The Death in Custody of a man
HMP Manchester - July 2004

Report by the Prisons and Probation Ombudsman for England and Wales

April 2006

This is a report into the circumstances of the death of a man on 3 July 2004. The man was in the custody of HMP Manchester. He was found in the prison's segregation unit at 6.50pm with a plastic bag over his head. Efforts by staff and paramedics to resuscitate him were unsuccessful. The results of the post mortem indicated that he died as a result of asphyxiation.

I would like to extend my condolences to the family of the man and to those touched by his death. I know that the man's mother feels strongly that prison was the wrong place for her son and that the health services had failed her him.

All deaths of prisoners in custody are investigated. Until April 2004, the responsibility for carrying out these investigations fell to the Prison Service, but on that date it passed to the office of the Prisons and Probation Ombudsman. This case was dealt with under the transitional arrangements I had agreed with the Prison Service. The Senior Investigating Officer nominated to complete the investigation was Governing Governor. The investigation was overseen by one of my Assistant Ombudsmen. The report was written by the Governor and then edited by my colleague. An independent review of the man's clinical care in prison was carried out by one of my Deputy Ombudsmen and Head of the Fatal Incidents Investigation Team, who is a Registered General Nurse.

I would like to thank the Governor, the Principal Officer, who acted as the liaison officer and the staff at HMP Manchester for their co-operation during this investigation.

The man's death is one of the disproportionately high numbers that has occurred in segregation units that I have had the mournful duty to investigate. Whilst the decision to put the man in the segregation unit on 2 July for his own protection was a reasonable one, the prison could have put more measures in place to support him during his time in segregation.

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

Stephen Shaw CBE
Prisons and Probation Ombudsman

April 2006

CONTENTS

Page

1. Introduction …………………..……………………………………..……… 2
2. Summary……………………………..………………………………… 4 - 5
3. Investigation Process ……………………………………………..……. 6 - 7
4. HMP Manchester ………………………………………………………. 8
5. The man .... 9 - 10
6. The man's admission and early period in Manchester prison ………. 11 - 13
7. The man's period in hospital ……………………..…… 14 - 15
8. The man's return to Manchester ………………………………………. 16 - 17
9. The man's placement in the segregation unit ………………………… 18 - 21
10. The prison's response to the man's death………………………..…. 22 - 23
11. Issues considered during the investigation……………………………. 24 - 29
    - The decision to segregate the man on 2 July
    - Suicide and Self-Harm Prevention and compliance with PSO 2700
    - Compliance with PSO 1700 Segregation of Prisoners
    - Other issues and findings from other investigations
12. List of recommendations and good practice ………………………… 30 - 31

Summary

The man arrived at HMP Manchester on the 25 October 2003 having been arrested two days earlier for possession of a firearm with intent to cause fear of violence. He had no previous convictions. The man had a high IQ and was educated above degree standard. He was a high achieving student both at school and at university, obtaining a first class degree in physics at the age of 20. His mental functioning became adrift in his early twenties, he abused alcohol and to a lesser extent cannabis and amphetamines, finally manifesting in a nervous breakdown when he was 22. From this time until his arrest he was under psychiatric care, much of the time as an inpatient under section.

The man was seen regularly by mental health professionals at Manchester prison. He self harmed on a number of occasions and was often on an F2052SH (a system used to support and monitor those felt to be at risk of suicide or self harm. This document has now been replaced by the ACCT system). Prior to custody he had stayed as an in-patient at mental health units, including some compulsory detention under the Mental Health Act, and had considerable interaction with community mental health services. He was prescribed various anti-psychotic and anti-depressant medication during his time in custody and in hospital.

Prior to sentencing, the man was moved to hospital for assessment. The discharge report noted his violent conduct but concluded at 'as he does not have a major mental illness, he does not require treatment in a psychiatric ward'. It was felt that he had a mixed personality disorder and that it might be appropriate for him to be sent to a prison run along therapeutic lines. The man was subsequently sentenced to five years in prison.

At the time of his death, the man was located in the segregation unit. He had been moved from one vulnerable prisoner unit (A Wing) to another such unit (E Wing) after he wrote what was construed as a racist essay in education. This essay was found and read by other prisoners, who then threatened to assault him. Unfortunately, this issue followed him to E wing and he was moved to the segregation unit the next day, 2 July 2004, for his own protection. Staff who knew the man felt that he was not racist and other prisoners might have misconstrued the intent of the article.

He was appropriately assessed by the duty governor, medical and discipline staff in relation to his placement in segregation. A Segregation Safety Algorithm was completed and a Care Plan drawn up to support the man during his time in segregation. Unfortunately, not all of the elements of the Care Plan were implemented. He was not given a radio or access to a Samaritan phone. I am critical of the fact that more thought was not given to appropriate 'distractions' for him during his time in segregation. He had nothing in his cell but a few books and writing materials.

On the day of his death, the man was still subject to an F2052SH watch, this having been set at five times an hour since his placement into segregation. An F2052SH case review was not held on 2 or 3 July, as required by Prison Service Order 1700. This meant that a multi-disciplinary group of staff did not review how he was feeling or coping with segregation. It would appear though that the man gave staff no cause

for concern during the day or early evening of 3 July. He spent some time in the afternoon on association with other prisoners in the segregation unit and had several long chats with an officer. The man was found with a plastic bag over his head during a staff check at handover to the evening staff. Half an hour before this, he had had a positive conversation with the officer that gave her an optimistic opinion with regard to his mental state at that time.

It is impossible to determine the man's intent in putting a plastic bag over his head. There was no suicide note. Staff reacted in a professional manner upon discovering him. Unfortunately he could not be resuscitated by staff or paramedics.

The man's mother raised a number of concerns about the court process and the handling of her son's case by the police, probation and court services. None of these issues is directly within the remit of my investigation, although the enhancements to the court diversion service that have now been proposed have nationwide implications. The man's mother feels very strongly that prison is simply an inappropriate place to care for people like her son.

The man received high levels of support from both prison staff and NHS mental health professionals who worked at HMP Manchester. He lived particularly successfully on a wing and the staff there are to be commended for their commitment, professionalism and patience in working with him.

The report makes nine recommendations.

Investigation Process

On 6 July 2004, my Investigator's visited Manchester to have an orientation tour and to examine documentation. The Prison Officers' Association (POA) were made aware of the investigation in person, as were the Independent Monitoring Board (IMB). The Governor issued notices to staff and prisoners explaining the investigation and inviting them to contact the investigation team if they had information that they wanted to share. Written evidence was read along with an examination of randomly sampled F2052SH's to look at audit compliance and the quality of the care recorded therein. Most of the documentation required for the investigation had been made ready in an ordered fashion to facilitate the investigation, and the team who carried out this task are to be complimented for this. The Governor also gave the investigators a full briefing on the events and any issues that had arisen as a result. He also provided background information on the man and family contact details.

A review of the suicide prevention meeting minutes and the results of the last standards and internal audits were examined. Wing observation books and the prison records pertaining to the man were also assessed. Local procedures relating to in possession prescribed medication were also compared and compared with Prison Service and NHS standards.

The following people were interviewed during the course of the investigation:

Three Governor grades
One Principal Officer
Two Senior officers
Four Officers
Two Prison Service Nurses
One Community Physiatrist Nurse

In addition to those named above, the suicide prevention co-ordinator, the Healthcare Senior Officer, and the Principal Officer responsible for the detoxification unit were interviewed informally. Discussions centred on the establishment's procedures and systems to care for those prisoners who were either suicidal or self harming. Many other staff contributed to this process and the investigator discussed such issues with a number of staff at the prison.

The man's mother, was contacted and a meeting arranged. This meeting took place at her home and she raised a number of issues regarding the treatment of her son by the police, NHS and the court services. None of these issues is within the direct remit of my investigation, although I have recommended a separate review be carried out into the care and treatment provided to the man when he was in hospital. The man's mother did raise a specific issue regarding the plastic bag in the segregation unit cell. She also advocated a court diversion service being promulgated by a mental health charity in the hope of the Prison Service becoming a partner in the implementation of this strategy. I have considered these concerns as part of the

investigation and hope that the report provides the man’s mother with answers to her questions.

HMP Manchester

HMP Manchester is a high security local prison. It is situated just outside Manchester city centre and is part of the high security directorate within the Prison Service. The prison is now generally known in the Prison Service to be a progressive and well managed establishment. Manchester operates under a Service Level Agreement (it is therefore managed under similar lines and protocols to private prisons and subject to the same performance monitoring procedures).

The last standards and security audit rated the establishment at 87% for Standards and 95% in Security. When considering the specific performance issues that are key to the care of prisoners, the audit scores were 95% for suicide prevention, 58% for safer establishments (anti-bullying), 88% for health services to prisoners, and 94% for prisoner induction. With the exception of anti-bullying, these scores are all in the good range.

The last inspection of Manchester by HM Chief Inspector of Prisons was in 2001. The inspection report concluded that 'there was much good about the cultures and priorities of Manchester prison. It was certainly not a prison giving major cause for concern; indeed the flexibility and positive approach of staff and managers, and their achievements against considerable pressures are a lesson to many other local prisons.'

The prison's certified normal accommodation is 961 and its operational capacity (maximum crowded capacity) is 1,261. On 3 July 2004, some 1,217 prisoners were held in the prison.

The Man

The man was born on 8 September 1970 in Kent and was brought up in Edinburgh until the age of 15, at which point his family moved to Market Rasen where he spent three years. He has one sister. The man described his family as moderately wealthy but said also that it was dysfunctional. He claimed to have suffered emotional distress caused by his father. The man said that he lacked self confidence and became shy and withdrawn. He was very bright and gained three 'A's at A level before leaving home at 18 to attend Manchester University. At university, he gained a first class honours degree in physics. He was then accepted at Cambridge University to undertake Part 3 Mathematics Tripos, but did not enrol as he could not afford the fees.

Instead, he enrolled at the University of Newcastle as a postgraduate (PhD) to study Theoretical Physics and was the top student after the first year. Sadly, he suffered a nervous breakdown shortly after completing his first year and was unable to continue with his studies. The man had never undertaken any further studies and never had gainful employment. He reported that whilst living in shared accommodation, a well known drug user was violent towards him and that it was through him that he started taking drugs. He smoked cannabis and then went through a period of injecting amphetamines. The man also began to drink quite heavily.

In 1992, the man began to harm himself by making superficial scratches to his wrists. He subsequently developed a long history of cutting, overdosing and even self-immolation, resulting in 30 percent burns and admission to a plastic surgery unit.

In early 1993, after further deterioration, he was admitted to a psychiatric unit. There he was treated for severe psychosis and was diagnosed as being schizophrenic. He was sectioned under the Mental Health Act at that time. The man had severe alcohol dependency problems and began to abuse amphetamines and benzodiazepines.

He married when he was 23 years old and the couple had a son. The relationship foundered after a year, and he continued to be treated with various periods of time as an in-patient or in supported accommodation. The man's suicidal and self-harming ideation continued. In August 2001, he went into a rehabilitation unit in Scotland and was there for a period of nine months. On discharge he remained sober and functioning for three months. His mental state then began to deteriorate. The man agreed to attend the rehabilitation unit again, but this time his stay was not so successful. He was there only three months and did not really engage with the programme as he had done before. During this time, the man met a woman, who was also being treated in the unit, and they began a relationship. He left the unit in April 2003. His mental health again declined.

The man's mental health key worker in Newcastle Upon Tyne knew him for six years. She said that he initially did have a diagnosis of schizophrenia, but by the end of their contact they had begun to feel that the man had a personality disorder. She said that, although he did at times appear to suffer from psychotic symptoms, these were in connection with alcohol or substance misuse.

The man's most recent admission into hospital prior to his arrest was under section 136 of the Mental Health Act after threatening to shoot himself with an air rifle. He was admitted to a clinic on 1 August 2003. The man was treated with an antipsychotic drug (Olanzapine) and an antidepressant (Paroxetine). However, he continued to drink and smoke cannabis when he was on leave from the ward. The man's psychotic symptoms resolved rapidly, and he was discharged at his own request on 27 August 2003 and against medical advice.

He then moved to Manchester to be with his girlfriend. He was seen in two outpatient clinics and reported drinking half a bottle of vodka a day, smoking cannabis and the sporadic use of amphetamines. He did not complain of psychotic or depressive symptoms. On 23 October, the man was arrested after the police were called by his sister who feared for his safety as he was threatening to shoot himself. He was in possession of a firearm, again an air pistol. The man discharged the weapon twice when the police came to arrest him and he resisted arrest. There were no reported injuries as a result of the discharge of the firearm. Whilst in police custody on 24 October, he was assessed by the Forensic Medical Officer as having no signs of alcohol withdrawal. The man's mental health history was recorded in the initial detained person's medical form and he was rated as being a medium risk of self-harm.

The man's admission and early period in Manchester prison

The man arrived at Manchester on 25 October 2003 and underwent a modified medical screening process. This recorded that he suffered from mental illness and admitted to previous self-harm, but not suicidal ideation. He advised the medical screener that he had a history of misusing drugs and alcohol. He said he drank 16 units of alcohol a day, a mixture of spirits and beer. Following this initial clinical assessment, he was seen by the duty doctor. A decision was made for him to be admitted to the healthcare centre for a period of psychiatric assessment.

The man started detoxification for Benzodiazepines on 26 October. He was also seen at length by healthcare staff who took a more comprehensive history from him. An action plan was drawn up, which included the need for an assessment by the psychiatrist. This was carried out the following day (27 October). The psychiatrist did not find any evidence of acute psychotic symptoms and gave no firm diagnosis. The man was commenced on an appropriate alcohol detoxification programme and, over the following week, was reviewed twice more by the psychiatrist.

A referral to the mental health in-reach service at Manchester resulted in him being assessed as having borderline personality disorder but with no evidence of psychosis to suggest schizophrenia. His key worker was a Community Psychiatric Nurse (CPN). An undated Care Plan was opened regarding his management.

The man spent the whole of the month of November in the Healthcare Centre at Manchester. There are numerous entries in his medical record regarding his treatment and to some extent his behaviour. On 3 November, there are comments alluding to him having 'general feelings of fear'. On 5 November, there are notes pertaining to the man stating that he suffered from psychotic episodes and feelings of paranoia. The following day he was seen by a psychiatrist.
The psychiatrist recommended the man should be put on a special watch (to be seen by staff five times an hour) and a Suicide and Self-harm warning form (F2052SH) was opened. The psychiatrist referred the man to the Mental Health In-Reach Team and recommended a forensic opinion.

On 9 November, the man had his first F2052SH case review meeting. It is not recorded which staff attended this meeting. The case review noted that he said his self harming was impulsive and mainly when he was in stressful situations. The man said he had avoided self harming a few days earlier by talking to staff and Listeners. He also said he had no suicidal intentions at that time. The support plan included regular contact with the doctor, medication, the special watch to continue and for him to share a cell. The next day, the CPN contacted the man's care manager at Newcastle. She advised the CPN that the man had drug and alcohol problems that exacerbated his self-harm behaviour. She did not feel that he was suffering from a severe and enduring mental illness. The following day, the man burnt himself deliberately, and on 12 November was reported as being 'on edge'. The psychiatrist reviewed the man again and advised stopping the special watch as he was not expressing suicidal ideation and did not feel like self harming. He diagnosed borderline personality disorder.

There are further entries concerning the man's self-harming behaviour, and on 14 November he was noted to be 'distressed and tearful'. He was seen by the Psychiatrist and the Mental Health Team on 18 November. The Psychiatrist noted that the man was fit for, and agreed to be, discharged from the healthcare centre to the main prison. He would be supported in this move by attendance at the day care centre. This did not happen immediately.

On 22 November, the man was volatile and banging on his cell door in the hospital. There were several other treatment entries about him up to 1 December when it was recorded by the CPN that he was hostile and argumentative. Some of this was in relation to the proposed move from the hospital onto the wings. This seemed to cause anxiety for the man. The CPN reassured him that help and support would continue to be made available to him once he was on one of the residential units.

The man moved to G Wing on 4 December and was put in a shared cell. An F2052SH case review on 6 December kept the form open and noted that he was trying to cope with his move onto G wing. On 10 December, he handed a note to an officer stating that a young man had spat at him and that he was worried he might murder him. The man's key worker saw him the next day and thought he had settled better than expected and said he had no suicidal ideations. On 12 December, there is an entry in his F2052SH that the man was very upset and agitated because his girlfriend had not been permitted to drop off a CD player for him. He became abusive and threatening towards staff and then cut himself. A member of the Mental Health In-Reach Team visited the man later that afternoon and spoke to him about what had happened. He calmed down and was more amenable to trying to resolve the situation.

On 16 December, the man claimed other prisoners were bullying him and so was moved to K Wing and then A Wing, one of the vulnerable prisoner units within Manchester. His F2052SH form was closed on 20 December. On 25 December, The man was put onto another F2052SH due to threats to himself and the next day was put into the segregation unit. It is not clear from the Segregation Safety Algorithm what the reasons were for his segregation, nor what issues had been considered in taking that decision. Later that day, the man self harmed in the segregation unit by hitting himself in the face. He threatened to continue self harming if he was not admitted to healthcare. The man was moved to healthcare as a result and placed on special observations. On 27 December, a cell sharing risk assessment was conducted by a wing manager, indicating he had written a letter stating he would kill another prisoner. This cell sharing risk assessment was not completed correctly.

The man returned to segregation on 29 December. This appears to have been due to an incident in healthcare where he kicked over his TV and set fire to a book and papers in his cell. The Segregation Safety Algorithm was fully completed on this date by the duty governor. The man was reviewed by the CPN of the Mental Health In-Reach Team on New Year's Eve. He acknowledged his own responsibility for the situation he found himself in and said that the threats he made were impulsive and that there was no intent behind them. The man remained in segregation until 5 January, on which date he returned to A Wing.

On 9 January, the man harmed himself by punching himself in the eye. At the end of January, he handed a note to an officer threatening to self-harm if he could not go to segregation. He said he had stopped taking his medication and that, if he could not get a single cell, he would harm himself or his cell mate. A multi-disciplinary case review was held to discuss the man's recent behaviour. It was agreed that his behaviour would be treated as a discipline problem by wing officers. However, his support from the Mental Health In-Reach Team would continue.

In early February, the man said to the CPN that he 'just liked to put a spanner in the works every now and then'. He used this as the reason to explain his recent behaviour. The man also tried to write to another prisoner of a high profile case around this time. He then seemed to settle down for the rest of February.

He was next seen by the Mental Health In-Reach Team in mid-March. The multi-disciplinary review of his F2052SH decided that his enhanced support and monitoring should continue. The man expressed a desire to go to Rampton Hospital and was planning disruptive behaviour to achieve this. He was encouraged to reflect on this and agreed that such behaviour was unlikely to get him the outcome he desired. On the weekend of 19 to 21 March, the man stated he had taken 50 Ibuprofen tablets and that he had bought these from another prisoner. He was admitted into Healthcare. On the Monday, he was seen by the Mental Health In-Reach Team and the Psychiatrist. The man reflected on his behaviour and attributed it to the fact that his friend did not turn up for a visit and his 'plan' to get a transfer to Rampton Hospital. The man agreed to return to A wing. By the end of March, he had once more settled into life on a residential unit. He attended education and had a job as a wing cleaner.

The man's F2052SH was closed on 3 April but another form was opened on 12 April due to a letter from him in which he stated that he might ask his cellmate to kill him. On 13 April, the man made further threats to kill himself. During this period of time he was becoming anxious about his imminent court case.

He appeared in court on 16 April and was remanded back to Manchester pending a transfer to hospital for a psychiatric assessment. On 20 April, the man was admitted into healthcare after he made serious threats of self harm. He was put into a gated cell and was watched constantly. The doctor and the CPN saw the man the next day. He was uncommunicative and subdued and so he remained in the gated cell under constant observation.

The man's period in Hospital

After his court appearance on 23 April, the man was transferred to hospital under Section 35 of the Mental Health Act for a 28 day assessment. His admission to the hospital was described as being 'chaotic' in the report prepared by a doctor (faxed to Manchester's Prison Mental Health In-Reach Team on 7 June 2004). During his arrival, the man was described as hostile, uncooperative and threatening to staff. On his first day, he wrote a threatening letter to the doctor, and the next day a threatening letter to nursing staff saying that he was a high risk of killing a patient or staff member. Throughout his stay in hospital, he was never on less that two to one or three to one observations.

On 24 April, the man spent time banging his head against his bedroom wall. He talked about auditory hallucinations and a conspiracy involving a Masonic order, but when challenged about this latter belief he accepted and agreed with the objections raised. The next day, he continued to be argumentative and easily aroused and eventually was restrained and given intramuscular Lorazepam. During the night he was restrained on two more occasions. The man later attempted to harm himself and to flood his room using the wash basin. When nursing staff intervened, he punched and scratched the member of staff which led to him being restrained and given further medication.

In the doctor's ward round on 26 April, the man was apologetic about the incidents but said he had no memory of them. He agreed to draft a contract about his behaviour on the ward, but later that day denied such discussions and became hostile and threatening to staff after his request for Lorazepam was denied. The man engaged in self harm by stabbing cigarettes on his forehead, trying to suffocate himself and head banging. The information about this attempted suffocation was passed to Manchester's Mental Health In-Reach Team, via the doctor's report, when it was faxed on 7 June 2004. There is no evidence in the man's medical record or F2052SH forms that this was brought to the attention of medical or prison staff at the time.

Over the next few days, the man was at times warm and pleasant but then became agitated one evening when he could not contact his mother by telephone, and was given Olanzapine which reduced his distress. During the first week of May, the man was sometimes apologetic for his behaviour, claimed he could remember little of what had happened and was often pleasant and interactive. However, on 9 May he became very angry when a request to bar a member of staff from observing him was denied and he smashed his CD player.

On the doctor's ward round the next day, nursing staff reported him attempting to 'split' staff at times. For example, he would have the same conversation with several different staff and claim amnesia about the previous discussions.

A Forensic Psychiatrist who assessed the man on 5 May advised the team that the man did not appear to be psychotically driven at that time. He felt that the man had borderline and psychopathic personality traits. A clinical psychologist tried to interview the man on 10 May, but he refused to be seen. After reviewing his notes,

she felt that a diagnosis of Sociopathy would be most appropriate and that he might benefit from a prison that could provide a therapeutic community environment.

The doctor's report went on to say that discussions with the Mental Health In-Reach Team at Manchester indicated that they did not feel that the man was suffering from a major mental illness, and that he did not need their regular input.

In concluding her report, the doctor stated there was no objective evidence that the man was suffering from a major mental illness at that time. There was evidence that he had suffered from psychotic symptoms in the past, but it seemed highly likely that these were related to alcohol and substance misuse. It was not felt that any of his impulsive or aggressive behaviour at hospital had been psychotically driven. The most likely diagnosis in her opinion was a mixed personality disorder, with both emotionally unstable and dissocial traits (this latter confirmed by completion of the Hare Psychopathy Checklist). The doctor said that the man did not require treatment in a psychiatric ward. She felt it was unclear to what extent his condition was treatable. She went on to say that he might benefit from being in a prison run along therapeutic community lines.

The man was returned to prison after only 17 days of the 28 day hospital order.

The man's return to Manchester

On 12 May 2004, the man returned to Manchester and was located on G Wing for his induction. At court, he had been sentenced to a five-year term of imprisonment with an extended period of two years for possessing an imitation firearm with intent to cause fear of violence. An F2052SH was opened upon the man on this date. He remained on this form until his death. His Cell Sharing Risk Assessment form rated him as a low risk to others and so he was put into a shared cell on G wing. The man initially settled fairly well on the unit.

At 10pm on 19 May, the man pressed his cell bell and told staff that he felt like self harming. They contacted healthcare and arranged for the CPN to see him the following day. The next morning, wing staff noted that information had come in that two prisoners had taken tobacco off the man and that this was the real reason behind last night's cell bell press. The rest of May passed fairly uneventfully and he got on with his new cell mate. On 31 May at 6pm, the man passed a letter to staff saying that he was in fear of being attacked because another prisoner was spreading rumours that he was a sex offender. He requested to be moved to the segregation unit or A wing (the vulnerable prisoner unit that he was on prior to going to hospital). The letter also included threats to attack other prisoners. Some 25 minutes later, the man self harmed by cutting his forehead. He refused to go back on G Wing after treatment and so was moved to the segregation unit. The next day he was found guilty on adjudication of disobeying a lawful order. His application for vulnerable prisoner status was approved by both the referring officer and the duty governor and he was moved to A wing. His Cell Sharing Risk Assessment was changed to a medium risk, but he was still put in a shared cell. Staff on A wing said that the man expressed no thoughts of self harm on his arrival and that he was happy to be back on A wing.

He settled down on A wing and re-applied for education and employment as a cleaner. However, he wrote a series of inappropriate letters to the governor. He said this was impulsive and because he enjoyed the reaction he got after sending the letters. The man's F2052SH case review on 12 June recorded that he was reasonably content, settled on A wing and content with his cell mate. He also said that he had regular contact with the CPN, had no thoughts of self harm and would be happy to come off the F2052SH system. The review team decided to keep the man on the system until a further review involving mental health in-reach could be arranged. When the CPN spoke with the man on 18 June, he told her that he was feeling low because of spending long periods in his cell. The wing senior officer organised for the man to attend education, which raised his spirits by that evening.

On 19 June, the man said he was unhappy on A wing and said he did not want to be a vulnerable prisoner anymore. Two days later, he cut his face but refused to comply or co-operate when taken to the treatment room. The next day, the CPN found that the man was initially unwilling to discuss the incident. However, he finally admitted that he had done it because he was 'bored' and wanted to get a reaction. The man said he wanted a 'single cell in Rampton and that he would get there'. His F2052SH case review that day recorded that he was very depressed and saw no value in life. Healthcare were asked to assess him but could not do so until the next day. The man was therefore put onto a 30 minute watch.

The CPN saw the man the next day and noted that he had stopped taking his medication. He said he understood the negative consequences of doing this. The CPN encouraged him to start taking his medication again. The man said he had no suicidal thoughts but continued to have thoughts of self harm. The CPN saw him again the next day (23 June) and said that the man was talking more positively about himself. He said he still had thoughts of self harm, but did not want to act on them and would seek help if he felt that he would self harm. He later told wing staff that he was happy on A wing and did not want to create problems.

The man later wrote a threatening and unpleasant letter to the then Home Secretary.

The man's next F2052SH case review was on 27 June. During this review it was noted that he was very keen to transfer to Grendon (a prison that operates as a therapeutic community). The review noted that the man might be disappointed in this respect and then seems to have gone on to tell him that he had childish tantrums. He was noted to be unhappy, but then over the next couple of days seemed okay on the wing.

The man's placement in the segregation unit

On 1 July, an essay paper written by the man containing fascist and racist theories and comment was found by prisoners in education. The man asked to be moved from A wing for his own protection. Due to the racist content of the essay, prisoners from minority ethnic backgrounds were unhappy with the man and believed him to be racist. The man said he was threatened. He was therefore moved to E Wing, the other vulnerable prisoner unit that was occupied in the main by sex offenders. A Governor described the wing as being settled, with generally older and more mature prisoners, and that it was hoped he would settle there. The man appeared to be okay for the rest of the day and night.

The next morning, he was interviewed regarding the essay found in education by the Race Relations Liaison Officer (RRLO). The man said he was not racist. Shortly after, he told an officer on E wing that he had been threatened due to his alleged racism and that he now felt unsafe on that wing too. He did not name the prisoners who had made threats towards him, but described them as an Asian man, an Irishman and a Rastafarian.

I have read the essay. Concerned to promote a 'New Order' based on Aryan supremacy', it is rambling and manifestly the disordered mind. A flavour is contained in the following extract:

> "The religion of the New Order in Roman Catholism seen as independent of bourgeois' influences, and aggregating in the context of unitary neo–fascism in the international domain… The Ecclesiastical Territory of Rome may enjoy special status, Europe's port, and it is not paradoxical that the Order's spiritual centre lies just north of the Byzantine Empire"

However, there is no surprise that Black prisoners might have found the essay deeply offensive. The man wrote:

> "…there should be no difficulty or emotional obstacles to imagining or realising Afro-Caribbean's (sic) to be rather more similar to the monkey than to the white superior".
>
> "Black man can find work, of relatively simple type, for example as nursing orderlies on low-skill hospital wards, but as an aside, who wants to be nursed by African queens and buffalo soldiers?"

The duty governor, decided to move the man into the segregation unit for his own protection. He was moved there at 10am on 2 July. The duty governor considered other wing options, including moving the man to the upper part of the prison, but felt that he would not survive in any other area of the jail until matters had calmed down over the essay. The duty governor felt the primary issue was the threat of attack. He discussed with the nurse in segregation if she was happy that the man's condition would not deteriorate and that there were no self harm or clinical reasons against him being segregated. The nurse said there were no reasons. The duty governor also spoke with the man. He asked him about his F2052SH status and how he felt. He said that the man told him he was fine and that he had not self harmed for a while.

The duty governor also spoke with the E wing Senior Officer and was satisfied after all his discussions that, at that time, the self harm issues were secondary to the risk of the man being attacked. He said he did not want to put the man into healthcare because of the difficulties when he had been there previously.

He went on to say that there was no clinical reason for the man to be in healthcare and that he felt satisfied that the man was not going to self harm. He also considered other wings in the prison, including the top section of the prison. H wing is a detox wing, so that would not have been right, G wing is induction and the man had already asked for protection when he was on that wing. K wing is a big, open, 'hurly burly' wing and the duty governor felt that would be completely the wrong environment. The duty governor said he honestly considered that segregation was the safest place for the man at that time.

The segregation safety algorithm was completed by (nurse qualified) health care officer. This indicated that there were no healthcare reasons against The man being in segregation at that time. The algorithm was then completed by The duty governor and the other required paperwork to authorise segregation was filled in. The man was located in cell E2-S12 in the segregation unit. A care plan was to be put in place and he was to be observed five times an hour at irregular intervals.

At 3.30pm, he was seen by a nurse from the Mental Health In-Reach Team. She noted that the man was 'very remorseful' over the situation he found himself in. She put him down for a further review on 5 July. He told her he was in real trouble because of the essay and would have to remain on rule 45 own protection.

The duty governor spoke with the governing governor shortly after 4pm that afternoon. The governor told him that the man's letter to the Home Secretary had included threats against other prisoners and that his Cell Sharing Risk Assessment needed to be reviewed. The man's rating was subsequently upgraded to high. This meant that he was not deemed suitable to share a cell with another prisoner.

The duty governor later telephoned the segregation unit to check the care plan for the man had been written up and implemented. The senior officer assured him that all was in place. The care plan listed six things to be implemented. These were special observation (five times an hour), case reviews every Monday and Friday, staff support, a radio, a Samaritan phone and a review of his Cell Sharing Risk Assessment. By the time of his death the next evening, the man had not been given a radio.

The man spent the night in segregation and was seen writing several times when checked by staff. One of the things he wrote that night was a letter to a friend. He told this friend that the biggest problem in his cell was that there was no electricity and that therefore he had no radio or television. He said that he knew he would deteriorate being in there, but that his deterioration was reversible. The man knew that his next review was on Monday. He said that he was currently 'together' and, if not exactly happy, was safe. His closing remarks were reassuring and acknowledged that his current situation was only for a finite time. The man also wrote to the Governor. In this letter, he reflected on how he had ended up in custody

and the segregation unit. He said that he had failed to cope on the wings and was now asking the governor either to keep him segregated, or more ideally, move him into the healthcare centre. Neither of these letters was read by staff prior to the man's death.

In the afternoon of Saturday 3 July, the man had association with other vulnerable prisoners in the segregation unit and reported no problems to staff. During this time, the man asked an officer if he could share a cell with another person in the segregation unit. The officer explained to the man that this would not be possible because of the letter he had written threatening to kill a cell mate if he were to share a cell. The man wrote several letters that Saturday. One was to his solicitor, asking her to destroy the allegedly 'racist' essay he had sent her. He said that 'some serious attention seeking had gone horribly wrong' and that he was not really a racist. In this letter, the man told his solicitor that he was in fear of being killed and had seriously contemplated suicide. He said his life was not worth living at the moment and that even the hospital wing would not have him back. He wrote another letter to his mother. He asked her to send in some stamps so that he could keep sending lots of letters. He told his mother that the prospect of spending a long time in his segregation cell was an ominous one and that, because there was no power in his cell, he had no radio or TV. He also mentioned missing things like newspapers. He said he had written to the governor asking to be moved to the healthcare centre and asked his mother also to write a letter on his behalf. The man said that he 'counted his blessings' in the cell he was in compared to prison regimes elsewhere in the world, but that he found it difficult to see what he had done to deserve it all. He said the only thing that stopped him killing himself was his instinct and the knowledge that ending it all meant that his life would never have got better. He ended the letter by saying he would speak to his mother the following week and that he knew that one day he would be released. None of these letters was read by staff prior to the man's death.

At about 5pm, while the man collected his tea meal, he asked an officer if there was any chance of him going to healthcare. As it was a Saturday, his location in the segregation unit was due to be reviewed on Monday. The officer informed that going to healthcare was not an option at that time because he was not seen to have mental health problems, just a personality disorder. Prison Service rules dictate that prisoners can only be admitted to healthcare on clinical grounds and by clinical staff and, as he had been deemed medically fit for segregation, her assertion was correct. They then spoke about a transfer for the man and about him coming off vulnerable prisoner status in order to facilitate a move to another prison.

The officer unlocked the man in order for him to get his medication. Then she looked up his details on the computer and saw that he had been allocated a transfer to another prison, Grendon she thought. She went back up to talk to the man at about 6.20pm. During this conversation she said she would contact OCA – the department that arranges the transfer of prisoners - on Monday when they were back in, and that she would help to sort out a transfer for him. The officer said they spoke for some time and that the man had seemed 'really quite happy'. Even with hindsight, the officer said normally staff could tell when the man was low in mood, but that on that day he had seemed fine. She was sure he had gone on exercise, he spent time on association with others and spoke with her several times during the day.

At 6.45pm, the officer gave a handover to the arriving evening officer, and then went towards H1 landing in the top prison.

Shortly before 6.50pm, the evening officer checked on the status of all the prisoners in segregation, starting on the two's landing. Upon lifting the observation flap of the cell belonging to the man, he saw him on the bed with a white plastic bin bag over his head. His body was covered in blankets. He tried to get a response from the man and banged on the door, but none was forthcoming. The officer then tried to use his radio to call for assistance but the battery was low on power and he could not transmit a message. He went quickly to the wing office and telephoned through to the control room. This call was logged at 6.51pm. the officer requested Oscar 1 and Hotel 1 (Orderly Officer and Healthcare Response) attend immediately.

The Prison Response to Finding the Man

The officer returned to the cell and was almost immediately joined by a second officer responding from E wing. They entered the cell together, using the cell key in the sealed pouch. The second officer removed the plastic bag from the man's head and checked for a pulse or breathing. The first officer said he remembered the man's lips being blue and that his eyes were half shut. The officer to whom the man had been speaking to at 6.20pm had heard the emergency message and immediately returned to the segregation unit. She was very distressed upon seeing the man and was ushered into the office by other staff. The first officer went to the end of the two's landing and fetched the suicide prevention equipment box. He then got out a face shield in order to start CPR (cardio-pulmonary resuscitation). At this point two nurses arrived.

The orderly officer, a senior officer, arrived at 6.54pm along with healthcare staff. The orderly officer requested an ambulance and one was called immediately from the control room. Healthcare staff checked the man's vital signs. He was extremely cyanosed (blue in colour) with fixed pupils and had no pulse. They commenced CPR.

At 7pm the duty governor was contacted and then the governor and the deputy governor. The deputy governor informed the prison that he was on his way in. The ambulance arrived at 7.03pm. The gates were quickly opened and the ambulance arrived at the segregation unit at 7.07pm.

The paramedics examined the man in the presence of healthcare staff and performed an ECG on him. There was no cardiac output and so paramedics stopped resuscitation attempts at 7.21pm.

The duty governor arrived at 7.23pm and took control.

At 8.40pm a request was made for a doctor to be called from the locally contracted service provider. A doctor from Primacare arrived at the prison at 9.45pm

The local death in custody action plans were activated appropriately with no issues of non-compliance. A hot debrief was held and staff were later contacted by the Care Team within the prison. Counselling was taken up by some of the staff involved.

Norwich police were asked to break to news to the man's mother. She then spoke with the duty governor, at around 6am the following morning.
The man's sister also contacted the prison and she and her husband decided to take up the offer of a visit, to the prison where they met with the Governor and duty governor. During this visit, the man's sister said that her brother had tried to suffocate himself before with a plastic bag when he was at the hospital. The duty governor said she was shocked by this as she had no notion of this at all. In fact, the report from the doctor at the hospital does make reference to the man 'trying to suffocate himself', although does not specifically mention plastic bags. This report was faxed to the Mental Health In Reach Team at the prison on 7 June, but the information within it does not appear to have been assessed, summarised or communicated to other staff in the prison. The CPN, the man's in-reach worker, said

she did not know about the incident at hospital either. I make a recommendation about this.

The man's sister attended a service in the prison chapel and spoke with a number of prisoners who had known her brother. She also visited the segregation unit and the cell where he had died.

Issues Considered During the Investigation

The decision to segregate the man on 2 July

The man was put into the segregation unit for his own protection at 10am on 2 July. The governor who authorised the man's segregation, felt the primary issue was the threat of attack from other prisoners and not the man's open F2052SH status. He discussed with the nurse in segregation if she was happy that the man's condition would not deteriorate and that there were no self harm or clinical reasons against him being segregated. The nurse said there were no reasons. The governor also spoke with the man. He asked him about his F2052SH status and how he felt. He said that the man told him he was fine and that he had not self harmed for a while. The governor also spoke with the E wing senior officer and was satisfied after all his discussions that at that time, the self harm issues were secondary to the risk of the man being attacked. He also considered other wings in the prison, including the top section of the prison.

The governor said he honestly considered that segregation was the safest place for The man at that time. He felt he had satisfied himself that the man was not going to self harm.

The governor made sure that a care plan was put in place and that the man being observed five times an hour at irregular intervals.

I think that the governor's decision to segregate the man at 10am on 2 July was reasonable, and that he had explored other options appropriately before deciding upon segregation.

Suicide and Self Harm Prevention and compliance with PSO 2700

During his time at Manchester, it would appear that the man was the subject of four F2052SH forms, although only three were presented to my investigator. The man carried out several acts of self-harm, including burning himself. There were also many threats made by him during his stay at Manchester either to kill or harm himself. He also made threats against other prisoners and occasionally staff. He presented as a difficult individual to manage in a custodial setting. There is no evidence that, while in custody at Manchester, the man was physically violent to any member of staff or prisoner. However, during his stay at Wythenshawe Hospital, it is apparent that he was restrained and medicated on a number of occasions and was violent towards nursing staff. My investigators examined the F2052SH's opened on the man. They showed regular and good quality entries. There were several minor faults in the completion of these documents, none of which could be deemed as demonstrating a failure in the care of him.

The investigators also examined other F2052SH's and found a small number of common faults but none of these could be deemed to affect the care and support being provided to vulnerable prisoners within Manchester.

There was a high degree of staff awareness of the F2052SH system and the level of care provided to prisoners was also high. Staff were generally well aware of The man and his difficulties and responded in a sensitive manner to his behaviour. Case conferences were routinely held in a timely manner, except the case review that should have taken place within 24 hours of him being placed in segregation on 2 July. This is explored below in more detail.

There are no safer custody cells in HMP Manchester as a whole, and none specifically in the segregation unit. While such cells do not make it impossible for prisoners to take their own life, they do make this task more difficult and therefore help to preserve life.

Suicide prevention meetings are attended by a cross section of staff. The committee appears to operate well as a multi-disciplinary approach to the management of the suicidal or vulnerable. Part of the committee's remit is to examine all closed F2052SH documents. This is completed by the safer custody manager. Management checks on F2052SH forms and the prisoners thereon are adequate. Self-harm kits are in place.

There is a thriving Listener scheme in the establishment, supported by the visiting Samaritans. Notices were evident (except in Reception) within the prison to highlight the scheme, and prisoners were alerted to the service throughout the induction programme.

Whilst PSO 2700 does not advocate the automatic removal of items such as shoelaces and belts from a prisoner thought to be at risk of self harm or suicide, it does state that items can be removed if there is justification for doing so and that these reasons are recorded. (Needless to add, the decision to place a prisoner on an open F2052SH in segregation should only be taken exceptionally and for the shortest possible time.) In the man's case, his previous known history of cutting and burning might have led to a decision to remove matches and razor blades from his possession. If the information about his previous attempt at suffocation whilst at the hospital had been shared around the prison, it might also have led to a decision to remove plastic bags from his cell.

Mental health services are provided through a community trust service to nationally recognised NHS standards. They provided the man with a high and frequent level of care.

Chapter 4 of PSO 2700 is titled 'Managing Prisoners Identified at Risk to Self'. It states in para.4.1.2.1 that an F2052SH case review must be held as soon as possible after segregation to take account of events leading up to the decision to segregate. PSO 1700 further defines the maximum time that can lapse without a

review as 24 hours (see next section).

Para.4.1.2.2 states 'A mental health assessment must be undertaken by healthcare staff of all prisoners at risk of self harm or suicide who are placed in the segregation unit, and the reviewed care plan implemented... The decision to segregate must also be regularly reviewed by health care staff.'

A member of the Mental Health In Reach Team visited the man on the day he was segregated. She spoke with him briefly and then arranged for a further appointment on the Monday (three days hence). She did not indicate any concerns with the man in the note of her visit at 3.30pm on 2 July. Healthcare staff visited him in the segregation unit on 3 July and said in his medical record that there were no issues arising. Manchester prison complied with this paragraph of PSO 2700.

Compliance with PSO 1700 Segregation of Prisoners

The section in PSO 1700 on 'initial segregation' states that prisoners on an open F2052SH should only remain in segregation in exceptional circumstances. These reasons need to be outlined on the Segregation Safety Algorithm form and a self harm case review should take place the same day whenever possible, up to a maximum of 24 hours. A safer cell should be used to accommodate a prisoner on an open F2052SH whenever possible.

The Segregation Safety Algorithm completed at 10.20am on 2 July does not indicate the 'exceptional reasons' why the man, on an open F2052SH, was being segregated. However, during interview, the governor indicated that he had spoken to the nurse who was in the segregation unit and had ascertained from her that there were no clinical or self harm reasons against The man being in the segregation unit. The governor also spoke to the man, the E wing senior officer, and segregation staff prior to making his decision to authorise an initial period of segregation for him. He explained during interview that he was satisfied that the risk of self harm was secondary to the risk of the man being attacked by other prisoners at that time. He said there were no clinical reasons why the man should be in the healthcare centre. Although I am concerned when any prisoner on an open F2052SH is placed in segregation, I judge that the decision to put him in the segregation unit at that time was a reasonable one given the circumstances. However, the Safety Algorithm should have been more fully completed with the exceptional reasons justifying segregation.

The man's F2052SH booklet indicated he arrived in the segregation unit at 10.03am on 2 July 2004. An F2052SH case review should therefore have been conducted before 10am on 3 July. No case review was held on 2 or 3 July. The man's last case review took place on 27 June, before the finding of the 'essay' that triggered his removal from A wing and E wing and into the segregation unit. PSO 1700 was not complied with in this respect and meant there was no overview of what had happened to him, how he was feeling, how he could best be managed and supported whilst in the segregation unit.

The man was not located in a safer cell because there are no safer cells in Manchester's segregation unit.

Recommendation 1 – The governor should remind senior colleagues that Segregation Safety Algorithms should be fully completed, including the exceptional reasons for segregation of a prisoner on an open F2052SH.

Recommendation 2 – The governor should remind staff that an F2052SH case review must be held for all at risk prisoners put into segregation within 24 hours of their arrival.

Recommendation 3 – The governor should consider the conversion of one of the segregation unit cells into a safer cell. This cell could be used to accommodate prisoners on an open F2052SH who are put into segregation because of exceptional circumstances.

In the 'initial segregation' section of PSO 1700, there is a specific instruction that states 'measures are put in place to safeguard the mental health of prisoners who are kept in segregation'. The section entitled 'Promoting and Safeguarding the Mental Health of Prisoners Held in Segregation Units' lists a number of measures that can be implemented in order to try to safeguard a person's mental well being. It states that difficult cases should be managed by way of a case conference involving the governor, doctor, nurse and other relevant people. The practical measures listed include increased medical support, increased staff observations, providing Listeners, Samaritan phones, encouragement to keep in touch with their friends and family via visits, letters or phone calls, periods of exercise or fresh air, ways to relax such as listening to the radio, watching TV, reading newspapers or books, in-cell education or hobbies and talking to people (chaplain, segregation staff, mental health in-reach).

There is a Segregation Unit Care Plan for the man, but it is not clear whether it is in relation to his segregation on 2 July or an earlier period. It is not dated or signed and so is very unclear as to who wrote it or what information they had at the time of writing. It states that the reason the man is in segregation is 'he has requested own protection, he has made a number of threats which have been towards a number of people, some being sent in letters to the Home Secretary, one stating he will kill a cell mate. He is currently on a self harm form'. There is no mention of an essay interpreted by prisoners as being racist. It is possible therefore that this care plan is not in relation to the 2 July segregation, even though it was presented to my investigators as such. The plan goes on to state several supportive measures such as special observations (five times an hour), a radio, F2052SH case reviews every Monday and Friday, staff support and access to a Samaritan phone. If this was the 2 July care plan, it was not fully implemented. Although I commend the frequent staff observations and obvious staff support from an officer, the planned timing of the F2052SH case review was not in line with PSO 1700 requirements. Nor did the man have a radio in his cell when he died on the evening of 3 July and Samaritan phones were not available in the prison at that time.

It is disturbing that the man was segregated for his own protection and yet made subject to a very limited regime that involved long periods of being locked in his cell with nothing other than a few reading and writing materials to occupy his mind.

Careful thought should be given to the segregation regime for all prisoners on an open F2052SH, but particularly when they are also well known to the Mental Health In-Reach Team and in segregation for their own protection. I do not think that the spirit of PSO 1700 on safeguarding a person's mental health was given appropriate consideration. The man should have been provided with a radio at the very least. He should also have been provided with more reading materials such as a newspaper or magazine. In the absence of in-cell electricity, the governor may wish to give consideration to providing a number of hand held televisions and/or battery powered radios for use by prisoners in the segregation unit.

Recommendation 4 – A review of segregation care plans for those on an open F2052SH should be undertaken. Care plans should be dated. The author should print and sign their name clearly. Measures in the care plan should be audited by managers on a regular basis to ensure they are implemented.

Recommendation 5 – In the absence of electricity in segregation cells, the Governor should give consideration to the purchase of a small number of hand held televisions and/or battery powered radios for use by prisoners in the segregation unit.

Other issues identified

The man wrote several letters when he was in the segregation unit on 2 and 3 July. None of them was a suicide note. Although suicide is referred to in some of the letters, the overall tone is an acceptance of the reasons why he found himself in segregation and an acknowledgement that he was being considered for transfer to another prison and that his prison sentence was for a finite period.

When alerting other staff of a serious incident whereby a prisoner, or indeed a member of staff, is injured, it is not part of Manchester's procedures to have a code red / code blue system for health staff to respond to incidents with the appropriate equipment. Code red and code blue procedures have now been adopted in the majority of establishments. These help alert medical staff as to the type of emergency to be faced, and the correct equipment to bring to the scene.

Recommendation 6 – The governor should consider implementing a code red / code blue system of notifying medical staff about the nature of an emergency. They would then be able to ensure that the right equipment was taken to each situation according to need.

The clinical review, carried out by the deputy ombudsman made two recommendations which I endorse. Her most significant recommendation concerned the care given to the man when he was in the hospital. The man was sectioned for a 28 day assessment but was then returned to prison after only 17 days. His behaviour on the unit was challenging and required intensive nursing. He was diagnosed with personality disorder, but the deputy ombudsman felt there was an inadequate assessment of his suitability for treatment within a mental health setting. There were also significant delays in hospital communicating their findings and the man's behaviour whilst in hospital.

Recommendation 7 – A copy of this report should be sent to the local PCT requesting a review of the appropriateness of the care afforded to the man and the delay in communicating relevant information to HMP Manchester by the hospital.

As part of this investigation, the action plans of previous deaths in custody were examined to see if HMP Manchester has complied with the recommendations. The investigations that have been considered are those into the deaths of two prisoners.

My investigator focused on actions that had not been taken forward, or had been recorded as complete, but not in evidence within the establishment. These were found to be:

- A higher priority needs to be given to regular management checks of live F2052SH's that concentrate on compliance with the requirements of PSO 2700, paying particular attention to the timing of any representation at case reviews and the quality and progress of action plans.

- Handovers of all F2052SH's from each shift, including night staff, should be documented and signed for.

List of Recommendations

Medical

- The governor should consider implementing a code red / code blue system of notifying medical staff about the nature of an emergency. They would then be able to ensure that the right equipment was taken to each situation according to need.

The Prison Service responded by partially accepting this recommendation and said, "A full review of the medical emergency response procedures by healthcare staff will be conducted by the Head of Healthcare. The review will examine the feasibility of introducing a code red/code blue system".

- A copy of this report should be sent to the local PCT requesting a review of the appropriateness of the care afforded to The man and the delay in communicating relevant information to HMP Manchester by the hospital.

The Prison Service responded by accepting this recommendation and said, "A copy of this report will be sent to the local PCT requesting a review of the appropriateness of the care afforded to the man. This should then be forwarded to the PCT covering the hospital".

- Healthcare staff should be reminded of the importance of fully completing the reception screening documents in order to obtain a comprehensive picture of the patients' physical and mental health.

The Prison Service responded by accepting this recommendation and said, "A review of the reception procedures will be completed by the Head of Healthcare and any training needs identified. All staff working in reception will be reminded of their duties and importance completing reception screening documents".

Local

- The governor should remind senior colleagues that Segregation Safety Algorithms should be fully completed, including the exceptional reasons for segregation of a prisoner on an open F2052SH.

The Prison Service responded by accepting this recommendation and said, "Advice and information has been given to Senior Managers and Duty Governors reminding them that Segregation unit Safety Algorithms must be fully completed. The advice highlighted the circumstances which could be considered exceptional and requested that alternatives to segregation be examined".

- The governor should remind staff that an F2052SH case review must be held for all at risk prisoners put into segregation within 24 hours of their arrival.

The Prison Service responded by accepting this recommendation and said, "This is now incorporated into ACCT. The local policy will be reviewed and all staff reminded of the need to complete a case review within 24hrs.The practice of immediate reviews and implementation of a comprehensive care plan is currently well established and encouraged".

- The governor should consider the conversion of one of the segregation unit cells into a safer cell. This cell could be used to accommodate prisoners on an open F2052SH who are put into segregation because of exceptional circumstances.

The Prison Service responded by accepting this recommendation and said, "Two cells have been converted into safer cells and a protocol for use implemented. (This does not undermine our policy of not segregating prisoners on ACCT without exceptional reason)".

- A review of segregation care plans for those on an open F2052SH should be undertaken. Care plans should be dated. The author should print and sign their name clearly. Measures in the care plan should be audited by managers on a regular basis to ensure they are implemented.

The Prison Service responded by accepting this recommendation and said, "A full review of the procedures for segregation unit care plans has been conducted by the Director of Residence. The local policy has been reviewed and the recommendations included in the relevant paperwork. With the implementation of the new ACCT procedures all the recommendations have been covered".

- In the absence of electricity in segregation cells, the Governor should give consideration to the purchase of a small number of hand held televisions and/or battery powered radios for use by prisoners in the segregation unit.

The Prison Service responded by accepting this recommendation and said, "Five wind up radios are now available on the segregation unit. The prison will order subject to security measures battery powered hand held televisions which will be available to prisoners".

National

- The Prison Service should consider being a partner in the development and delivery of the proposed court diversion service being developed by mental health charities (Rethink document)

The Prison Service responded by partially accepting this recommendation and said, "Health & Offender partnerships are developing a new programme of work focussing on the health and social care needs of offenders from first point of contact with the CJS through re-integration into the community. A key element of this will be work around the courts and the provision of services to identify and appropriately address those with health and social needs. Mental health and those with complex multiple needs will be a major component within this".

Recommendations about staff performance

The CPN should be commended for the professional support she provided to the man while he was under the care of the Mental Health In-Reach Team.