was an excellent example of a multi-disciplinary review attended by a number of staff from different departments.
111. The man was then kept under constant supervision for nearly two weeks, a surprisingly long time for what is supposed to be a measure of last resort. Annex 8Y of PSO 2700 describes constant supervision as follows:
- ‘Constant supervision is where a prisoner is supervised by a designated member of staff on a one-to-one basis, remaining within eyesight at all times and within a suitable distance to be able to physically intervene quickly. It is required when it is believed that the prisoner could, at any time, make an attempt to kill themselves.’
112. The man transferred from Belmarsh back to Pentonville after a court appearance on 27 July, whilst he was still subject to ACCT monitoring and apparently still under constant supervision in a gated cell in the healthcare centre. Although staff acted sensibly by moving him directly to the healthcare centre at Pentonville, there is no recorded evidence that the transfer followed the guidance set out in PSO 2700:
- ‘The intention to transfer a prisoner on an open ACCT Plan (or in the post-closure phase of ACCT) must be discussed with the receiving establishment, a record must be retained in the sending establishment to show this has been done (as well a record made in the ACCT Plan), and relevant information must be conveyed either with or ahead of the prisoner.’
113. I have provided the Governor of Belmarsh with a copy of this report. Although I have highlighted concerns about the way that ACCT monitoring was managed in 2009, they should not detract from the achievements of staff at both Belmarsh and Pentonville. They successfully managed the risk that the

man presented to himself. The risk was taken very seriously and ACCT monitoring was only stopped after three months, once the level of risk had reduced and psychiatric assessments had been completed.

### **Mental health crisis in 2009**

114. Opinions about the man's mental health in 2009 differed widely. The psychiatrist thought that he was suffering from PTSD but did not have a psychotic illness. Later in the summer, the doctor thought that he was psychotic and prescribed antipsychotic medication. His cousin and his partner told the psychiatrist that they did not recognise him as somebody who had experienced mental health problems before he went into prison. Finally, another psychiatrist was unconvinced by his symptoms. She concluded that he was (to some extent) exaggerating the extent of his mental health problem and did not have either a mental illness or PTSD. By the autumn, he had been discharged altogether by the mental health team.
115. The prisoner told the investigator that the man confided in him that he had pretended to have mental health problems in the past in order to manipulate prison staff and get his own way. He also told his offender supervisor at Hollesley Bay that he had previously manipulated staff by exaggerating the extent of his mental health problems.
116. Both a psychiatrist and the man himself suggested that he was exaggerating his symptoms. It does seem remarkable that he was able to sustain the illusion of serious mental health problems for such a long time in 2009. Nonetheless, after this prolonged crisis period, he never again showed similar deteriorations in his mental health at either The Mount or Hollesley Bay.

### **Clinical care**

117. The clinical reviewer has reviewed the man's clinical care. He comments that the man had no significant physical health problems in prison. He considers that any minor ailments were appropriately dealt with. He finds that his drug and alcohol use was clearly recorded in the medical records. As regards his mental health, the clinical reviewer concludes that:

'...the assessments were comprehensive and complete, his risk of self harm was considered and appropriate action taken.

'Where there was doubt, further opinion was sought.'
118. The clinical reviewer notes that the man underwent a detailed health assessment during the reception process at Norwich. He has reviewed both of his periods of imprisonment at Pentonville. He found these clinical records to be 'full and detailed'.
119. Although the handwritten clinical record from Belmarsh does not contain a reception health screening, the clinical reviewer considers it to otherwise be

'full and detailed'. He notes that the reason for prescribing olanzapine (an antipsychotic drug) is not fully documented.

120. When the man arrived at The Mount, the clinical reviewer considers that he was comprehensively assessed. He finds that his mental health was reassessed and no problems were identified.
121. The clinical reviewer considers that the man was thoroughly assessed during the reception process at Hollesley Bay and was treated appropriately for several minor ailments (such as a painful thumb) during the next few months.
122. Concluding his review, the clinical reviewer comments that the clinical care the man received throughout his custodial sentence was comparable to that he could have expected in the community.

### **The man's mood whilst at Hollesley Bay**

123. The man seemed to be making good progress at Hollesley Bay. He was never subject to ACCT monitoring, nor did he ask to speak with a mental health worker or was he ever referred for mental health treatment. During the reception process, he denied having any mental health problems and also denied ever having harmed himself in the past. He did not present with any symptoms of depression or demonstrate concerning behaviour.
124. He was granted regular periods of release on temporary licence. He spent time in the nearby community with friends and family whilst on weekend day release and also spent two longer periods at home with his family in east London. There was no record of unusual or concerning behaviour when he was temporarily released. He complied with the terms of his licence and returned to the prison as instructed on each occasion.
125. The investigator interviewed three staff who had regular interaction with the man whilst he was held at Hollesley Bay. An officer was assigned as his personal officer between August and December whilst he stayed in Willford Unit. His offender supervisor met him several times. An officer ran the workshop which he went to every weekday between November and January to take part in his plastering course.
126. None of the three staff remembered him behaving unusually or expressing suicidal thoughts. They did not recall that his mood was low or that he seemed anxious. None of them remembered him showing signs of a mental disorder.

#### *Workshop Officer*

127. The workshop officer was the member of staff who spent most time with the man, because the plastering course ran five days a week. He told the investigator that he was very pleasant and placid and mixed well with other members of the group. He said that he was a very good student who attended on time and had a positive attitude. He seemed to enjoy the course.

128. He remembered that the man talked about the problems he was having with his transfer to Latchmere House. He recalled that he wanted to be closer to his family. The officer telephoned one of the governors on his behalf because his anxiety about the transfer was affecting his work. He thought that other prisoners had 'jumped the queue'. The officer also consulted his offender supervisor, who advised him that Latchmere House was likely to accept the transfer. He passed the positive news onto him.
129. The man was about half way through the plastering course when he died. He persevered when other members of the group dropped out. The officer was very pleased with his progress. He told the investigator that prisoners who are experiencing mental health problems usually struggle to attend the course, but he had no such difficulties.

*Offender Supervisor*

130. The offender supervisor had identified the man's history of mental health problems when he arrived at Hollesley Bay and talked to him about it. She knew that there had been no further recorded problems since autumn 2009. He told her that he had manipulated staff at the time in order to get his own way. (This comment seems to echo the psychiatrist's psychiatric assessment in September 2009.) The offender supervisor confirmed with mental health staff at Hollesley Bay that they had not identified any concerns with regard to him.
131. The offender supervisor told the investigator that she was in the process of arranging a transfer for the man to Latchmere House when he died. This would have meant that he was closer to his family in London. She recalled that the transfer was looking likely and that he was aware of the positive progress. He had been anxious about the transfer, but the issue had apparently been all but resolved.

*Personal officers*

132. The personal officer remembered that the man was well supported by other prisoners and that he had a reasonable rapport with the staff. My investigator also spoke to the personal officer who was allocated to him after he moved to Stow Unit in the middle of December. However, this officer was on leave for a couple of weeks during Christmas and the New Year, so had very little opportunity to interact with him before he died. He could not remember anything about him.

**The road traffic incident**

133. The man's death was investigated by the Serious Collision Team of Suffolk Constabulary, who are based at the Traffic Unit at Martlesham Heath Police Headquarters. The officers involved told my investigator that they are satisfied that nobody else was involved in causing him to be hit by the HGV.

The toxicology report produced for the Coroner shows that he did not have any drugs or alcohol in his body when he died.

### **OASys risk assessment**

134. At about the time the man moved to Hollesley Bay, a probation officer in east London amended his OASys risk assessment to 'high'. He had previously been assessed as presenting a medium risk of harm to the public. (However, the author of the original pre-sentence report in June 2009 had also assessed him as presenting a high risk of harm to the public because of his offence of causing death by dangerous driving.)
135. The man was unhappy with the increase in his risk assessment because it impeded his progress in an open prison. Because he was a high risk prisoner, he was told that he could not carry out either paid or voluntary work in the community. He subsequently complained to the prison itself, to the Independent Monitoring Board at Hollesley Bay, to London Probation Trust and to the Prisons and Probation Ombudsman.
136. He felt that he had made efforts to address his risk whilst in custody. He had completed a significant number of courses, including Prisoners Addressing Substance Related Offending (PASRO), an Access to Higher Education course, a victim awareness course and an Assertiveness and Decision Making course. He had completed the majority of his original sentence plan and offending behaviour work. He had worked as a wing cleaner and had received good reports.
137. The offender supervisor told the investigator that he did not like being labelled a high risk prisoner and was unhappy that the assessment meant that he was not allowed to work in the community. She remembered that he was sometimes agitated about the risk assessment when they discussed it. She said that the decision 'bothered' him.
138. I can understand how the decision by probation staff to increase his risk assessment when the Prison Service had just approved his move to open conditions was frustrating for him. Although the two decisions were legitimately made by different branches of the National Offender Management Service, they seem contradictory and appear to reflect a lack of joined up thinking.

### **Family liaison**

139. After a prisoner dies, prison staff are normally expected to break the news to their next of kin in person. However, because the man died in the community, his family immediately travelled to Suffolk and were informed of his death by police and hospital staff.
140. The PO (a trained family liaison officer, or FLO) telephoned the Governor on the evening of 15 January to discuss the way in which they would liaise with the man's family. The Governor told the investigator that he advised the

officer not to make contact with the family immediately. He came to this decision because he felt that the family were already grieving, had been to the hospital and had been briefed by the police. He thought that the prison had 'nothing to add' and that he wanted to spare the family further contact with another criminal justice agency.

141. The Governor said that he was solely responsible for deciding not to contact the man's family over the weekend. He checked his records and confirmed that there were no concerns with regard to mental health or self harm whilst he was held at Hollesley Bay. (If there had been, he thought that this would have been relevant information to pass on to his relatives.)
142. However, the PO did then telephone the man's sister (on Monday 17 January) and mother (on Thursday 20 January). The Governor told the PO not to offer a home visit to the family in order to express condolences in person from the staff at Hollesley Bay. He also instructed that the prison should not be represented at the funeral. The prison did contribute towards the funeral after the Governor spoke to my investigator and consulted his area manager. A SO and the PO subsequently returned his property to the family in person.
143. The Governor thought that the police would have given the man's family all of the relevant information that they needed. He reiterated during interview that they would have been aware of the circumstances of his death. However, it was conceivable that not all family members knew about his temporary release from prison on that particular day. They may therefore have been surprised to learn of his death outside the prison.
144. The guidance contained in PSO 2710 (Follow up to deaths in custody) is not directly applicable to the events surrounding the man's death. The advice in the PSO is based on the assumption that the prisoner dies in the prison. In this instance, the man's family had direct contact with NHS staff and the police.
145. Nonetheless, on balance I consider that the prison should have made contact with the man's family the day after he died. It would have been appropriate to offer information and condolences as soon as possible, even if the family declined the offer. Because the Governor decided that the family would not want to be contacted, they did not have the option to make this choice. My investigator made this point when he interviewed the Governor.
146. I hope that the Governor will consider how best to prepare for the eventuality of another death at Hollesley Bay in the future. I am concerned that the prison does not have a second trained FLO. There is currently no contingency plan in place if a death in custody occurs when the PO is on leave. I also have reservations about the way in which the PO was required to fulfil the role of duty governor on the weekend the man died and also then act as the FLO. It is more helpful if the FLO has not been involved in events surrounding the death in custody, in case the prisoner's family have questions about the way the prison handled the situation. I make the following recommendations:

**The Governor should arrange for a second member of staff to be trained as a Family Liaison Officer.**

**In recognition of the open conditions at Hollesley Bay, the Governor should develop a policy for dealing with the death of a prisoner whilst on temporary release in the community.**

### **Allegations of racial discrimination**

#### *The Prisoner*

147. The investigator originally interviewed a prisoner when he visited Hollesley Bay to open the investigation on 25 January. The prisoner was the man's friend and spent the day in the same hotel as him whilst released on temporary licence on 15 January. He was returned to closed conditions at HMP & YOI Norwich on 13 April after he failed a mandatory drug test.
148. On 16 April, the prisoner wrote to the investigator making allegations about the treatment that black and minority ethnic (BME) prisoners receive at Hollesley Bay and the effect that this discrimination apparently had on the man. He claimed that he had been under 'immense pressure' when the investigator originally spoke to him not to talk about certain issues for fear of repercussions. Another investigator interviewed the prisoner when he visited Norwich on 10 May.
149. The prisoner alleged that a senior officer, an officer and the PO (the family liaison officer and the Ombudsman's liaison officer in this case), visited him the day before the investigator came to Hollesley Bay to open the investigation. He alleged that it was inferred that he would jeopardise his categorisation and risk a return to a closed prison if he spoke to the investigator about matters other than the events on the day the man died.

#### *The PO's response*

150. Two investigators interviewed the PO on 12 July. He told my investigators that he talked to the prisoner in an office on Wilford Unit approximately three or four days before the investigator arrived for his opening visit. He described his conversation with the prisoner:

'...there was some concern from staff that malicious allegations were being thrown on the unit and your name was brought up to say that he was throwing those out which was unsettling the unit. So I do remember telling him, look mind your own counsel. Its all well and good throwing accusations but you are not the one that's investigating it if you've got any concerns... see the PPO.

'I said if you saw it, tell them you saw it. If you didn't see it, tell them you didn't see it.

'I said to him exactly what I've just said to you, that it's his opportunity to say what he has to say and that he needs to tell the truth and you know I did say to him be mindful to tell the truth.

'[I said] Don't tell any lies and don't embellish...'

151. The PO thought that he might have been accompanied by a SO when he made these remarks, but he did not recall having another officer present. During interview, he stressed that he had definitely not alluded to the potential threat of recategorisation to a closed prison when he spoke to the prisoner.
152. I accept that the PO's intervention was probably well intentioned. Nevertheless, I consider that it was unacceptable. However well meant, his advice to the prisoner constituted interference in the Ombudsman's investigation and affected its course. Because the PO spoke to the prisoner, the latter claimed that he felt unable to talk openly to the investigator when he first visited. He only felt able to make his allegations once he transferred to another prison. The PO's intervention appears to have stopped the investigator from obtaining evidence at the earliest opportunity.
153. The responsibility of the member of staff liaising with the Ombudsman's investigator is to facilitate the investigation and make arrangements. They should not be offering advice to prisoners or trying to influence their comments in any way. I make the following recommendation:

**The Governor should provide the following guidance to staff about interviews with prisoners during death in custody investigations:**

- **staff should neither discuss the content of a PPO interview with a prisoner who is due to speak to an investigator, nor seek to influence the content**
- **staff may offer reassurance to a prisoner about the nature and purpose of PPO interviews**
- **staff may accompany a prisoner to a PPO interview if they request it**

*The prisoner's other allegations*

154. The prisoner said that the man had believed that some of the staff on Wilford Unit had behaved towards him in a racially discriminatory way. He said that he had been affected by the treatment he experienced. He claimed that a lot of other BME prisoners felt similarly. He recalled that the staff on Wilford Unit 'kept on [the man's] case'. He told the investigator:

'The man... told me with his own words, and [on] numerous occasions, that he couldn't handle [the staff concerned] and that they were doing his head in and he doesn't know what to do.'

155. The prisoner alleged that two officers had both made racist remarks to the man and other prisoners. Both officers work on Wilford Unit, where the man

stayed from August until December before moving to Stow Unit a month before he died. He said the man had wanted to move off Wilford Unit. He commented:

‘...they targeted [the man] mainly, like he got it worse than the rest of us if you know what I mean. But he didn’t really handle it the best way...

‘...on the day... he died I was sat in the car with him outside the Holiday Inn and I had a room next door to him. So like he was saying to me in there like ‘oh I need to get off that wing, that officer is just as bad as the other two...’

(This worked on Stow Unit.)

156. The prisoner indicated that the two officers would make racially discriminatory remarks to BME prisoners when they were working together, but that they would be more discreet in front of other colleagues. He alleged that Officer A:
- Called the man names.
  - Referred to prisoners from BME backgrounds as ‘your type of people’.
  - Tried to reduce the man’s IEP regime to basic by claiming that he was bullying other prisoners for food in the dinner queue (something the prisoner said was not true) and told him to go to the back of the queue, maintaining that he had jumped the queue when in fact he had not.
157. The prisoner claimed that the man had written graffiti about Officer A on the toilet wall in Wilford Unit. (My investigator was given a photograph of graffiti mentioning the officer by name, which was found by staff on 27 November 2010.) He also alleged that the officer made a deliberately provocative remark in front of the BME prisoners on Wilford Unit that resulted in another prisoner losing his temper. The prisoner claimed that this prisoner transferred to another prison the next day.
158. The second prisoner moved to HMP & YOI Chelmsford on 16 December. This was the same day that the man moved to Stow Unit. My investigator has confirmed that the two moves were unconnected. This prisoner was returned to closed conditions after he was unable to account for an absence of five hours whilst he was released on temporary licence on 10 December to attend a hospital appointment. Staff considered that he required closer supervision than could be offered in an open prison. He had also received a proven adjudication for drinking alcohol whilst released on temporary licence.

#### *The second prisoner*

159. Another of my investigators interviewed the second prisoner at Chelmsford on 11 July 2011. He said that staff had made life difficult for the man. He described Hollesley Bay as ‘a very racist establishment’ where staff victimise prisoners from a BME background. He said that the man was ‘very unhappy’ because of the way he was treated. He alleged that the man had been

subjected to four cell searches, which he considered to be a disproportionately high number. (My investigator has confirmed that there is only one record of his cell being searched at Hollesley Bay, on Stow Unit on 22 December after the second prisoner had left the prison.)

160. The prisoner said that he had no faith in the internal complaints procedure. He did not think that it was confidential because officers would know exactly who had complained about them.
161. Without being told about the first prisoner's allegations, he stated that two officers were primarily responsible for racial discrimination on Wilford Unit. He said that they thought of themselves as 'untouchable' and that they racially discriminated 'very openly'. He described Officer A as the 'most racist officer' he had met at Hollesley Bay.
162. During interview, the prisoner alleged that BME prisoners would be transferred back to closed conditions as soon as they committed one misdemeanour. He claimed that white prisoners were given many more chances to remain in open conditions.
163. When he was interviewed, he described how the man became more upset than the first prisoner or himself about the alleged racial discrimination. He explained how, the more he reacted and became angry, the more the bullying increased. He said that the man would become visibly upset, prompting the staff to carry on deliberately provoking him. He also claimed that Officer B had persecuted the man when he was sick, making him do the cleaning although he was unwell.

#### *The officers' responses*

164. Two investigators interviewed both officers on 12 July. My investigators put the allegations to both men during separate interviews and both denied any racially discriminatory behaviour.
165. In order to investigate the claims made by both prisoners, the investigator and his colleagues examined a number of different sources of evidence:

#### *Documented complaints*

166. The investigator asked for details of any formal complaints made by prisoners against the two officers. None had been made by both prisoners or the man.
167. In the twelve months from July 2010 until July 2011, one Racist Incident Report Form (RIRF) was submitted about Officer A and one about Officer B. Both complaints were from BME prisoners. During this period, three other RIRFs were submitted about other officers, making a total of five across Hollesley Bay.
168. Six more general complaints were made about Officer A during the same period. (Three of these were made by BME prisoners.) No general

complaints were made about Officer B. 12 general complaints were made about other officers during this period. This means that 33 percent of all general complaints were made about Officer A (who constitutes less than one percent of the staff).

169. The only complaint that the man made to the Prisons and Probation Ombudsman related to his OASys risk of harm assessment. Although other prisoners have made a number of complaints to the Ombudsman about Hollesley Bay, none of these related to allegations of racially discriminatory behaviour.

*Recent internal investigation*

170. The race equality officer, or REO, and deputy REO completed an investigation of issues raised by Wilford Unit Race Equality Action Team (REAT) representatives in October 2010. BME prisoners on the unit felt that they were being treated differently 'due to their ethnicity'. During their investigation, both REOs interviewed a large number of prisoners, including the man. The following is their interview with him taken directly from the investigation report:

'The man said, 'This is a small community, in prison, and I do not want to be targeted, but I have seen different officers treat BME prisoners differently, and get away with it.'

'He was asked, 'What do you mean by 'treating them differently'?''

'He replied, 'For example, I was late for roll check and got an IEP warning. I saw the SO who said I had negative entries. I have, but others were late with no entries.'

'He was asked, 'Were these other prisoners white or BME?'

'He replied, 'White.'

'He was asked, 'How do you know they have had no entries?'

'He replied, 'I don't.'

'I said to the man, 'It is interesting to see that you have raised concerns about being in a group, because, to the best of my knowledge, and reading the documentation, I have not seen anywhere where you have been linked to being in a group. I have read your case notes, and for the past six weeks, there are only two negative entries, the one you mentioned about being late for roll check, and the other, on the same day, was from an officer for playing your stereo loudly. The other entries are concerning your OASys status.'

'He said, 'Yes, I am high risk, and that is causing me problems with my home leave. Since this app[lication] has been put in, it has got quieter

and some have been shipped out. The group gang thing is not a problem, but I don't want to have to look over my shoulder 'cause I don't feel relaxed with a group of us.'

'The SO asked, 'Why do you feel that you have to look over your shoulder and who you mix with?'

'He replied, 'Problems since I arrived, high risk, and who I associate with. I know this, as this is what people say. I have not experienced this myself, but because I am black, nobody who is black gets away with anything, only if you are white.'

'The SO asked, 'How does this affect you?'

'He said, 'I do not ask when he is on, I wait until different officers are on.'

'He was asked to whom he was referring, but he was not prepared to disclose this information.'

171. During the investigation, the man also told both REOs:

'[Officer A] scares people, he has an abrupt attitude and so I have changed jobs to the CES [clothing exchange store].'

172. Both REOs interviewed Officer A's colleague. She said that Officer A is stricter and louder than his colleagues. She told the REO that she had not seen or heard her colleague making any racist gestures or comments. She explained:

'He will challenge anyone who needs challenging, regardless of their colour, age or anything.'

173. The findings of the investigation were discussed at the subsequent REAT meeting held in November 2010. The then REAT representatives said that the problems were still ongoing, so the next day the Governor met the Wilford Unit manager, both REOs and the two REAT representatives. The representatives said that BME prisoners were afraid of repercussions if they complained and had little faith in the complaint system.

174. Both REOs concluded their investigation as follows:

'[The prisoners who complained] perceived that they were being targeted unfairly because of their ethnicity. However, the results of the enquiries indicate that it was the behaviour of those prisoners which had brought them to the attention of staff, and not their ethnicity.

'It is to be hoped that the intervention work carried out by the Race Equality Department, in liaison with the Unit Manager, will help to

bridge the apparent void in communications, or the use of unacceptable language and behaviour, between staff and prisoners.'

175. In relation to his behaviour towards three prisoners, the REO wrote to Officer A on 11 November 2010:

'It is accepted that these comments and actions were not made with malice or with intention to insult. But this was unprofessional conduct, which is unacceptable. It is close to being interpreted as racism and must not be repeated.'

*The opinion of the Independent Monitoring Board*

176. The IMB made the following observations about race equality at Hollesley Bay in their latest annual report:

'During 2010, 21 racist incidents were reported at Hollesley Bay compared with 36 the previous year. Racist Incident Reports were all thoroughly investigated, including one very complex complaint that involved prisoners already discharged from prison and/or moved back to closed conditions. Such investigations are lengthy but the IMB was satisfied that the reported incident was thoroughly investigated and that the complainants were clearly informed of the outcomes; all expressed themselves satisfied.

'Investigations into racist incidents are conducted by two part-time Race Equality Officers (REOs) with strong support from the Race Equality Administration Officer. Records are kept up to date and all reported incidents tracked carefully including a monthly report from the REO to the Race Equality Action Team.

'During 2010, Race Equality Action Team (REAT) meetings were held monthly, with the exception of August. Meetings were chaired by the Governor and included prisoner representatives from each residential unit. Active participation from prisoners was encouraged. The Governor was keen to hear prisoners' views on race equality at Hollesley Bay and to develop confidence in the systems for monitoring and promoting good race relations. Issues raised in 2010 included [Black and minority ethnic] access to resettlement opportunities, food service during Ramadan, access to [Release on Temporary Licence] and staff prisoner relations. Prompt action on these issues was taken with staff reporting directly to the Governor on outcomes, which were then shared with the staff and prisoners on the REAT. Minutes of the REAT meetings were given to prisoner representatives to share with fellow prisoners. Each residential unit has a member of staff with whom the prisoner representative regularly meets. Each prisoner representative on the REAT must have at least six months of his sentence left to serve so that there is continuity within the REAT.

'A Diversity Day celebrating diverse faiths, cultures and foods was held for the third year running, and Black History month was marked for the first time through a series of events for prisoners...

'The IMB monitors race equality at Hollesley Bay through IMB applications, Racist Incident Report forms, Request and Complaint forms, regular attendance at the monthly REAT meetings and talking with prisoners and staff.

'The IMB continues to believe that the Governor and his Senior Management Team are active and committed advocates of race equality. At the end of 2010, 100% of staff and all the REAT prisoner representatives had been trained in race equality. As reported last year, the Governor remains unequivocal in his insistence that all prisoners and staff at Hollesley Bay are treated equally. However, there continues to be a perception amongst some of the prisoners that the prison has racial tendencies; although, from conversations IMB members have had with prisoners, this may be a failure to understand that a prison might not be racist, stemming from previous experiences. The IMB is confident in the integrity of the systems at Hollesley Bay for promoting and maintaining good race relations.'

177. The investigator spoke to the Chair of the IMB at Hollesley Bay by telephone on 8 July. She remarked that there is an ongoing perception of racial discrimination amongst BME prisoners. However, she said that Hollesley Bay is not a racist prison in the IMB's opinion. She confirmed that the Board can find no evidence to support such a claim. She stated that the IMB have not received any applications from prisoners about racial discrimination. She remarked that prisoners feel very able to approach members of the Board, but have never done so to express concerns about race equality.
178. She accepted that the prison's location and the composition of the local community seem to have hampered efforts to recruit BME staff. She told the investigator that the IMB has tried and failed to recruit a board member from a BME background. However, she said that the managers at Hollesley Bay go to great efforts to address issues of diversity and make sure that BME prisoners are always given equal opportunities to obtain work placements.
179. She told the investigator that the IMB had raised the issue of Officer A's attitude towards staff and prisoners at their last three meetings with the Governor. She confirmed that, although the Board is unhappy with the way that he speaks to others at work, they do not consider that he has demonstrated racially discriminatory behaviour. She said that Wilford Unit is the most problematic residential unit in recent times, as far as the Board is concerned. As a result, she said that members of the IMB are keeping a close eye on life on the unit.

*Her Majesty's Chief Inspector of Prisons*

180. Following HMIP's most recent inspection of Hollesley Bay, HM Chief Inspectorate made the following comments about race equality:

'Diversity arrangements were underdeveloped and, despite a commendably strong lead from the governor, further work was required with staff to raise cultural awareness and with black and minority ethnic prisoners to satisfy them that they were treated equally.

'Thirty-five per cent of prisoners were from black and minority ethnic backgrounds and many came from the London area. By contrast, almost all staff were white and from a rural area. There were only three black and minority ethnic members of staff.

'None of the managers who attended the REAT [Race Equality Action Team] were from black and minority ethnic backgrounds.

'Black and minority ethnic prisoners believed they were generally treated fairly, but many were not confident that staff understood and accepted them. In our survey, only 74% of black and minority ethnic prisoners compared to 92% of white prisoners said they had a member of staff they could turn to if they had problem, fewer black and minority ethnic prisoners than white prisoners said most staff treated them with respect and 21% compared to just 4% of white prisoners said they had felt threatened or intimidated by a member of staff. Some said they were reluctant to raise issues about race because of potential repercussions.

'...racist incidents were taken seriously and that staff tried to respond fairly and urgently to complaints.'

181. She made the following recommendations about race equality (I have included the latest responses from Hollesley Bay to each recommendation in italics):

- Renewed efforts should be made to find a representative from an external organisation promoting race equality to be co-opted onto the race equality action team, attend regularly, contribute to the development of local policy and scrutinise investigations of racist complaints.

*'Efforts have been made to find an external organisation to attend regular Equalities Action Team meetings, contribute to local policy and scrutinise investigations and complaints and we note the desirability for this to happen. We will again renew our efforts in the local community to seek support for our work in the Equalities Action Team. An independent person analyses and scrutinises the reports arising from complaints and Racist Incident Reporting Forms.'*

- Representatives from the chaplaincy and education should attend the race equality action team regularly.

*‘This is fully in place with the Head of Learning & Skills representing Education and a chaplain representing the Chaplaincy Team.’*

- Racist incident investigations should record more fully how findings and conclusions are reached.

*‘This has been fully acted upon and is now part of all investigation reports.’*

- Feedback forms from racist incident complainants should be analysed and any concerns followed up.

*‘A quarterly summarisation of all equality complaints is conducted and discussed on the Equalities Action Team meeting. Any concerns raised are discussed at this meeting and are also discussed at Senior Management meeting which takes place the following day.’*

#### *BME monitoring*

182. Both investigators interviewed the REO on 12 July. He provided statistics for the last 12 months which demonstrate that the progress and treatment of BME prisoners is monitored on a monthly basis. I understand that this is something that the Governor has prioritised.
183. Of 117 staff working at Hollesley Bay (excluding healthcare staff), three are from a BME background. (This equates to 2.6% of the workforce.) One is a Principal Officer and two are employees in the works department. None are officers working day-to-day on the residential units. This number actually exceeds the Key Performance Target set by NOMS of 2.1% of staff in contact roles.
184. The Governor told my investigator that the National Offender Management Service (NOMS) has advertised in specialist publications and attended local job fairs in order to recruit BME staff, to little avail. The primary reason for the lack of BME staff at Hollesley Bay would seem to be its location. It is in a rural and isolated part of Suffolk. It takes forty minutes to reach the prison in the car from Ipswich. When the census was taken in 2001, the proportion of the population which identified themselves as BME was less than three percent. According to this figure (about to be superseded when the latest 2011 census results are published), the prison’s staffing is in line with the population it draws upon.
185. However, Suffolk County Council published a document entitled ‘Diversity of Suffolk: Ethnicity and Nationality’ in May 2010. The report found that the BME community in Suffolk had more than doubled in size to 5.6% of the population between the census in 2001 and 2007 (the most recent figure available). It is

therefore questionable whether the number of BME prison staff any longer accurately reflects the composition of the local community.

186. The proportion of BME staff compares unfavourably with the number of BME prisoners at Hollesley Bay. The percentage of prisoners who identify themselves as BME was as follows in the 12 months from July 2010 to June 2011:

June 2011	38.9%
May 2011	39.3%
April 2011	36.9%
March 2011	38.1%
February 2011	37.3%
January 2011	36.2%
December 2010	35.3%
November 2010	37.1%
October 2010	36.5%
September 2010	37.8%
August 2010	34.8%
July 2010	36.6%
<i>Average:</i>	<i>37.1%</i>

187. Hollesley Bay receives a significant number of BME prisoners from the London area. The difference between a London prison such as Pentonville and an open prison like Hollesley Bay cannot be overstated. Prisoners transferring from London will no longer regularly encounter BME staff.

188. In the 12 months between July 2010 and 2011, 94 prisoners were recategorised and returned to closed conditions from Hollesley Bay. Of these, 42 were BME prisoners. This figure constitutes 44.7% of those returned and somewhat exceeds the proportion of the population which BME prisoners constituted over the same period. Nonetheless, it is not so large as to be unduly concerning.

189. The BME population are (broadly speaking) spread equally across the five residential units. The amount of BME prisoners in each unit between November 2010 and June 2011 was as follows:

	<i>Jun</i>	<i>May</i>	<i>Apr</i>	<i>Mar</i>	<i>Feb</i>	<i>Jan</i>	<i>Dec</i>	<i>Nov</i>
<b>Bosmere Unit</b>	<b>30</b>	<b>32</b>	<b>32</b>	<b>31</b>	<b>33</b>	<b>31</b>	<b>31</b>	<b>31</b>
Cosford Unit	30	28	26	28	28	26	27	27
<b>Hoxon Unit</b>	<b>24</b>	<b>28</b>	<b>23</b>	<b>25</b>	<b>16</b>	<b>22</b>	<b>19</b>	<b>21</b>
Stow Unit	30	26	26	26	29	27	26	27
<b>Wilford Unit</b>	<b>28</b>	<b>25</b>	<b>25</b>	<b>26</b>	<b>26</b>	<b>26</b>	<b>22</b>	<b>28</b>

190. The Governor told my investigator that one hundred percent of his staff have received up-to-date diversity training reflecting the message 'Challenge it, change it'.

*Prisoner representatives who attend Equality Action Team (EAT) meetings*

191. The Governor chairs monthly EAT (previously known as REAT) meetings. These are attended by staff and prisoners. Both investigators spoke to the current prisoner EAT representative for Wilford Unit and another EAT representative who also lives on Wilford Unit. One has been at the prison since February 2011 and the other since March 2011. Neither lived on Wilford Unit at the same time as the man. The investigation conducted in October 2010 resulted from complaints by their predecessors.
192. Both current representatives had favourable impressions of Wilford Unit and the steps that staff took to ensure that race equality was achieved at Hollesley Bay. They thought that the Governor took the issue very seriously. They said that they wanted to stay on Wilford Unit and that they had not witnessed any incidents which they considered to be racially discriminatory. They were unaware of any other complaints from prisoners about racial discrimination.

*Conclusion*

193. I am encouraged that race equality is prioritised and actively promoted at Hollesley Bay. My investigator was reassured by his conversations with the current EAT representatives, the Governor, the chair of the IMB and the REO. I welcome the monthly monitoring of the BME population and commend this proactive approach. When my investigator visited Hollesley Bay, the REO was able to effectively demonstrate the steps that the prison has taken to monitor the progress BME prisoners.
194. I am concerned that the prison has not managed to recruit more BME staff members. I would encourage the Governor to pursue this matter when further recruitment opportunities eventually arise. However, I understand that the current public sector cuts mean that it is highly unlikely that further officers will be recruited in the near future.
195. Both prisoners made some serious allegations about three members of staff. All three denied the allegations when they were interviewed. I am concerned about the volume of complaints about Officer A. However, I am minded to agree with the chair of the IMB that the problem with this officer is not isolated to BME prisoners. I hope that the Governor, his management team and the IMB keep a close eye on life on Wilford Unit in the months to come. I make the following recommendation as a precautionary measure:

**The Governor should ensure that staff-prisoner relations on Wilford Unit are discussed as an agenda item at EAT meetings for the next 12 months.**

196. The IMB considers that there is a perception of racism at Hollesley Bay. The Board's comments are supported by both prisoners' statements, as well as the need for an internal investigation of Wilford Unit last autumn. The Stephen Lawrence enquiry defined a racist incident as:

‘...any incident which is perceived to be racist by the victim or any other person...’

197. By this definition, the Governor and his staff still have some way to go to complete the race equality work that they have begun. As long as prisoners perceive racial discrimination, a problem persists. The staff at Hollesley Bay need to think carefully about how race equality can be achieved. They also need to consider why some prisoners might not have confidence in the work being done. I make the following recommendation:

**The Governor and the Race Equality Team should:**

- **consider why some prisoners might perceive racial discrimination and implement a plan to address these concerns**
- **publicise the good work already being undertaken in relation to race equality and diversity**

## CONCLUSION

198. The man's time in custody seemed to consist of two distinct periods. In 2009, he seemed to be experiencing significant mental health problems which resulted in a series of psychiatric assessments, admission to the healthcare centre, a period of constant supervision and ACCT monitoring lasting for three months. However, a psychiatrist subsequently determined that he did not have a mental illness.
199. His state of mind then seemed to improve and he gave no further cause for concern for the next 16 months. He progressed to an open prison and was trusted to spend time in the community on temporary licence. Then, suddenly and tragically, he seems to have taken his own life in a road traffic collision. There is no evidence that he talked about harming himself or required mental health treatment at Hollesley Bay.
200. The investigation was asked to consider the issue of race equality at Hollesley Bay. Prisoners raised serious concerns. The overall balance of evidence suggests that strenuous efforts are being made to proactively address this issue. Nonetheless, the perception of racial discrimination seems to persist to some degree. I hope that the evidence my investigators collated gives the man's family some understanding of the environment he experienced as a BME prisoner. I commend the efforts of the race equality team thus far and encourage the Governor to strengthen and renew the efforts he has already made.

## The man's family's response to the draft report

201. Following the publication of the draft report, the man's mother wrote to the family liaison officer providing a very thoughtful response. She expressed her opinion that racism still exists in some prisons. She wrote:

'I believe that racism and discrimination [are] an individual thing and if [these individuals come] together as a group it becomes a powerful thing.'

202. The man's expressed concern that individuals who may be inclined to racially discriminate against prisoners could potentially be placed in roles that give them the opportunity to act on their beliefs. She expressed her hope that the conduct of the officers who the prisoners named during their interviews would be closely monitored by the management team at Hollesley Bay.
203. The man's mother commented that it was 'unacceptable' for staff to speak to prisoners in advance of their interview with the Ombudsman's investigator. She thought that any information or instructions should simply be passed to the prisoner in writing prior to an Ombudsman's interview.
204. The man's mother further added:

'However, I do not believe that being targeted by racism played a part in [the man's] death as we as a family grew up facing this and dealt with it appropriately and learned to deal with it day by day.'

'Prisoners are serving time for an offence, not for the colour of their skin, and if racism is being dispersed throughout the prisons and complaints are made, they should be passed on to correct departments without mishandling and dealt with in the appropriate way and not swept under the carpet.'

205. The man's mother asked the investigator for further information. She wanted to know why her son had been moved from Wilford Unit to Stow Unit. Although paragraph 69 outlines the reasons for the move, I should explain that this kind of move is common practice and managers are at liberty to relocate prisoners to improve the stability of the prisoner population. For this reason, it was felt at the time by staff that the man should, along with a number of other prisoners, move off Wilford Unit.
206. The man regularly complained about his assessment as a high risk prisoner. His mother asked why he was assessed as high risk. The reasons for the change in risk assessment are outlined in paragraphs 73 and 74. Offender managers (also known as probation officers) make individual risk assessments based on the prisoner's offending history, in consultation with their managers. The individual responsible for the risk assessment may not then be the same person who then manages the offender. The risk assessment has to be evidence-based.

207. The man's mother also asked why prison officers are not monitored. In a similar way to other public sector organisations, prison staff are subject to annual performance appraisals. If their performance is found to be unsatisfactory, then it can be monitored and measures can be taken. It is the responsibility of managers to identify performance deficiencies and manage the individual. However, officers often work alone or in pairs on the residential units and are not always working in the company of managers day to day due to staffing constraints.

## RECOMMENDATIONS

### For the Governor:

1. The Governor should arrange for a second member of staff to be trained as a Family Liaison Officer.

The Governor accepted the recommendation and provided the following response:

‘A member of staff has now been identified for the next available training course.’

2. In recognition of the open conditions at Hollesley Bay, the Governor should develop a policy for dealing with the death of a prisoner whilst on temporary release in the community.

The Governor accepted the recommendation and provided the following response:

‘The Deputy Head of Residence will compile a suitable action plan to respond to the death of a prisoner whilst that prisoner is on temporary release in the community.’

3. The Governor should provide the following guidance to staff about interviews with prisoners during death in custody investigations:

- staff should neither discuss the content of a PPO interview with a prisoner who is due to speak to an investigator, nor seek to influence the content
- staff may offer reassurance to a prisoner about the nature and purpose of PPO interviews
- staff may accompany a prisoner to a PPO interview if they request it

The Governor accepted the recommendation and provided the following response:

‘A notice to staff will be published covering these important issues.’

4. The Governor should ensure that staff-prisoner relations on Wilford Unit are discussed as an agenda item at EAT meetings for the next 12 months.

The Governor accepted the recommendation and provided the following response:

‘This item has now been entered onto the agenda for the Equalities Action Team meeting and is being discussed on a monthly basis.’

5. The Governor and the Race Equality Team should:

- consider why some prisoners might perceive racial discrimination and implement a plan to address these concerns
- publicise the good work already being undertaken in relation to race equality and diversity

The Governor accepted the recommendation and provided the following response:

‘The Senior Management Team notes the issues arising from the Equalities Action Team meeting and continuously seeks to address any concerns arising.

‘The Equalities Action Team will publish statistics and other information as required to dispel misconstrued perceptions and to emphasis the positive issues in regard to diversity at Hollesley Bay.’