

**Investigation into the circumstances
surrounding the death of a man at
HMP Wormwood Scrubs in November 2005**

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

November 2007

This is the report of an investigation into the circumstances surrounding the death of a man at HMP Wormwood Scrubs in November 2005. The man was found hanging in his cell in the segregation unit at around 2.40pm on that day. He had been moved there a few hours previously following an incident on the wing in which he had barricaded himself into his cell. At the time of his death, he was serving a sentence of 16 months imposed following his recall to prison from an early release on licence. He was 28 years of age.

The post mortem finding was that the man's death resulted from hanging. A toxicological examination concluded that there were no indications of unauthorised substances, including illicit drugs, present at the time of his death.

I offer my sincere sympathy and condolences to all members of the man's family and to his friends.

I must also apologise to the family and to others for the unacceptable length of time it has taken to produce this report. Two of my colleagues were involved in carrying out the investigation. Two family liaison officers were also involved. One of the family liaison officers first met with the man's mother but the liaison role was then taken on by another liaison officer. One of the investigators and the second family liaison officer visited the man's mother and her sister at her home, and made a separate visit to the man's father.

My thanks go to the Governor and staff at Wormwood Scrubs - in particular the Safer Custody Governor, and the Suicide Prevention Co-ordinator - who worked hard to ensure that every facility was available to my investigators. I am grateful too for the assistance given to this investigation by a Detective Inspector of the Metropolitan Police.

The man left no note as to his intentions, and the conclusions I have drawn are necessarily speculative. However, I do not judge that his actions could reasonably have been predicted by those staff responsible for his care. Nevertheless, as in other investigations I have conducted, the sad circumstances of the man's death draw attention to the importance of sharing information between healthcare and mainstream prison staff.

I have made five recommendations.

Stephen Shaw CBE
Prisons and Probation Ombudsman

November 2007

CONTENTS

Summary

The Investigation Process

HMP Wormwood Scrubs

Key Events

Issues

Conclusions

Recommendations

SUMMARY

The man died in HMP Wormwood Scrubs in November 2005. He had returned to custody when the licence to which he became subject at the end of an earlier sentence was revoked. He was further sentenced in September 2005, to 16 months imprisonment for the offence of assault occasioning actual bodily harm. The man had served previous prison sentences and was in prison continuously between May 1996 and September 2004. He was at liberty for just a few months before his licence was revoked.

During his final period in custody, he was subject to four disciplinary reports and it is fair to say that prison staff did not find him an easy prisoner with whom to deal. In addition to the formal disciplinary hearings, scrutiny of his history sheets F2052A (a running narrative of events) shows that on ten occasions he was recorded as being 'argumentative' 'abusive' or 'having tantrums'. Some of his disagreements with wing staff arose from his often being the last person to go to his cell when the prison was to be locked up for the night. In July 2005, following two incidents, the man was moved from C wing at Wormwood Scrubs to B wing. On 1 August, he was suspected of bullying other prisoners and was placed on the prison's anti-bullying monitoring procedure. He remained subject to the enhanced monitoring until 16 August 2005.

Earlier, in February 2005, his 'Care Plan' records that he said he had panic attacks. In April, he told medical staff at Wormwood Scrubs about his condition, which he described variously as "panic attacks" or "claustrophobia", and for which he was prescribed medication. Relaxation classes were also recommended but the man did not attend. It is probable, having regard to his reluctance to be locked in at night and the entries in his record showing that he wanted to be the last person on the wing to lock up, that he maximised his time out of his cell, even to the point of incurring the displeasure of staff, as the prospect of being locked in was frightening for him. The man usually had a cellmate and consequently was not alone, but his transgressions often meant he had to move location. However, he was sometimes in a single cell, particularly when he was sent to the segregation unit. On one such occasion in July, he set fire to his cell.

Although treating the man for his condition, healthcare staff did not share the diagnosis with wing managers or other staff. It was left for him to explain his problems, but wing staff appear either not to have believed him or to have disregarded his claims. He had spent many years in prison and they could have seen his claims of claustrophobia as a means to stay out of his cell when others were required to go in theirs. Some staff found him manageable, particularly his regular wing senior officer. Others found his constant challenges, and the threats to the good order of the prison, an unwelcome disruption. The man often gained and lost privileges, moving from one level to another under the prison's incentive scheme.

During the morning of the day the man died, his wing senior officer told him he was to be downgraded under the incentives scheme and must move to

another cell (one of a number set aside for prisoners on the basic regime). The man refused and built a barricade. Although he was in a shared cell, his cellmate took no part in the building of the barricade. The incident ended peacefully. However, because he had refused to move and had barricaded himself, he was not located in the cell which had originally been intended for him but in the segregation unit. A nurse, using a safety algorithm, assessed that he could be safely accommodated there and the duty governor concurred. The man walked, while handcuffed, to the segregation unit and staff did not have to use force.

When the man arrived in the segregation unit, he was located in a single cell. He came out to collect his lunch and returned there. CCTV recording shows that he seemed relaxed, stopping to talk to another prisoner who was having a shower. Between lunchtime and early afternoon the unit was in 'patrol state'. This meant that prisoners were locked in their cells and not subject to observation unless they were thought to be at risk of suicide or self harm. The safety algorithm had not identified him as being at risk.

At about 2.40pm, an officer visited him and other prisoners to advise them that the afternoon exercise would be delayed. He saw him apparently standing behind his bed. He considered this to be unusual, went into the cell and found that he was hanging by a bed sheet fixed to his neck and the hinge of the cell window. The officer raised the alarm. Wing staff and nurses attended in good time, as did a helicopter rescue team who were in the prison on an unrelated contingency exercise. Emergency resuscitation was commenced but it was unsuccessful. At 3.25pm, the doctor from the emergency team pronounced the man dead.

The Governor activated his contingency plan for deaths in custody. He tried to find the man's next of kin, identified by the man as a partner who was the mother of his youngest child. She was not at home. Meanwhile, his mother had heard of his death when another prisoner telephoned her from Wormwood Scrubs. She telephoned the prison and spoke to the Governor. Together with her legal representative, the man's mother visited the prison a few days later.

The post mortem finding was that the man's death resulted from hanging. A toxicological examination concludes that there were no indications of unauthorised substances present in his body at the time of his death.

THE INVESTIGATION PROCESS

1. The investigation into the man's death was opened on 18 November 2005 when an investigator from my office, visited HMP Wormwood Scrubs and met the Safer Custody Manager. Notices were displayed prominently throughout the prison, informing prisoners and staff how they could contact my investigation team. No prisoners asked to see my investigators.
2. During nine follow up visits, the lead investigator, assisted by other investigators, met the Governor, the Chairman of the local branch of the Prison Officers' Association and a member of the prison's Independent Monitoring Board. The investigators interviewed 13 members of staff, including prison officers, governors and nurses, and one prisoner.
3. Unfortunately, the investigation was put on hold when the lead investigator became ill part way through her work. When it was clear she would be unable to complete the investigation due to continuing ill health, another investigator took it over in October 2006. He reviewed all available information, including transcripts of interviews. He met a Detective Inspector of the Metropolitan Police and reviewed forensic evidence including CCTV coverage. He visited Wormwood Scrubs and met the Safer Custody Governor. He interviewed the Prison Service London Area Investigator, but who at the time of the man's death was Deputy Head of Safer Custody at the prison. My investigator, together with my senior family liaison officer visited the man's mother at her home. The investigator met separately with the man's father.
4. I commissioned a clinical review of the care and management of the man's health needs during the time he was at Wormwood Scrubs. This was conducted by a reviewer and I am most grateful for her assistance.
5. The Metropolitan Police based at Hammersmith readily shared all information at their disposal. This included a comprehensive video tape of his removal from B wing to the segregation unit, and camera coverage of the man's cell from his being located in the segregation unit until after his death.

HMP WORMWOOD SCRUBS

13. Built between 1875 and 1891, Wormwood Scrubs holds more than 1,200 adult male prisoners. The buildings have undergone extensive refurbishment over the years, including the addition of a new hospital wing in 1994. Many prisoners are unconvicted and the daily movements to and from courts are considerable.
14. In the report of her full announced inspection in November 2003, Her Majesty's Chief Inspector of Prisons found: "... a greatly improved prison [where] almost all of our concerns and recommendations arising from our last inspection had been fully addressed or were in the process [of being addressed]..." A subsequent report, published in December 2005 following an unannounced inspection in October of that year, said:

"There had been improvement in the management of suicide and self-harm and significant improvement in the management of bullying and violence reduction. The two full-time coordinators working in these areas shared an office and had developed good working links. In the light of the prison's history, it is positive to record that staff-prisoner relationships, as observed during the inspection, remained relaxed and cordial, including in the segregation unit."
15. Although the report identified weaknesses, particularly in the provision of purposeful activity for prisoners, it concluded:

"Over the last few years, our inspections have recorded gradual, but discernible, progress at Wormwood Scrubs. That owes a great deal to steady and consistent senior management over the last four and a half years. This inspection found significant improvements in resettlement work had taken place, including the creation of a dedicated resettlement wing. Plans were well advanced for similar improvements in first night and induction procedures, as recommended at our last inspection."
16. Prior to the man's death, there had been seven apparently self-inflicted deaths at Wormwood Scrubs between 2003 and 2005 (two in 2003, three in 2004 and two others in 2005).

KEY EVENTS

17. On 11 April 2005, the man alerted the doctor to his condition which he described as "claustrophobia". He said he did not feel able to cope with cellular confinement. The doctor could not validate this claim. The man told him that he was not registered with a GP practice in the community. Although medical staff requested back records, the hospital wrote to say they were untraceable.
18. On 20 May, during a time when the man was travelling regularly to and from prison and court, the prison doctor wrote that the man "is unable to cope in a small transport van". Further information regarding his fear of confined spaces appears in his medical record on 2 June and 27 June.
19. On 7 July, staff from the Community Prison Mental Health In reach Service assessed the man's condition and recorded that he "now suffers from anxiety, panic attacks and stress." The man was recommended to attend the prison's day care facility to take part in relaxation classes. He was also prescribed mirtazapine, an anti-depressant drug. The notes say, "Seen by the doctor on 7/7/2005. Reluctant to take mirtazapine." (Nevertheless, he appears to have continued to take his medication as he had repeat prescriptions on 19 September and 24 October.)
20. On 26 July, the man was due to start weekly relaxation classes but failed to attend. He did not attend subsequent classes. His name was removed from the register on 3 August. However, his wing records show that he afterwards told wing staff many times that he should not be in a cell on his own as he suffered from claustrophobia.
21. In July, the man refused to transfer to HMP Belmarsh and was placed in the segregation unit. He asked for a Listener. (A Listener is a prisoner trained by the Samaritans to listen to and support other prisoners.) It was not possible to grant his request immediately and he set fire to the contents of a wastepaper bin in his cell. He stayed in the segregation unit until 29 July when the Incentives and Earned Privileges Board reviewed his progress and allowed him to return to normal location on A wing.
22. On 7 August, following a return from court, he was seen by the duty nurse. The entry in his medical record reads, "location now and transport tomorrow. I can see no evidence why he cannot be located in the segregation unit. He is back at court again tomorrow. Very angry at the moment. He has seen In Reach Mental Health team (day care and consultant psychiatrist) who feels that he suffers from situational panic attacks. Was referred to day care to learn coping mechanisms, however he did not attend."
23. Entries on his wing record show that between 9 September and 14 October he again alerted staff to his condition:

9 September 2005 – “When banging him up he claimed he was not allowed to be on his own. Same story as entered on 17.7.2005. Banged up door anyway.”

18 September 2005 – “Still trying to convince staff that he suffers panic attacks and is claustrophobic. Told him he was in the wrong place to suffer with claustrophobia.”

14 October 2005 – “He has managed to persuade the SO to let the basic [another named prisoner] bang up with him. He stated he does not want a TV if this is allowed.”

24. On 10 September, a doctor (signature illegible) certified the man as fit for adjudication: “No obvious mental illness. He says that he is suffering from claustrophobia.” In certifying him fit for adjudication, the doctor concluded that should the man be given cellular confinement there was no impediment to his being located in the segregation unit.
25. On 18 September, the man sustained an eye injury probably due to an assault. The incident is not well documented and is not mentioned in his general prison record. A letter from the hospital shows that he was examined and treated for the injury which had required steri strips. On 20 September, he was given further treatment in prison including paracetamol. Although I understand and share his mother’s concern, I can find no other information about how the injury was caused. The man refused to say and his wing senior officer said she believed, “he got a right smacking, he had to go to hospital when he’d allegedly gone to intimidate the wrong people and a group of them retaliated against him. And I begged him, please get out of that situation. He was manipulated by them.”
26. Between 3 and 10 November, several entries were made in his record to the effect that he was regularly refusing to comply with the wing routine. He was an experienced prisoner, albeit a relatively young one, and he confronted staff on many occasions. The wing SO told my investigators that the man was subject to influence from other prisoners, “undesirables ... who used him as the muscle side of it. I used to say to him, they’re not your friends, look what they are doing to you ...”
27. The wing SO described him as being like a naughty boy who had to keep up appearances in front of his friends: “On occasion he could be difficult but generally he was okay.”
28. The SO recalled an incident the day before the man died when he wanted to go to the gym at 10am. The session was full and she could hear him, “shouting and screaming at the top of his voice”. She went upstairs to where he was and advised him to go for the 2pm session but he said, “I am going to go now.” The wing SO told him to go in his cell to calm down and he did. She knew him very well and said that he was “manageable but

erratic". However, "When he went into shouting mode there was no reasoning with him."

29. During the afternoon of 10 November, the man was apparently sulking. The wing SO said: "He wouldn't speak to me. I thought, he'll come round, he always does. Later in the evening he called me every name under the sun, but to be honest it went right over my head, you know, I've been called worse. But the PO told me he had given him a written warning about shouting." The wing SO said, "If it [the wing] kicked off, you don't know how many others are going to join in, especially as he's got a few friends. He'd sworn at the staff on the threes landing, so it got to the point where we were going to pull the reins in."
30. On 11 November, the Incentives and Earned Privileges Board met. Three members of staff attended and reviewed the man's privilege level. They decided that he would be downgraded from standard to basic for unacceptable behaviour: "Rude and abusive to staff. Fails to comply with regime." The wing SO chaired the board. Its findings were endorsed by the PO. Although the 'enhanced regime' box is ticked on the form as the outcome of the board, it is clear from what is documented that the man was to be downgraded to basic. The wing SO said she went to him and gave him the paperwork. She said she told him: "You're going on basic. If you're going to behave like a kid, I am going to treat you like one. I unplugged his telly, but he grabbed it and held it above his head. I don't think he would have thrown it at me, but a wing officer moved me out of the way and shut the cell door." The wing SO told the man that he was to move to a cell set aside for prisoners on basic regime. He refused, built a barricade in his cell and poured detergent on his cell floor.
31. The man had told his cellmate that, "He was feeling low and had problems with his girlfriend who hadn't visited him." His cellmate said that the man had told staff he could not be on his own in a cell and that he (cellmate) had moved in straightaway after the man's previous cellmate moved out. His cellmate said: "The man had been down the block [segregation unit] many times and has always dealt with it. All he wanted was to go to the gym every day and to be left alone. He didn't say he was worried about going down the block."
32. While the incident was going on – it lasted for about an hour and a half – the duty governor asked the staff nurse to check the man's medical record to establish whether or not he could be located in the segregation unit. The nurse went to check the record. On return, he said the man could be located in the segregation unit and completed a Segregation Safety Algorithm form confirming his opinion. The completed algorithm gave no details of his claustrophobia. The duty governor validated the form and, at 11.30am, authorised segregation. There seemed to be no bar to the man going to segregation and he had been there before. Staff put on protective clothing to effect the man's removal should force be necessary.

33. In interview with my investigator, the man's cellmate said that he had known the man for five or six years. They were friends. He told my investigators that he knew from the moment the barricade incident started, "it could only end one way. We both knew the routines and what happens." The cellmate himself took no part in building the barricade. He confirmed that the wing senior officer told the man that he was being downgraded to basic regime. He added that they did not like the wing SO who, the cellmate said, treated the man unfairly. He described the moment when the man picked up his television and the wing SO and the wing officer left the cell. He said that the wing SO "screamed" at him to get out of the cell, but he was reluctant to leave the man on his own to face the music. After the barricade went up, staff tried to negotiate a peaceful ending to the incident. The PO assured the man and his cellmate that staff did not want to use force, but the cellmate said they could see the Control and Restraint Team outside the cell door. He said they reached an agreement with staff. The plan was for him to relocate to A wing and for the man to stay in his own cell on basic regime. The cellmate said that the incident ended quietly when he walked from the cell and the man removed the barricade and allowed full access to staff. The last time his cellmate saw the man was when he looked back and saw staff talking to him.
34. At about 11am, the man walked to the segregation unit, wearing handcuffs and accompanied by officers. Staff did not need to use force as the man was compliant. The duty governor supervised the move and the nurse attended. The man was located in a cell within the segregation unit. Video film shows that he appeared relaxed, stopping to look into another cell in the unit before being located in his own. Shortly afterwards, a prison officer unlocked his door and he walked downstairs to a hotplate where he collected lunch. Video film shows nothing unusual.
35. According to the duty officer in the unit, the duty governor spoke to the man while he was doing his rounds and present at the hotplate. He asked him if he had anything he wished to raise but the man said, "There's nothing you can help me with anyway so why should I talk to you? You'd better get me out of the seg today." The duty governor said, "What do you mean by that?" but the man was reported to have ignored him.
36. The man returned to his cell, pausing to talk to a prisoner who was having a shower. His cell door was re-locked and no one passed it or entered the cell until early afternoon. (There is no requirement to observe prisoners at regular intervals in the segregation unit unless they are perceived to be at risk of suicide or self harm, in cases where the Safety Algorithm has not been completed, or if they are being punished with cellular confinement.)
37. At about 2.40pm, the duty officer visited all prisoners to advise them that, because of a fire exercise taking place in the prison, their exercise period would be subject to delay. He looked through the observation panel in the man's cell door and saw him apparently standing behind his bed. The duty officer thought this was unusual, went into the cell and saw a sheet round the man's neck attached to the hinge of the cell window. He shouted the

alarm signal “Code 1” and within 15 seconds the second and third wing officers and the second SO arrived. The third wing officers burned through the sheet and the officers lowered the man to the floor. The first emergency box did not have scissors in it and a second box was brought. This box did have scissors and the second SO cut the ligature from around the man’s neck and tried to revive him. Medical staff were present within two or three minutes, but they could not save his life. He was pronounced dead at 3.25pm by a doctor from the helicopter emergency medical service. By chance, he was in the office on a joint emergency healthcare training exercise.

38. After the man was pronounced dead, the prison’s contingency plan following a death in custody was followed. At 4.15pm, the Governor conducted a meeting known as a ‘hot de-brief’. (The purpose was to see what could be learnt while the memory was fresh in the minds of those who had responded to the emergency, to offer mutual support, and to ensure that the prison’s Care Team were on hand to support staff.) The meeting was attended by 25 members of staff.
39. The Governor went to the home of the man’s partner, but she was not there. The Governor then learned that the man’s mother had heard of his death from another prisoner who had telephoned her. The mother telephoned the prison and the Governor and the Safer Custody Governor, spoke to her and offered to visit her at home. The mother said that would not be necessary as she had arranged to visit the prison, together with her solicitor, on 17 November. That visit took place as arranged and she talked to a number of staff and prisoners.
40. The Governor wrote a letter to prisoners and staff expressing his sorrow and sympathy for the man’s family and friends.

ISSUES

41. The clinical review confirms that the care extended to the man by healthcare staff was comparable to that which would have been available to him in the community. However, no consideration appears to have been given to his fear of being located in the segregation unit despite at least 12 entries in his medical records documenting that he said he suffered from claustrophobia.
42. The staff nurse believed the man could safely be located in the segregation unit. However, it is possible that, had he given a full verbal account of his claustrophobia, the duty governor might have written some cautionary note in part C of the form authorising segregation. This could have alerted staff in the unit to monitor his condition, at least in the early period following arrival.
43. Whilst the healthcare team observed the rules of medical confidentiality in respect of the man's condition, it is important that relevant information is shared appropriately to protect the wellbeing of staff and others

Healthcare staff should inform wing staff of information which may be relevant to decisions about prisoners' location.

44. The clinical review highlights shortcomings in the way some medical records were kept:

“Recognised standards for clinical record keeping were not always met. Written documentation in the man's Clinical Records was less than satisfactory. Entries were not always informative and at times very difficult to read. It is unclear as to how much support the man was given regarding his claims to be claustrophobic and how much counselling and help he was offered to help him cope with the emotional and psychological impact of this condition.”
45. The review makes the following recommendations to improve current practice which I endorse:

Healthcare staff should be reminded of the requirements of accurate and contemporaneous record keeping in accordance with the required standards of the General Medical Council and the Nursing and Midwifery Council.

Healthcare staff should be reminded of the importance of reading the patient's medical records when completing an algorithm. This document is designed to highlight any medical condition which would question the prisoner's suitability for location into the segregation unit.

It is important that suicide prevention equipment boxes are placed on each landing and that all members of staff are aware of their existence.

46. A further recommendation is made in the clinical review regarding issuing staff with a cutter to save valuable time when dealing with similar situations. However, this has been addressed separately as, since the man's death, a Prison Service Order has been published making it mandatory for all frontline staff to carry anti-ligature knives.

Claustrophobia

47. The entries in the man's wing record for 9 September and 18 September suggest that wing staff were either not persuaded by his claim that he suffered from claustrophobia or that they were unconcerned about it. The entry for 14 October, while capturing the essence of his predicament in that he was prepared to forego a television rather than stay in a cell on his own, did not conclude that he really was anxious about being alone. Significantly, there was no communication between healthcare staff and wing staff. Although entries in the medical record entries simply describe what the man said as distinct from making a diagnosis, it is likely that healthcare staff accepted his account since he was prescribed medicine and referred for relaxation classes. Better communication between healthcare and wing staff might have helped them to understand the man's condition and be more tolerant of it. Even if healthcare staff were not wholly convinced of his claustrophobia, had wing staff been alerted they might well have attached more importance to his claims. For example, they might have concluded that his reluctance to go into his cell was more than just a matter of disobeying the rules.
48. For obvious reasons, many prisoners prefer to be out of their cells for as long as possible. But for the man it went further. If he had to be in a cell, he did not like being alone. Much of the trouble in which he found himself arose from being last to go in his cell at locking up time. As early as February 2005, he identified his problem as "panic attacks". In April, he told a First Night Centre Assessment at Wormwood Scrubs that he suffered from "night sweats". On 20 May, he told the prison doctor that he was unable to cope with journeys to court in a small cellular van and the doctor recommended "that he travel in a larger transport".
49. On 20 July, the man signed up to relaxation classes to help him cope with his condition. He was due to start on 27 July. Unfortunately, he did not attend that class or any subsequent ones.

Segregation

50. The Incentives and Earned Privileges Board met on 11 November to discuss the deterioration in the man's behaviour on B wing. The board downgraded him, not for the first time, to the basic privilege level. I am

satisfied this was a fair decision, having regard to the deterioration in his behaviour.

51. As a consequence of downgrading to basic, the man was required to move to a different cell. Again, I am satisfied that this was proper.
52. When he refused to move to another cell in B wing and built a barricade, staff decided to move him if necessary by force. Once more, there can be no criticism of staff actions. Indeed, the incident ended well and I am pleased that staff were able to secure a peaceful conclusion without recourse to force.
53. As the man had refused to move, and had built a barricade, it was almost inevitable that he would then be moved to the segregation unit. This would be the standard response in virtually all circumstances.
54. The man had spent time previously in the segregation unit. He had started a fire in his cell in the unit some months earlier, but no-one seems to have treated this as anything other than a disciplinary matter. Although healthcare professionals had prescribed medication, arranged relaxation classes and advised that the man should not travel in a small van, they stopped short of giving any direction in respect of shared accommodation. Thus, while the man's preference for shared accommodation could usually be met, it was not a requirement. As noted, the staff nurse completed the segregation algorithm on 11 November and the duty governor validated it. There was no separate conversation between them.
55. In the segregation unit, the man appeared relaxed as he collected his lunch and went to his cell. There was no reason to believe he would harm himself. However, with the benefit of hindsight, it would obviously have been better had a close watch been kept on him during the settling-in period. I believe this might also apply to all newly-located prisoners in the segregation unit and thus recommend:

The Governor should consider introducing a local order requiring segregation unit staff to regularly supervise newly located prisoners, even those not subject to suicide and self harm watches, in the period immediately following their location in the segregation unit.

CONCLUSIONS

56. The man had been in trouble with the law for much of his life. He had been to prison on previous occasions and had spent all but a few months of the nine years before his death in custody. Although just 28 years of age, he was well versed in the way prisons operate. He challenged staff on a regular basis, and those who could not deal with him found him a difficult and disruptive young man.
57. Not everybody found him unmanageable. His wing SO challenged and regulated his behaviour. He did not enjoy her close attention and she described her relationship with him as “a bit like cat and dog”. But from her interview with my investigators, it is clear that she cared deeply for his welfare. Other staff may not have been so tolerant or understanding. From their perspective, they had a prison to run and his casual approach to rules did not endear him to them. When he said he was claustrophobic, I suspect they either did not believe him or did not give sufficient weight to his problems.
58. Better communication between healthcare professionals and wing staff would have given a clearer picture of the man’s fear of being alone. Sadly, and for reasons which must necessarily be speculative, he did not attend the relaxation classes that had been suggested for him. He may have thought the classes would have little value or he may not have wanted others to see him going to them.
59. Equally, it is not possible to say what was in his mind when he tied the sheet around his neck. He did not like being closed in on his own, but he had previously spent periods in the segregation unit. His mother thought that he may have tied the ligature not to kill himself but to bring attention to himself in order to get away from the segregation unit. He appears to have said to his cellmate that he was feeling low about his relationship with his partner and, although his letters to her were cheerful enough, he mentioned that he wanted her to write to him.
60. Given the circumstances I have described, we can never know what his intentions may have been when he fixed the ligature. However, I do not believe his actions could reasonably have been predicted by those staff responsible for his care.

RECOMMENDATIONS

- 1. Healthcare staff should inform wing staff of information which may be relevant to decisions about prisoners' location.**
- 2. Healthcare staff should be reminded of the requirements of accurate and contemporaneous record keeping in accordance with the required standards of the General Medical Council and the Nursing and Midwifery Council.**
- 3. Healthcare staff should be reminded of the importance of reading the patient's medical records when completing an algorithm. This document is designed to highlight any medical condition which would question the prisoner's suitability for location into the segregation unit.**
- 4. It is important that suicide prevention equipment boxes are placed on each landing and that all members of staff are aware of their existence.**
- 5. The Governor should consider introducing a local order requiring segregation unit staff to regularly supervise newly located prisoners, even those not subject to suicide and self harm watches, in the period immediately following their location in the segregation unit.**