Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Daryl McNamee, a prisoner at HMP Isis, on 9 August 2019

A report by the Prisons and Probation Ombudsman

Third Floor, 10 South Colonnade
Canary Wharf, London E14 4PU
Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk
T I 020 7633 4100
F I 020 7633 4141

Our Vision

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

Our Values

We are:

Impartial: *we do not take sides*
Respectful: *we are considerate and courteous*
Inclusive: *we value diversity*
Dedicated: *we are determined and focused*
Fair: *we are honest and act with integrity*

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

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

Mr Daryl McNamee was found hanged in his cell in the segregation unit at HMP Isis on 9 August 2019. He was 32 years old. I offer my condolences to Mr McNamee's family and friends.

Mr McNamee spent 29 days in the segregation unit before he died. His mental health deteriorated significantly in the last two days of his life. I am very concerned that staff underestimated Mr McNamee's risk of suicide or self-harm and failed to respond to his mental health issues with sufficient urgency.

I am also concerned that officers did not check Mr McNamee hourly, as required, in the three hours before he was found dead.

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

Sue McAllister, CB
Prisons and Probation Ombudsman **November 2020**

Contents

Summary

Events

1. In April 2015, Mr Daryl McNamee was sentenced to six years and six months in prison for robbery. He was released in September 2018. In February 2019, Mr McNamee was recalled to custody on further charges. In April he received an 18-month sentence for these offences.

2. On 17 April, Mr McNamee moved to HMP Isis. He had a history of heroin use in the community and was placed on a methadone reduction programme, which he completed successfully on 13 June. He worked as a cleaner and was on the enhanced regime because of his positive behaviour.

3. On 2 July, staff recorded that Mr McNamee was under the influence of drugs and they found heroin tablets in his underwear. He told officers that he was at risk from other prisoners because staff had confiscated the heroin tablets.

4. On 12 July, Mr McNamee jumped onto the netting between landings and stayed there for five hours. Officers moved Mr McNamee to the segregation unit, pending a disciplinary hearing. Three days later, he was punished with 21 days cellular confinement. On 18 July, he threw urine and excrement out of his cell and was punished with further cellular confinement.

5. Apart from this incident, segregation unit staff described him as polite, compliant and friendly and he caused no concerns until 8 August.

6. On 8 August, Mr McNamee's offender supervisor gave him a copy of his parole report, which did not recommend his release. He had an unsettled night and began expressing paranoid ideas. The next morning, he said he thought staff were conspiring to hang him and that people were tampering with his mail. The segregation unit manager asked an officer to contact the mental health team to review Mr McNamee as she had concerns about his mental health. The mental health team did not treat this as an urgent request and no one came to see him. A general nurse planned to review him later that day.

7. At 3.46pm, staff went to Mr McNamee's cell to let him out to make a telephone call. They found Mr McNamee suspended from the corner of the door by a ligature. They radioed a medical emergency and attempted to resuscitate Mr McNamee. Healthcare staff attended and continued with resuscitation efforts until paramedics arrived and pronounced Mr McNamee dead at 4.40pm.

Findings

Assessment of risk

8. Mr McNamee had been segregated for 29 days before his death and had begun to express paranoid ideas. Segregation can damage mental health and significantly increase a prisoner's risk of suicide or self-harm, and we consider that staff under-estimated the risk Mr McNamee posed to himself.

9. Mr McNamee became paranoid, anxious and emotional in the last two days of his life. We consider that staff should have requested an urgent mental health

assessment and that he should have been managed under suicide and self-harm prevention procedures (known as ACCT).

10. At the very least, Mr McNamee should have been checked hourly, in line with the segregation's unit local policy. This did not happen in the three hours before he was found dead.

Segregation

11. We found several failings in the management of Mr McNamee in the segregation unit. He had been segregated for 29 days when he died and we consider that more should have been done to support his mental wellbeing; healthcare staff did not carry out sufficiently thorough checks; and his unlock levels were not properly recorded.

12. In addition, there is no evidence that staff had at least three meaningful conversations a day with him, as they should have done. This was a missed opportunity to engage with him and identify his deteriorating mental health and increased risk.

Offender Management

13. The day before he died, Mr McNamee's offender supervisor gave him his parole report, which did not recommend release. We cannot say if this played any part in Mr McNamee's decision to take his life, but we are concerned that she did not tell segregation unit staff or suggest they consider putting extra support in place.

Recommendations

- The Governor should ensure that staff manage prisoners at risk of suicide or self-harm in line with national guidelines, and that, in particular, staff working in segregation units should:
    - be aware of the particular vulnerability of segregated prisoners;
    - have received recent training on ACCT and mental health awareness;
    - identify and consider all risk factors when assessing a prisoner's level of risk of self-harm and suicide; and
    - open ACCT procedures when required.

- The Head of Healthcare should ensure that:
    - all healthcare staff are aware of the particular vulnerability of segregated prisoners to suicide and self-harm; and
    - mental health staff treat requests for a mental health assessment of a segregated prisoner as a priority.

- The Governor should ensure that:
    - Segregation Review Boards assess how well the prisoner is coping, plan for their relocation to more appropriate accommodation, and develop a careplan to help prevent deterioration in mental health;
    - staff have at least three meaningful conversations a day with segregated prisoners and record these;

    - all segregated prisoners are checked at least hourly and this is recorded; and
    - controlled unlock levels are clearly recorded to avoid any confusion among staff.

- The Head of Healthcare and the lead GP should ensure that doctors and nurses:

    - have meaningful conversations on at least some days with segregated prisoners, particularly those who are segregated for long periods, in order to assess their wellbeing, and do not just rely on segregation unit staff to alert them to possible concerns; and
    - allow sufficient time for this in their segregation unit rounds.

- The Governor should ensure that offender supervisors:

    - receive training in ACCT procedures; and
    - make sure that support is in place for prisoners before they disclose potentially distressing material, such as parole reports.

- The Governor should ensure that this report is shared with Mr McNamee's new offender supervisor, the segregation unit manager and staff working in the segregation unit and that a senior manager discusses the Ombudsman's findings with them.

The Investigation Process

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

15. The investigator visited Isis on 29 August 2019. He obtained copies of relevant extracts from Mr McNamee's prison and medical records.

16. The investigator interviewed 15 members of staff and 3 prisoners at Isis between November and December 2019. NHS England commissioned a clinical reviewer to review the clinical care at the prison. He jointly interviewed 10 members of staff with the investigator.

17. We informed HM Coroner for Southwark of the investigation. The coroner sent us the results of the post-mortem examination. We have given the coroner a copy of this report.

18. One of the Ombudsman's family liaison officers contacted Mr McNamee's father, to explain the investigation and to ask if he had any matters he wanted the investigation to consider. Mr McNamee's father wanted to know:

    - if Mr McNamee used a bedsheet as a ligature;
    - why nobody noticed the sheet he used to kill himself outside his door;
    - when officers last checked on him;
    - Mr McNamee's movements on the day he died.

    We have addressed these questions in this report.

Background Information

HMP Isis

19. HMP Isis is a Category C training prison in South East London, holding about 600 young adults and men aged 18-30. Oxleas NHS Foundation Trust provides healthcare services.

HM Inspectorate of Prisons

20. The most recent inspection of HMP Isis was in August 2018. Inspectors reported that the prison's culture and atmosphere had improved since the previous inspection in 2016. They noted that 80% of prison officers were in their first year of service and that this brought challenges, although the Governor saw it as a long-term opportunity.

21. Inspectors reported that conditions in the segregation unit were good. They found that, although the unit's regime was basic, it had improved since the last inspection and was better than in some other prisons. The systems to trigger assessment and reviews of prisoners held in the segregation unit for over two weeks were satisfactory. Reviews of longer-term prisoners in the segregation unit were timely and there was good evidence of planning to return them to normal location.

22. Inspectors reported that the quality of ACCT documentation was generally good, with reasonable quality entries by staff and named case managers. There was a range of community-equivalent interventions for patients needing primary and secondary mental healthcare. Working relationships between healthcare and other areas of the prison were generally positive. Inspectors reported that few members of staff had received mental health awareness training.

Independent Monitoring Board

23. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report, for the year to December 2018, the IMB reported that all prisoners during the year had been lawfully segregated, and that staff had taken appropriate action to authorise the continuing segregation of longer-term prisoners. The IMB was concerned about the increase in the number of prisoners with ACCTs and mental health problems in the segregation unit.

24. The IMB continued to express concern that a small number of prisoners with significant mental health problems made a disproportionate demand on the prison's resources in terms of cost and staff time. The IMB pointed out that Isis cannot treat prisoners with serious and enduring mental health problems, and that those individuals should be treated in an alternative healthcare environment.

Previous deaths at HMP Isis

25. Mr McNamee was the second prisoner to die at HMP Isis since it opened in 2010. The previous death, in 2016, was drug-related.

Assessment, Care in Custody and Teamwork (ACCT)

26. ACCT is the Prison Service care-planning system used to support prisoners at risk of suicide or self-harm. The purpose of ACCT is to try to determine the level of risk, how to reduce the risk and how best to monitor and supervise the prisoner. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011*, Managing prisoners at risk to self, to others and from others (Safer Custody)*.

Incentives and Earned Privileges (IEP) Scheme

27. Each prison has an Incentives and Earned Privileges scheme which aims to encourage and reward responsible behaviour, encourage sentenced prisoners to engage in activities designed to reduce the risk of re-offending and to help create a disciplined and safer environment for prisoners and staff. Under the scheme, prisoners can earn additional privileges such as extra visits, more time out of cell, the ability to earn more money in prison jobs and to wear their own clothes. There are three levels, basic, standard and enhanced.

Segregation units

28. Segregation units are used to keep prisoners apart from other prisoners. This can be because they feel vulnerable or under threat from other prisoners or if they behave in a way that prison staff think would put people in danger or cause problems for the rest of the prison. They also hold prisoners serving punishments of cellular confinement after disciplinary hearings. Segregation is authorised by an operational manager at the prison who must be satisfied that the prisoner is fit for segregation after an assessment by a member of healthcare staff.

29. Segregation unit regimes are usually restricted and prisoners are permitted to leave their cells only to collect meals, shower, make phone calls and have a daily period in the open air. A manager, a member of the chaplaincy team and a member of the healthcare team should visit the segregation unit daily and speak to each segregated prisoner to check their welfare. A doctor should visit at least every three days and a registered nurse on the other days to assess the physical, emotional and mental wellbeing of the prisoners and whether there are any apparent clinical reasons to advise against continuing segregation.

HMP Isis' controlled unlock protocol

30. The standard procedure in the segregation unit at Isis is for prisoners to be unlocked by two officers. However, additional staff may be required to manage a prisoner's behaviour for staff safety. The controlled unlock protocol describes the different levels of unlock. It says that a Supervising Officer (SO) may initiate controlled unlock at any appropriate stage and record any changes or reviews in a log. The levels will be reduced in stages depending on positive prisoner engagement. Negative prisoner behaviour or non-compliance will result in continued or increased unlock levels.

- Stage 4 – Unlock level of two officers. Prisoners will have access to meals, exercise, shower, phone call, and hot water if requested. This is the standard level.
- Stage 3 – To last 72 hours minimum, progression is dependent on continuous compliance and absence of other negative behaviour. Unlock level is three officers. Prisoners will have access to meals, exercise, shower and phone call.
- Stage 2 - To last 72 hours as a minimum, progression dependent as above. Unlock level is a SO and three officers. Prisoners will have access to meals, exercise, a shower and a phone call.
- Stage 1 - To last 72 hours as a minimum, progression dependent as above. The unlock level is a SO and three officers in full Personal Protection Equipment (PPE) and a shield. Prisoners will have access to meals (served in cell), exercise and shower if no refractory behaviour on the day.

Key Events

31. On 22 April 2015, Mr Daryl McNamee was sentenced to six years and six months in prison for robbery. He spent time in different prisons including HMP Elmley where he had mental health assessments, although doctors did not diagnose a mental illness. Mr McNamee said that he suffered from a personality disorder. He was released on 7 September 2018.

32. On 21 February 2019, Mr McNamee was recalled to custody at HMP Belmarsh after he committed further offences including dangerous driving, damage to property, handling stolen goods and going equipped for theft. On 8 April, Mr McNamee was sentenced to 18 months in prison for these offences.

33. Staff at Belmarsh assessed that Mr McNamee was high risk to share a cell as he had a history of hostage taking and violence. Staff recorded that he was not at risk of suicide or self-harm. Mr McNamee was on a methadone reduction programme. He started taking 30ml of methadone daily, which healthcare staff reduced by 2ml a week.

34. On 17 April, Mr McNamee moved to HMP Isis. On his Person Escort Record (PER - a document that accompanies prisoners when they move between prisons) officers noted no suicide or self-harm risk factors. During an initial health screen, Mr McNamee told a nurse that he did not have any mental health problems. The nurse referred Mr McNamee to the substance misuse team and continued his methadone prescription. The next day, a nurse and a prison GP reviewed Mr McNamee again and noted no concerns.

35. An officer was appointed Mr McNamee's offender supervisor. She liaised with his offender manager (probation officer in the community).

36. On 25 April, Mr McNamee had a safer custody induction interview with an officer. He said that he did not have any thoughts of suicide or self-harm. The same day, a member of the substance misuse team reviewed Mr McNamee and noted that he was taking 16ml of methadone a day and continued to reduce it by a rate of 2ml weekly.

37. On 29 April, Mr McNamee had his first key worker session. Mr McNamee told his key worker that he was confused about how long he was going to be in prison as he had been recalled and had committed another offence. The key worker said that she would follow this up. Mr McNamee talked about his family, raising no concerns. He also told the key worker that he had abused drugs, including alcohol, in the past but was looking forward to having a "fresh start" when released. The key worker told the investigator that Mr McNamee seemed well during this conversation.

38. On 9 May, his offender supervisor met with Mr McNamee who wanted to talk to her about his recall. Mr McNamee said that he felt his recall was unfair because although there was an allegation that he had committed a robbery, the police had taken no further action. Mr McNamee admitted that he had breached the terms of his licence. He said that he had also pleaded guilty to dangerous driving offences, but that he only did so because he was stressed about being recalled. She recorded that they spoke about emotional management.

39. On 1 June, the offender supervisor met Mr McNamee again and recorded that he had done well in his substance misuse recovery programme. She said that she was going to inform Mr McNamee's offender manager of his positive report.

40. On 7 June, Mr McNamee's key worker recorded that Mr McNamee had had a very positive period on the wing and had got a job as a cleaner. On 13 June, a SO upgraded Mr McNamee's IEP level to enhanced. The SO recorded that Mr McNamee was doing well in his work and had not had a disciplinary hearing for more than two months. The same day, Mr McNamee completed his methadone reduction programme and stopped taking methadone altogether.

41. On 26 June, a prison chaplain spoke to Mr McNamee and offered him support after he reported that his stepfather had died. (Mr McNamee did not in fact have a stepfather.)

42. On 27 June, a nurse carried out Mr McNamee's substance misuse follow up assessment. She reviewed Mr McNamee's withdrawal symptoms, but found none. The nurse recorded that Mr McNamee appeared to be calm and settled, and that he said that he did not have any thoughts of suicide or self-harm and was coping well after his methadone reduction programme.

43. On 2 July, staff noted that Mr McNamee was under the influence of drugs during the morning roll check. When Mr McNamee was searched, heroin tablets were found in his underwear. Staff filed a security intelligence report and placed Mr McNamee on a disciplinary charge. The disciplinary hearing took place on 5 July and the matter was referred to the police. A SO downgraded Mr McNamee's IEP level to basic, which meant he spent more time in his cell.

44. On 8 July, Mr McNamee's key worker went to speak to Mr McNamee for his third (and last) key worker session. She was very surprised by how much he had changed. Mr McNamee told her that he had fallen back into his bad habits after his stepfather's death. He said that he was very disappointed with himself. (As previously stated, Mr McNamee did not have a stepfather.)

45. On 10 July, Mr McNamee told a nurse that he had been using heroin for the previous two weeks because he was upset about the death of his stepfather. The nurse referred Mr McNamee to the substance misuse team for advice and counselling. The next day, Mr McNamee had an intelligence-led drug test, which was negative.

46. On 11 July, a SO recorded that he had spoken to Mr McNamee after he had a fight with another prisoner. Mr McNamee gave him a note saying that he was under threat from other prisoners because of the tablets officers had confiscated the previous week. The SO started a violence reduction investigation and filed a security intelligence report. The SO said that Mr McNamee did not disclose the names of the prisoners he claimed were threatening him, so they could not establish if he was being bullied or by whom.

47. The SO said that Mr McNamee said he wanted to move to the segregation unit, or he would "shut the houseblock down". He said that he knew all the rules about how long he could be segregated and that he was going to make sure he was transferred to another prison. The SO said that he encouraged Mr

McNamee to give names and co-operate with the investigation, but he refused. The SO told the investigator that this meant there was little the prison could do. He decided to leave Mr McNamee in his cell, but unlock him separately from the other prisoners in the morning. He recorded that he had told Mr McNamee that he could speak to the SO or wing officers about the threats at any time. He told the investigator that he did not think that Mr McNamee had any mental health issues, or was at risk of suicide or self-harm.

48. On 12 July at 10.20am, Mr McNamee jumped onto the netting between landings. He remained there until 3.50pm. (Prisoners who are in debt or being bullied may jump onto the netting in an attempt to secure a move to the segregation unit or another prison to get away from prisoners they are in debt to, etc.)

49. The prison could not find any records of this incident. The IMB Chair at the time of Mr McNamee's death, provided the investigator with the IMB records of it. The IMB recorded that Mr McNamee refused to engage with negotiators, "giving no more than a shrug to anything they said". Specially trained Prison Service negotiators arrived and eventually he climbed off the netting.

Segregation – 12 July onwards

50. After the incident, officers moved Mr McNamee to the segregation unit, pending a disciplinary hearing.

51. At around 4.00pm, a nurse completed a segregation health screen. She assessed that Mr McNamee did not show signs of being acutely unwell and could cope with a period of segregation. The segregation unit manager authorised Mr McNamee's segregation. Officers gave Mr McNamee a radio, books and a distraction pack (which contained crosswords, word searches and puzzles) to occupy him. There is no record of his unlock level.

52. On 15 July, Mr McNamee had a disciplinary hearing for jumping onto the netting. He was found guilty and punished with 21 days cellular confinement, 21 days stoppage of earnings and 21 days forfeiture of privileges. He remained in the segregation unit under Prison Rule 55 (cellular confinement for a prisoner found guilty of an offence against discipline). His unlock level was recorded as being "stage three" which meant that three officers had to be present when unlocking his cell.

53. At around 10.00am, a nurse completed a further segregation health screen. The nurse assessed that Mr McNamee did not show signs of being acutely unwell and could cope with a period of segregation. The Head of Safer Custody then authorised Mr McNamee's continued segregation.

54. The same day, Mr McNamee told an officer during a post-incident debrief, that he considered himself to be at in danger at Isis. He said he had told officers, but they had not listened. He said that he went on the netting to force a transfer to another prison. The officer told the investigator that Mr McNamee did not want to give the names of the prisoners he was at risk from. Mr McNamee told him that he was determined to get a transfer to another prison and would continue to cause trouble if he was forced back to the wing after his segregation. The officer filed a security intelligence report.

55. From 12 to 16 July, segregation unit staff recorded that Mr McNamee was polite and compliant and caused them no problems.

56. On 17 July, Mr McNamee threw urine and excrement out of his cell. The segregation unit manager told the investigator that she spoke to Mr McNamee during the segregation round on 18 July. She said he was very aggressive and did not want to engage. He said he was going to take an officer hostage to force a transfer out of Isis. He also threatened to start another dirty protest if he was not transferred out.

57. In the evening a cup of urine and excrement was found hidden in Mr McNamee's cell and a SO recorded that he had decided to increase Mr McNamee's unlock level to "one supervising officer and three officers at all times" (stage two) because of his behaviour. The segregation unit manager authorised it but recorded in the unlock log that Mr McNamee's level was "stage three + a supervising officer".

58. The same day, the offender supervisor told Mr McNamee's offender manager about the netting incident on 12 July. She also told her that she was leaving Isis so another member of staff was going to be Mr McNamee's new offender supervisor. The offender supervisor said that she had tried to arrange for Mr McNamee's new offender supervisor to see Mr McNamee, but officers had said that it would not be safe because Mr McNamee was threatening to take staff hostage.

59. On 19 and 20 July, staff recorded that Mr McNamee was polite and compliant and had laughed and joked with them. On 21 July, a SO decided to reduce Mr McNamee's unlock level to three officers because "his behaviour had improved". She recorded that Mr McNamee's unlock level was upgraded to "stage three" in the unlock log. He was also taken off the restricted regime.

60. On 22 July, Mr McNamee had a disciplinary hearing for throwing urine and excrement from his cell door and was given a further 14 days cellular confinement. A nurse carried out a further segregation health screen and had no concerns about Mr McNamee's mental health or his ability to cope with segregation. The same day, Mr McNamee spoke to the segregation unit manager and repeated that he was going to take an officer hostage and start a dirty protest if he was not transferred out of Isis.

61. On 31 July, an officer recorded that Mr McNamee was going to remain subject to a two officer unlock protocol (the lowest unlock level) in the segregation unit. She recorded that he complied with the regime and was polite and friendly. A SO recorded in the unlock log that Mr McNamee's level was upgraded to "stage four". There are no further records in the log of any changes to Mr McNamee's unlock level. Staff continued to record every day up to and including 7 August that he was polite, compliant and friendly.

62. On 2 August, the segregation unit manager spoke to Mr McNamee as part of her segregation rounds. She told the investigator that when she arrived at the unit, a SO told her that Mr McNamee had secured his parole. The segregation unit manager told Mr McNamee that she was pleased for him and said that he seemed positive. Mr McNamee's new offender supervisor, however, told the

investigator that Mr McNamee had not secured parole and that nobody from the Offender Management Unit had told officers that he had done so. She could not explain this misunderstanding.

63. On 5 August, Mr McNamee's new offender supervisor sent an email to the offender manager asking her whether she was going to recommend Mr McNamee's release at the forthcoming parole hearing. The offender manager replied that she was not going to recommend release, given Mr McNamee's recent drug relapse and her concerns that Mr McNamee turned to drugs and did not think about his actions when he found himself in a situation he could not cope with. She said she had also recommended a psychiatric report, which she did not think had been done.

64. From 5 August, Mr McNamee made five phone calls to his mother and one to his father. (Prisoners' phone calls are recorded and staff listen to a sample of them.) The investigator listened to these calls. In every conversation, Mr McNamee talked about frustrations with his partner, who he claimed was lying about him.

65. On 6 August, Mr McNamee's new offender supervisor went to speak to Mr McNamee. She recorded that he engaged well and agreed to engage with mental health services. She told him that she was going to finish her parole report and bring him a copy. She recorded that she explained to Mr McNamee that neither she nor his offender manager could recommend his release because he had received a new 18-month sentence in April. She recorded that Mr McNamee "seemed to understand" and said that he was going to use the opportunity to work with psychology. Mr McNamee's new offender supervisor told the investigator that Mr McNamee presented well on this occasion and she had no concerns about him.

66. On 8 August, at 8.00am, the segregation unit manager, spoke to Mr McNamee as part of her segregation rounds. She told the investigator that Mr McNamee was concerned that he had been given too many days cellular confinement – a total of 49 days. She told him she was going to investigate the matter and the next day she spoke to an officer who had held the disciplinary hearing on 22 July. They agreed that there had been an error and that Mr McNamee's total cellular confinement should not have exceeded 35 days, so his last day in the segregation unit should be 18 August.

67. At around 10.20am, a nurse reviewed Mr McNamee as part of the healthcare rounds. She recorded that he was well and he had no healthcare issues.

68. At around 2.30pm, Mr McNamee's new offender supervisor went to the segregation unit to give Mr McNamee his parole report. She told the investigator that she spoke to an officer but could not remember who or whether she told them about Mr McNamee's parole report. The officer told her that Mr McNamee's door could not be opened at the time because three officers needed to be present to unlock him. However, there is no record in the segregation observation book, case management records or Mr McNamee's unlock log that there were any security concerns. According to his log, Mr McNamee's unlock protocol had not changed since 31 July, when it was set at the minimum of two officers.

69. Mr McNamee's new offender supervisor went to Mr McNamee's cell and passed the report to him underneath his cell door. She spoke to Mr McNamee for a few seconds and asked him to read the report. She recorded that she told him that she would come back the next day to discuss it with him and that "he stated it was OK". She told the investigator that Mr McNamee told her he was going to read the report later. She said that she then left without speaking to anyone else. She said that she was not concerned about Mr McNamee being upset by the report because he already knew what it would say. She said that she understood that prisoners in the segregation unit were more closely supervised than elsewhere in the prison, so she thought he would be well-supported.

70. At 3.35pm, Mr McNamee made a phone call to his father. He sounded anxious about what people were saying about him. He told his father that the only way he could "sort things out" was to get out of prison and "clear his head".

71. At around 4.30pm, a SO recorded that Mr McNamee had been given a "copy of his OASys report" (the system, used by the Prison Service and the Probation Service to measure offenders' risks) and that he had been "pacing his cell and looks anxious". (Mr McNamee's new offender supervisor confirmed that she had given Mr McNamee his parole report, not his OASys report.) The SO recorded that she had spoken to Mr McNamee and that he had asked to make a phone call to his father. She had allowed this, even though he had already had his entitlements for the day, because she hoped it would put his mind at ease. She also recorded that she was concerned about how much longer he still had to spend in the segregation unit and would try to sort out some in-cell activities for him.

72. The SO told the investigator that Mr McNamee was calm after the phone call to his father, back to his normal self, and she did not think much more about it.

73. About midnight, an officer recorded that Mr McNamee had been shouting out of his cell door. He told her that he was being "played" and that staff did not know what he was like and to "watch" what he did. He said that "someone who was supposed to have his back" had said things about him and "now has everything he should have". He said staff did not know what he knew, and then asked her, "How was Jamie?", as if he knew someone from her personal life. She told him that she did not know anyone called Jamie, but he "laughed as if he knew better". She recorded that Mr McNamee was "shaking with anger" the whole time.

74. The officer wrote a note in the segregation unit observation book to staff to be aware when unlocking Mr McNamee. She also filed a security intelligence report.

Events of 9 August 2019

75. At 5.10am, Mr McNamee spoke to the officer again. She said that Mr McNamee became paranoid that staff were going to come and hang him. She recorded in the observation book that she tried to speak to Mr McNamee but he did not want to talk to her. After Mr McNamee's death, the officer told the Head of Safer Custody that he had been awake most of the night.

76. At around 8.48am, a prison GP reviewed Mr McNamee with a nurse as part of the healthcare rounds in the segregation unit. The prison GP told the

investigator that before he did his rounds, he would speak to the staff to check whether there were any specific concerns about any of the prisoners in the unit. He said the officers reported no concerns about Mr McNamee. The prison GP said Mr McNamee was lying on his bed. He asked him through his cell door if there were any problems, and Mr McNamee replied that he was "fine". The nurse recorded that Mr McNamee seemed calm and settled and that she had no concerns. His cell door remained closed throughout the brief conversation.

77. Mr McNamee went out for exercise from 9.00am until 11.30am. At around 10.00am, segregation unit manager, went to speak to him in the exercise yard. She told Mr McNamee that he had been given too many days of cellular confinement and confirmed that he would leave the segregation unit on 18 August.

78. The segregation unit manager recorded that Mr McNamee was highly paranoid during their conversation and told her that he thought that two SOs were conspiring against him with a man called "[Name]". She told the investigator that she asked Mr McNamee who [Name] was and Mr McNamee started to laugh.

79. She said that Mr McNamee then became angry and said that he believed that officers were going to throw hot water in his face and hang him but make it look like suicide. Mr McNamee also said that he thought that a SO was interfering with his mail. The segregation unit manager recorded in the observation book that, although she tried to calm Mr McNamee down, he was highly emotional.

80. The segregation unit manager reassured Mr McNamee that she did not know anybody called [Name] and that nobody wanted to harm him. She told the investigator that she was shocked by Mr McNamee's behaviour and was concerned about her safety during their conversation. She said she told Mr McNamee that she was going to contact the mental health team. She also upgraded Mr McNamee's unlock level to three officers unlock (stage 3) and made a note of this in the segregation unit observation book but did not record it on his unlock log.

81. At 10.12am, the segregation unit manager went back to the segregation office and asked an officer to contact the mental health team, which he did while she was there. The segregation unit manager could not remember what the officer said to the nurse during the call but did not think he said anything inaccurate.

82. The officer recorded at 10.38am that he had contacted the mental health team due to Mr McNamee's "strange and erratic behaviour on the exercise yard where he was crying and stating that he knows staff are planning on throwing hot water over his face and hang[ing] him".

83. A nurse took the officer's call. She told the investigator that the officer told her that Mr McNamee was screaming or crying at night and biting his hands. She said the officer did not mention that Mr McNamee was paranoid. The officer asked if someone from the mental health team could come to see Mr McNamee. The nurse said that the officer did not say that the matter was urgent or sound concerned but sounded as if he was just passing on a message from his manager. She said it was hard to tell from the phone call but that it crossed her mind that Mr McNamee might be self-harming. She asked the officer if he was

on an ACCT and when he said that he was not, she was not very concerned about him.

84. The nurse said that around 1.30pm, she discussed the phone call at a handover meeting with her manager and other nurses. A nurse, who was not a mental health nurse but who was responsible for the segregation unit, was present and said there were no concerns recorded about Mr McNamee. The nurse said her manager did not ask her to go and see Mr McNamee. She said that at about 3.00pm, she spoke to another nurse who said she was going to review Mr McNamee later that day. She said that no one else contacted the mental health unit during the day.

85. A SO was not on duty in the segregation unit that day because she was the designated 'Oscar 3' (responsible for ensuring prisoners attended education and training). However, she said she was in and out of the unit and heard the segregation unit manager speaking about her encounter with Mr McNamee. She asked if she could go to speak to him, even though she was not on duty, as she had a good relationship with him. The segregation unit manager agreed but told her not to enter the yard as she was concerned about her safety.

86. At 10.20am, a SO spoke to Mr McNamee in the exercise yard. She told the investigator that Mr McNamee asked her about his post and how it was delivered to him. She said that Mr McNamee thought that something had been done with his mail, and he was suspicious of her. He said that she was playing "mind games". The SO said that Mr McNamee was agitated, but she did not think that he was paranoid and he did not say that he thought she and other staff were planning to assault or kill him. She did not make a record of this conversation at the time. She said she spoke to Mr McNamee again briefly at 11.30am when she brought him in from the exercise yard.

87. Another SO told the investigator that at about 11.30am, he, and two other officers spoke to Mr McNamee in his cell for around 20 minutes. The SO told the investigator that Mr McNamee appeared angry - not screaming and shouting or physically aggressive, "just sort of pissed off". The SO said he could not remember the details but thought Mr McNamee might have been angry about his family. He recorded in the segregation unit observation book that Mr McNamee had "calmed down a lot" and had returned to his "normal self". He also recorded that Mr McNamee said that his friend had "stitched him up". Mr McNamee asked for a phone call and the SO agreed to facilitate it that afternoon. He said that Mr McNamee did not express any paranoid ideas and he had no concerns about his mental health or that he might be a risk to himself.

88. An officer said that the segregation unit manager had spoken to the unit staff in the morning and told them about Mr McNamee's behaviour, but that he had not seen him behaving oddly himself. He said Mr McNamee seemed "frustrated" when they spoke to him – he had talked about his girlfriend and how she was now with one of his friends who he described as a "brother" – but he did not seem paranoid and the officer was not concerned that he might be a risk to himself.

89. At 12.00pm, the SO spoke to Mr McNamee again. At about 12.30pm she recorded that he had spoken to her about his feelings and "conspiracy thoughts".

He apologised for accusing her of conspiring to assault him, but said he thought that she was playing mind games. She also recorded that another prisoner had told her that Mr McNamee thought his mother had been kidnapped and that there were hidden messages on the envelopes of his post. The SO also told the investigator that Mr McNamee had said that he wanted to return to the wing to clear his name as he had been called a "bacon" (prison slang for someone convicted of child sex offences).

90. The SO told the investigator that she had written this note in a hurry as she had been going backwards and forwards between duties all morning and was about to go off duty. She said the note was, therefore, a hurried mix of things Mr McNamee had said directly to her and things she had been told by others. She said that he had never told her that he thought she was part of a conspiracy to kill him, or spoken about hanging, and she said that he had only apologised to her for what he had said about his post and the way he had spoken to her earlier

91. Around 30 minutes after she spoke to Mr McNamee, the SO and the segregation unit manager left the unit and the SO went off duty. The SO said that she was not concerned about Mr McNamee when she left. She said she thought he had "had his thing" and had calmed down and was back to normal. Because she had not been on duty in the segregation unit that day, she did not know that an officer had spoken to the mental health team about him. She said she was very surprised when she heard later that Mr McNamee had hanged himself.

92. At 12.55pm, CCTV shows that an officer checked Mr McNamee's cell. (The officer resigned after Mr McNamee's death and declined to be interviewed for this investigation.) Officers did not check Mr McNamee again, although prisoners in the segregation unit should be checked at least every hour.

93. At 1.55pm, CCTV of the corridor shows that Mr McNamee was trying to place a piece of bedsheet near the edge of his cell door at the top. No one noticed this.

94. At 3.46 pm, CCTV shows that a SO went to Mr McNamee's cell with two officers. The SO told the investigator that he was going to let Mr McNamee out to make the telephone call that he had promised earlier. When he got to the door, he could not see Mr McNamee through the observation panel. He opened the door and saw Mr McNamee was suspended from the corner of the door with a sheet around his neck.

95. At 3.47pm, the SO shouted "code blue" (indicating that a prisoner is unconscious or having difficulty breathing) and an officer called the code over the radio. The SO cut the ligature. Neither he nor the other officer had had CPR training, but a third officer arrived and started resuscitation efforts. The control room officer called an ambulance immediately.

96. At 3.48pm, a nurse arrived at the cell, together with five other nurses and they continued resuscitation efforts. At 4.02pm, paramedics arrived at the cell. They pronounced Mr McNamee's death at 4.40pm.

Post-mortem report

97. The post-mortem examination found that Mr McNamee died of asphyxia and hanging. The toxicology examination found no alcohol or drugs in his body.

Contact with Mr McNamee's family

98. At 7.00pm, a member of the prison's chaplaincy team and the Operational Manger, went to Mr McNamee's father's house. They broke the news of Mr McNamee's death to him.

99. On 6 September, Mr McNamee's funeral took place. The prison contributed to the costs of the funeral, in line with national policy.

Support for prisoners and staff

100. After Mr McNamee's death, the Head of Safer Custody debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.

101. The prison posted notices informing other prisoners of Mr McNamee's death, and offering support. Staff reviewed all prisoners assessed as being at risk of suicide or self-harm in case they had been adversely affected by Mr McNamee's death.

Findings

Assessment of risk

102. PSI 64/2011 says that staff must identify prisoners at risk of self-harm and suicide. It provides a non-exhaustive list of risk factors that might increase a prisoner's risk of suicide and self-harm, including bereavement, drug misuse, debts and bullying, relationship problems and mental health issues. These require staff to take appropriate action, such as starting ACCT procedures or referring prisoners to the mental health team.

103. Up to the beginning of July 2019, Mr McNamee had successfully completed a methadone reduction programme, appeared to be drug-free and was on the enhanced level of the regime. He said he was looking forward to making a fresh start. Staff described Mr McNamee as "settled" and said he was a polite and compliant prisoner and that they had no concerns about him.

104. Mr McNamee's behaviour changed from this point and his risk factors increased. On 2 July, he was found under the influence of illicit drugs. He later told staff he had been using heroin for two weeks in response to the alleged death of his stepfather and that he was under threat from other prisoners (presumably for drug-related debts, although he did not say so). On 12 July, he engineered a move to the segregation unit to get away from the prisoners who were threatening him. Although this was what he wanted, it increased his risk further since prolonged segregation is known to damage mental health and is a recognised risk factor for suicide and self-harm.

105. Nevertheless, Mr McNamee appeared to settle in the segregation unit and, apart from 18 July when he threw urine and excrement out of his cell and threatened to take an officer hostage, he was polite, compliant and friendly. (It is possible that his behaviour on 18 July was a deliberate attempt to extend his stay in the segregation unit and/or to engineer a transfer to another prison.) Although we accept that staff had no obvious cause to be concerned about him during this period, we are concerned that segregation unit staff seem not to have recognised that he had a number of risk factors for suicide and self-harm.

106. Mr McNamee's mental health appears to have deteriorated significantly on 8 August and 9 August. This may have been triggered by the disclosure of his parole report, although we cannot be sure of this and we note that Mr McNamee had not seemed distressed when Mr McNamee's new offender supervisor had told him on 6 August that she would not be recommending him for parole. We also note that Mr McNamee's phone calls from 5 August onwards show that he was upset about his girlfriend, who he said was lying about him, and anxious about what people outside prison were saying about him.

107. That afternoon, a SO, who knew Mr McNamee quite well, was concerned because he was pacing his cell and looking anxious, but she was content that he had calmed down after she allowed him an extra phone call to his father. Nevertheless, she was concerned about the amount of time he had spent in the segregation unit – four weeks by this time, with another 10 days to go.

108. That night, Mr McNamee was awake most of the night, shaking with anger, expressing paranoid thoughts and making bizarre references. Although an officer recorded this, we are concerned that no one appears to have picked this up the following morning, and that neither the officer nor anyone else considered whether ACCT procedures should be opened to support Mr McNamee at this point.

109. We are also very concerned that no one passed this information to a prison GP when he did his rounds in the segregation unit in the morning. As a result, an important opportunity to check on Mr McNamee's mental wellbeing was missed.

110. Mr McNamee's paranoia appears to have increased noticeably later that morning when he told the segregation unit manager that he thought officers were going to throw hot water on him or hang him. The segregation unit manager appropriately asked for a mental health assessment, but we consider she should have asked for this to be done urgently and that she should have taken steps herself to ensure that the mental health team understood the full extent of Mr McNamee's dramatic mental deterioration, rather than leaving this to an officer.

111. The segregation unit manager was rightly concerned that Mr McNamee might pose an increased risk to staff and took appropriate action about this, but we consider she should also have recognised that this apparent breakdown in Mr McNamee's mental health might increase his risk to himself. We are concerned that she did not consider opening an ACCT at this point.

112. Although both SOs thought that Mr McNamee was calmer when they spoke to him later that morning, they both described him as agitated and frustrated. He made paranoid allegations that his mail was being tampered with and he was upset about his relationship with his girlfriend.

113. At this point Mr McNamee had been in the segregation unit for four weeks. He generally spent around 23 hours a day alone in his cell with only a radio, books and puzzles to distract him. We are concerned that those who spoke to Mr McNamee on 9 August under-estimated the risk he posed to himself.

114. Segregation is an extreme and isolating form of imprisonment which inherently reduces protective factors for suicide and self-harm, such as activity and association with others. A period of segregation may cause deterioration in a prisoner's health and well-being, compromising their ability to cope with segregated conditions. Concerns that may be manageable elsewhere may become much more significant in a segregation unit.

115. Staff therefore need to be aware that segregated prisoners are particularly vulnerable and should be alert to any signs, such as a breakdown in mental health or worries about relationships, which might increase a prisoner's risk to himself. Risk can increase very rapidly when a prisoner is isolated with his thoughts and staff must, therefore, take prompt action to provide support. The segregation unit manager and both SOs were not uncaring – they all spent time talking to Mr McNamee – but they were not sufficiently aware of the risks.

116. Healthcare staff also need to recognise the particular vulnerability of segregated prisoners. We accept that an officer may not have adequately conveyed the

seriousness and urgency of the request for a mental health assessment to a nurse. Nevertheless, we consider that the mental health team should be aware that mental health issues in segregated prisoners may have serious consequences and should be regarded as a priority. We consider that the nurse manager who was at the handover meeting on 9 August should have ensured that a member of the team saw Mr McNamee that day.

117. PSI 64/2011 highlights the importance of training for staff in suicide and self-harm prevention. It also says that staff should understand basic mental health issues. Prison Service Order (PSO) 1700, *Segregation*, also says that staff working in segregation units should be competent in suicide prevention and mental health awareness.

118. We are, therefore, concerned that an officer and a SO said that they had not had any recent suicide and self-harm prevention training and had not received mental health awareness training. The segregation unit manager said that she had not received any meaningful training on mental health in the past three years.

119. We make the following recommendations:

The Governor should ensure that staff manage prisoners at risk of suicide or self-harm in line with national guidelines, and, in particular, that staff working in the segregation unit:

- **are aware of the particular vulnerability of segregated prisoners;**
- **have received recent training on ACCT and mental health awareness;**
- **identify and consider all risk factors when assessing a prisoner's level of risk of self-harm and suicide; and**
- **open ACCT procedures when required.**

The Head of Healthcare should ensure that:

- **all healthcare staff are aware of the particular vulnerability of segregated prisoners to suicide and self-harm; and**
- **mental health staff treat requests for a mental health assessment of a segregated prisoner as a priority.**

Segregation

Care planning

120. PSO 1700 says that there should be adequate planning for segregated prisoners to enable them to return to normal location. On 12 July, staff created a segregation support and intervention plan. However, we found no evidence that, during the 29 days that Mr McNamee was segregated, he received any meaningful multidisciplinary support or care or that thought had been given to how to move him on from segregation.

121. PSO 1700 also says that those segregated for more than 30 days should have a care plan setting out how their mental wellbeing is to be supported. Mr McNamee had been in the segregation unit for 29 days when he killed himself. Although a SO recorded on 8 August that she would try to sort out some in-cell

activities for him, we have seen no evidence that he was about to have a formal care plan.

Meaningful conversations

122. PSO 1700 requires that staff should have three meaningful conversations with segregated prisoners each day and record these in the prisoner's segregation history sheet. We are concerned that there are no such entries in Mr McNamee's history sheet throughout the 29 days he was segregated. This may have been a missed opportunity to identify the deterioration in his mental health.

Observations

123. PSO 1700 requires all segregated prisoners to be observed at least hourly, and more frequently if necessary to manage a prisoner's mental health better. We consider that the segregation unit manager and a SO should have considered increasing Mr McNamee's observation levels when his mental health deteriorated on 9 August.

124. We are also very concerned that segregation officers did not carry out the minimum hourly checks for the three hours before he was found hanged. We cannot know whether the outcome would have been different if the checks had been carried out, but at the very least Mr McNamee would have been found earlier.

Controlled Unlock

125. The unlock level affects the regime and wellbeing of a prisoners in the segregation unit. Unlock decisions should therefore be justifiable and well-recorded.

126. Mr McNamee's unlock level was reviewed and changed on several occasions in the segregation unit. Although we consider that the decisions were justified, we are concerned that they were not always properly recorded in the log and that there was sometimes confusion about which level Mr McNamee was on. We recommend:

The Governor should ensure that:

- **Segregation Review Boards assess how well the prisoner is coping, plan for their relocation to more appropriate accommodation, and develop a careplan to help prevent deterioration in mental health;**
- **staff have at least three meaningful conversations a day with segregated prisoners and record these;**
- **all segregated prisoners are checked at least hourly and that this is recorded; and**
- **controlled unlock levels are clearly recorded to avoid any confusion among staff.**

Clinical Care

127. Mr McNamee did not present with any significant physical health problems, but did have a history of substance misuse. The clinical reviewer concluded that Mr McNamee's substance misuse was appropriately assessed and managed and that this aspect of his care was equivalent to that he could have expected to receive in the community.

128. The clinical reviewer did not have any concerns about Mr McNamee's mental health care before he was segregated. His concerns about the assessment of Mr McNamee's mental health in the segregation unit are set out below.

Healthcare rounds

129. PSO 1700 requires that a doctor visits all prisoners in the segregation unit at least every three days. Segregated prisoners must be reviewed by a registered nurse on all other days. The doctor/nurse must assess the physical, emotional and mental wellbeing of the prisoner and whether there are any apparent clinical reasons to advise against continued segregation. A note of each visit by a member of healthcare staff must be made in the prisoner's clinical record.

130. The clinical reviewer was concerned that some of Mr McNamee's healthcare assessments were carried out through the cell door, rather than face-to-face. The clinical reviewer also found that most of Mr McNamee's healthcare assessments were template-driven entries with no narrative text. The doctors' entries were inconsistent, and not all assessments were recorded in the medical records. When records were made, they were a single line stating, "Seen in segregation unit, no concern."

131. We recognise that PSO 1700 says:

> "It will not be necessary for the doctor/nurse to enter the cell every time, nor to undertake physical examinations: the prisoner's mental state can to an extent be assessed by observation and brief interviews through a hatch."

Nevertheless, when a prisoner is segregated for a long period, as Mr McNamee was, we consider that there should be at least some face-to-face assessments and that clinical staff should not simply rely on segregation unit staff to tell them if they have any concerns about individual prisoners. Nor do we think it sufficient for the doctor/nurse just to ask the prisoner if they are 'ok' as a means of assessing wellbeing. We consider that attempts should be made on at least some days to have a conversation with each prisoner.

132. We were also concerned that a prison GP said he had only 15 minutes to complete the segregation round before moving on to his other duties. Segregated prisoners are some of the most vulnerable prisoners in a prison and we do not think this is adequate time to undertake a meaningful check of 16 prisoners.

133. We agree with the clinical reviewer that the daily healthcare checks were not sufficiently thorough. This was a missed opportunity to identify Mr McNamee's mental health needs and offer support. We recommend:

The Head of Healthcare and the lead GP should ensure that doctors and nurses:

- **have meaningful conversations on at least some days with segregated prisoners, particularly those who are segregated for long periods, in order to assess their wellbeing, and do not just rely on segregation unit staff to alert them to possible concerns; and**
- **allow sufficient time for this in their segregation unit rounds.**

Offender Management

134. On 8 August, Mr McNamee's new offender supervisor gave Mr McNamee a copy of the report she had prepared for the Parole Board. This said that she could not recommend Mr McNamee's release. We do not know if this report played any part in Mr McNamee's decision to take his life, but we are concerned that she did not warn officers in the segregation unit about the nature of the report and did not consider asking for additional support measures to be put in place for Mr McNamee.

135. We are also concerned that Mr McNamee's new offender supervisor said that she had not received any suicide and self-harm prevention training, including how to open ACCT. Given the nature of the contact that offender supervisors have with prisoners, this is very concerning. We recommend:

The Governor should ensure that offender supervisors:

- **receive training in ACCT procedures; and**
- **make sure that support is in place for prisoners before they disclose potentially distressing material, such as parole reports.**

Learning lessons

136. In order to ensure that the lessons of this investigation are learned, we recommend:

The Governor should ensure that this report is shared with Mr McNamee's new Offender Supervisor, the Segregation Unit Manager and staff working in the segregation unit and that a senior manager discusses the Ombudsman's findings with them.

Prisons & Probation Ombudsman
Independent Investigations

Third Floor, 10 South Colonnade
Canary Wharf, London E14 4PU

Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk

T I 020 7633 4100
F I 020 7633 4141