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INVESTIGATION INTO THE CIRCUMSTANCES SURROUNDING THE DEATH OF A MAN IN DECEMBER 2006 WHILST A PRISONER AT HMP STAFFORD

Report by the Prisons and Probation Ombudsman for England and Wales

January 2008

This is the report of my investigation into the death of a man who died on Friday 15 December 2006. He had been received at HMP Stafford on transfer from HMP Liverpool at the end of August. He was 26 years old.

I offer my sincere condolences to the man's family, friends and all those touched by his passing. I hope that this report answers their questions, but recognise that it may not alleviate their distress or lessen their grief.

One of my investigators conducted this investigation. I am most grateful to the Governor of Stafford and his staff, the Prison Officers' Association, members of the Independent Monitoring Board and the chaplaincy who fully cooperated throughout. I am also indebted to the reviewer of South Staffordshire Primary Care Trust who led the clinical review into the man's care and treatment whilst at Stafford. I have also appreciated the ready assistance of Staffordshire Police.

The man's family have been in contact with both the prison and my investigation team from an early stage. A key part of the investigation was to ensure they had the opportunity to raise any concerns. One of my family liaison officers spoke to the man's mother.

At the time of his death, the man had been held in the segregation unit for over three months. In the days before his death, he had been identified as someone who might be at risk of self-harm after setting fire to his cell and injuring his head by banging it on the cell wall. He was placed on self harm monitoring and moved to a safer cell. He was seen by members of healthcare staff, but thought not to be suffering from mental illness. The man appeared to settle down and, three days before his death, he attended a review of his self harm status when it was decided that he no longer presented a risk to himself. However, he refused to leave his safer cell and was taken by force to the segregation unit. The next morning (Wednesday 13 December), he was found hanging in a seated position from his cell sink taps. Despite the best efforts of staff to resuscitate him, he died in hospital two days later.

Since April 2004, my office has been responsible for investigating all deaths in prisons in England and Wales. The death of this man was the first apparently self inflicted death to have occurred at Stafford in that time. I make five recommendations to the Governor and Primary Care Trust.

Stephen Shaw CBE
Prisons and Probation Ombudsman **January 2008**

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SUMMARY

The man was 26 years old when he was received into HMP Stafford as a sentenced prisoner in late August 2006. He had been transferred from Liverpool after apparently being bullied. This was not his first time in custody.

At Stafford, the man was initially located at his request on normal location. He subsequently tested positive for opiates, and received a punishment of 14 days cellular confinement in the segregation unit.

According to staff, the man liked his own company and refused to return to normal location. As result he received additional punishments for failing to comply with a lawful order to return to the wing. Although there was regular verbal communication with discipline staff, duty governors, healthcare and the Independent Monitoring Board (IMB), the man was adamant that he did not want to return to the wings. His mental health was assessed by healthcare at the request of prison managers, but he was deemed not to be suffering from mental illness.

On 7 December 2006, the man assaulted a member of staff and was forcibly restrained and returned to his cell. He immediately set fire to his cell and banged his head on his cell wall, causing an injury to his forehead. The fire was extinguished and he was removed by force into a safer cell. An Assessment, Care in Custody and Teamwork (ACCT) plan to monitor prisoners at risk of self harm was opened. Three days later, the man told the ACCT review panel that he had no intention of injuring himself again, but refused to leave the safer cell to return to the segregation unit. He was eventually moved by force on 12 December.

The man was discovered the next day, hanging by his neck from the sink taps from a ligature made from his bed sheet. Staff worked hard to resuscitate him and he was taken by ambulance to hospital. Sadly, he died two days later without regaining consciousness. His family were at his bedside.

This report makes five recommendations to the Governor and Primary Care Trust which have all been accepted.

THE INVESTIGATION PROCESS

1. The investigation was formally opened at HMP Stafford on 21 December 2006 by one of my investigators. The Governor and his staff produced the man's core record and a number of other documents for examination. Notices were issued to staff and prisoners informing them of the investigation and inviting anyone with relevant information to make themselves known to the investigation team. My investigators were given unrestricted access to the prison, staff and documentation relating to the man who died. My investigators also spoke with Staffordshire Police in relation to issues of common interest.

2. South Staffordshire Primary Care Trust conducted a Panel Clinical Review of the man's care and treatment The head of governance and engagement, and the risk manager, took the opportunity to visit the prison and familiarise themselves with the layout. Members of the panel formally interviewed healthcare staff.

3. A family liaison officer from my office contacted the man's mother. My investigation has attempted to answer her principal concerns:

    - Whilst the man was at the hospital his mother was told that he had been showing signs of distress, and noticed he had stitches on the bridge of his nose, and marks on his knuckles. She was told by prison staff that her son had self-harmed and, as a result, had been moved to a safer cell. He was later seen by the mental health team and assessed as fit to be returned to his normal cell. The mother has serious concerns that her son was assessed as fit to be moved back to a normal location.

    - The man's mother was told that her son was back in his normal cell when an officer took other prisoners for exercise. The officer asked the man if he wanted to go and he declined, saying he preferred to stay in his cell. When the officer returned from exercise, he looked into the man's cell but could not see him. He asked another officer where the man was and then realised he was still in his cell. The man was discovered hanging and his mother has concerns that he was left unattended, especially so soon after self-harming.

    - The man's mother was told by one of the governors that her son had asked to go in the segregation unit. She believes this does not sound like her son as he was not a loner. She believes that this was a sign that he was not well.

    - The mother spoke to her son a few days before he was taken to hospital and said he had sounded fine on the telephone. She described their conversation about the future and his release. He only had a few months left to serve. The mother was first aware that anything was wrong when she received a telephone call from a female chaplain who told her that her son had hanged himself and had harmed himself previously.

- The mother said that two uniformed officers watched her son at the hospital and she pointed out the irony that they were more staff watching him die than there were to keep him safe in prison.

- The mother also wanted to know what information was released by the prison to the press.

4. My investigator wrote to HM Coroner to inform him of the nature and scope of my investigation and to request a copy of the post mortem report. Upon completion, this report a copy will be sent to the Coroner to assist him in his enquiries into the man's death.

5. A number of staff were formally interviewed and those interviews were tape recorded. No prisoners asked to see the investigator but one prisoner whom the investigators wished to speak with declined the offer to meet.

6. At the conclusion of the investigation a copy of the draft report and annexes was sent to the man's mother and the Prison Service for their comments. The mother through her solicitor asked for the investigation to look at the man's involvement with drugs whilst in prison. My investigator formally interviewed the head of security at Stafford, who had no evidence of the man's involvement in illegal drugs other than him testing positive for illegal substances upon his arrival to the prison.

7. The Prison Service has accepted the recommendations of the PPO investigation.

HMP STAFFORD

8. The present prison was built in 1794. It holds 627 male category C prisoners. C wing, where the man was first accommodated, can hold up to 120 prisoners over three landings. It is staffed by a senior officer and four discipline officers.

9. There is a prisoner support (vulnerable) wing for 84 category C prisoners. There are assessment cells, which are fitted with safer fixtures and fittings on A, C, E and F wings. Four safer cells, which have the benefit of CCTV monitoring, are located in a discrete area between D wing and healthcare. Prisoners are allocated to the safer cells under the Assessment, Care in Custody and Teamwork (ACCT) process. Two of the safer cells are gated, allowing constant observation, but the area is not routinely staffed and prisoners are monitored by D wing staff watching the CCTV. The arrangements appear to be purely observational rather than supportive.

10. The prison was last inspected in a full announced inspection by HM Chief Inspector of Prisons (HMCIP) between 3 and 7 July 2006.

Segregation unit

11. The Chief Inspector judged the prison's segregation unit to be clean, bright and well maintained. It is located below D wing, and has 17 normal cells and one special cell. A number of cells contain cardboard furniture and are used for new receptions to the unit.

12. The governing Governor was appointed on 1 March 2006. He decided that prisoners should not be routinely transferred to other establishments if they demonstrated challenging behaviour. Transfers would be considered on an individual basis, the reasons including categorisation and compassionate grounds.

13. The Governor had determined that the prison would manage its own challenging prisoners and establish a care plan to reintegrate them back into normal location. The Chief Inspector found that these efforts had achieved some notable successes with some very demanding prisoners. Residential wing staff visited prisoners in the segregation unit every day, which was good practice.

14. Prisoners in the segregation unit during the inspection said that they were generally treated well by staff and the inspectors saw good evidence of interaction. However, the entries in prisoner's history sheets were poor and the majority were written by visitors to the unit rather than the unit staff. Prisoners in segregation are visited every day by healthcare, the duty governor, members of the IMB and chaplaincy. The arrangements for the chaplains to hold keys have been altered and they talk to prisoners through the observation panel in the door. I do not believe that this had a bearing on the man's death but I am pleased to report that the chaplaincy team now carry cell keys.

15. Prisoners have access to education, library and exercise.

Healthcare

16. The Chief Inspector found that, despite healthcare becoming the responsibility of South Western Staffordshire Primary Care Trust (SWSPCT) from 1 April 2005, there was no signed service level agreement (SLA) between the prison and the PCT. Other SLAs, such as for mental health services and the doctor, were unsigned. There was no health needs assessment, although plans had been made for a mental health needs assessment.

17. The prison has a limited primary mental health service, but no talking or counselling services. The work of the mental health in reach team was severely hampered by restrictions imposed on staff by their Trust (South Staffordshire and Shropshire Foundation NHS Trust), which stopped them from moving around the establishment without being stopped.

18. Primary healthcare is delivered from the healthcare department on the second floor of D wing (D2) and from wing based treatment rooms. There is no inpatient provision, although at the time of the inspection the Governor was exploring options for introducing additional shared accommodation alongside the assessment and observation accommodation adjacent to healthcare. He had begun preliminary discussions with the head of healthcare and the PCT, who had been asked to consider introducing two small dormitories for prisoners who would benefit from additional healthcare provision and support.

19. There was an automated external defibrillator (AED) in the prison which was located in the healthcare staffroom. This was checked daily and records were up to date.

20. The clinical review carried out for this investigation found that the healthcare facilities at Stafford, although old, were adequate for the level of healthcare provided. Relationships between healthcare staff and prisoners appeared to be good.

Assessment, Care in Custody and Teamwork (ACCT)

21. As at all prisons, ACCT has been introduced at Stafford to monitor and support prisoners assessed to be at risk of suicide or self harm. Once placed on ACCT, the prisoner is observed at pre-determined intervals according to the perceived level of risk.

22. Each prisoner is assessed within 24 hours and then reviewed at intervals decided on an individual basis. The ACCT guidance says that, to be effective, the review should involve the key people who know the person at risk or are involved in their care. The key questions for each review are listed as:

    - have the problems that caused the ACCT plan to be opened now been resolved?
    - if not, what needs to be done to resolve them?
    - have any further problems arisen that are now causing distress and more risk?
    - if so, what action can be taken to address these?
    - is the person at risk now in contact with friends, family or other support?
    - does the person at risk now have something in their lives that they feel good about?
    - if not, how can this be improved?

23. Over time, the reviews should also consider other factors such as:

    - distress – has anything changed to make the person at risk more or less desperate?
    - resources – has anything changed that makes the person at risk now feel more or less alone?

- previous suicidal behaviour – has anything changed that makes suicide more familiar or more acceptable to the person at risk?
- suicide intention or plan – has anything changed to show that the person at risk is more or less prepared to kill themselves?
- pattern of self harm – is self harm becoming more or less frequent?

Amongst other things, the ACCT guidance says that prisoners should be cared for in a safe environment and it is for the case review team to decide the most appropriate place to locate an individual prisoner.

24. The Chief Inspector noted that staff at Stafford had high levels of awareness and training regarding ACCT procedures. However, night duty staff had still not been provided with individual anti-ligature knives, despite the recommendations from previous investigations into deaths in custody. Overall, the inspectors found that the ACCT approach to managing prisoners at risk of self harm had been successfully introduced. ACCT documents were well maintained, care plans were clear and meaningful, and there was evidence of high levels of engagement with the prisoners concerned.

25. The Chief Inspector found that there was a comprehensive suicide prevention policy in place. All procedures relating to suicide and self harm were managed through the suicide prevention management group, which met each month and was chaired by the deputy governor. Meetings were well attended and included representation from the local branch of Samaritans and the Listeners (trained prisoners who offer support to those at risk of self harm and suicide).

Incentives and Earned Privileges (IEP)

26. Prison Rules require every prison to provide a system of privileges which can be granted to prisoners, in addition to the minimum entitlements under the Rules, subject to them reaching and maintaining specified standards of conduct and performance. The National Policy Framework described below applies to all prisons but governors may exempt prisoners from the scheme who have progressed onto a structured resettlement programme.

27. Establishments can tailor their individual schemes by including incentives and privileges available locally which are likely to prove attractive to their particular prisoners. The national aims are:

    - to encourage responsible behaviour by prisoners
    - to encourage effort and achievement in work and other constructive activity by prisoners
    - to encourage sentenced prisoners to engage in sentence planning and benefit from activities designed to reduce re-offending
    - to create a more disciplined, better-controlled and safer environment for prisoners and staff.

28. These aims are to be achieved by ensuring that privileges above the minimum are earned by prisoners through good behaviour and performance and are removed if they fail to maintain acceptable standards. The IEP scheme complements the discipline system by rewarding good behaviour.

29. The privileges available at each level should be sufficiently attractive to provide prisoners with a genuine incentive to progress upwards.

Basic Level

30. Prisoners are placed on basic level because they have failed to meet local criteria for admission to standard and enhanced levels. Their position should be different from those prisoners in the segregation unit who have been removed from association under Prison Rules. All prisoners on basic level should continue to receive the entitlements laid down in Prison Rules and other instructions in relation to visits, letters, telephone calls, provision of food and clothing etc, and any other minimum facilities provided locally for all prisoners, apart from those in segregation. They should continue to participate in normal regime activities, including work, education, treatment programmes and religious services, be allowed access to the prison shop, exercise and association, and attend offending behaviour programmes as necessary.

Standard Level

31. Prisoners on standard level are provided with a greater volume of the allowances and facilities at basic level, plus such additional privileges as are available locally. Typically they will include more frequent visits, more time for association and the provision of in-cell television. Standard level prisoners are also eligible for higher rates of pay for work, subject to those on the enhanced level being considered first for particular jobs, and a higher allowance of private cash.

Enhanced Level

32. Prisoners on enhanced level should receive the same privileges as those on standard level but in greater volume, with additional visits, if possible in better surroundings and with more flexibility over times, additional time for association (subject to local resources), more private cash, and priority consideration for higher rates of pay.

Independent Monitoring Board (IMB)

33. Every prison has an Independent Monitoring Board (IMB) made up of members of the public appointed by the Secretary of State. Their purpose is to monitor the day-to-day life in the prison, and ensure that proper standards of care and decency are maintained.

34. The most recent IMB annual report for Stafford that I have found covers the period 1 May 2003 to 30 April 2004. In relation to the segregation unit, the Board reported that staff in the segregation unit had a particularly demanding time and handled difficult prisoners with patience and understanding. Their actions were applauded by the Board.

35. Members of the IMB visit the unit frequently during rota visits and the monitoring of adjudications. They also visit prisoners placed in the safer cells.

KEY FINDINGS

36. In September 2005, the man was sentenced at Crown Court for an offence of unlawful wounding. He received a three and half year extended sentence, comprising a custodial term of eighteen months and an extension period of two years, The victim of the offence was a custody officer at HMP Altcourse where the man had been on licence recall following a conviction for assault and criminal damage. He was sent to HMP Liverpool and was due to be released in April 2007.

37. On 26 August 2006, whilst still at Liverpool, the man was seen with bruises on his face. He told staff that he had fallen out of bed but three days later asked to transfer to the vulnerable prisoners' wing as he was being threatened. (Vulnerable prisoners' wings are for prisoners who feel threatened on normal location.) He was transferred to Stafford the same day.

38. When the man arrived at Stafford, he went through the reception process and told the staff that he did not want to go to the vulnerable prisoners' wing. The cell sharing risk assessment completed on his arrival indicated that he was considered low risk of harm to others.

39. The man was seen by healthcare staff who recorded that he was not suffering from mental illness. (An older part of his medical record highlights that he had previously been prescribed medication for depression in 1997.) Significantly, as on previous health screens, no thoughts of self harm or suicide were identified. The reception screening highlighted that the man had coeliac disease, for which he was prescribed a gluten free diet. In addition he was prescribed Complan, which is a gluten free nutritional supplement.

40. The prison chaplain interviewed the man and recorded that he appeared to be settled and happy, but was concerned for his mother who had ill health. The man was allocated to normal location on C wing and the first wing officer showed him to his cell. He told the officer that he was comfortable and did not want anything. On 30 August, as part of the reception procedures, the man took part in a drug test and tested positive for opiates.

Segregation unit

41. On 15 September, staff noted in the man's wing history sheet that he had no problems. He appeared the following week before the independent adjudicator who imposed a punishment of 14 days cellular confinement for his having administered a controlled drug. The man was taken to the segregation unit where the officer in charge of C wing, the wing SO, visited him later in the day. The SO said that the man did not present any management problems and wanted to return to the wing upon the conclusion of his segregation.

42. The man received a written warning on 28 September, for swearing at the SO in charge of the segregation unit. The next record, dated 1 October, noted that he was in good spirits.

43. Another C wing member of staff, the first wing officer, saw the man on 4 October and asked if he was going to return to the wing the following day which the man confirmed. However, in fact he refused to leave the unit to return to C wing and was placed on a disciplinary report for failing to obey a lawful order. He remained segregated, awaiting a further adjudication by the independent adjudicator.

44. On 6 October, the man attended a segregation review board, chaired by the discipline governor. The man still refused to leave the unit but it was recorded that he had no real problems.

45. A member of the chaplaincy team visited the man on 10 October. She also recorded that he had no problems and spent a lot of time meditating. In interview, she described him as very quiet, and said that he did not talk very much and used to sit on the pipes at the far end of his cell.

46. The Registered Mental Health Nurse (RMN) has worked as a staff nurse at Stafford since 2003. He met the man on several occasions as part of his nursing duties. He described him as pleasant, amenable, and a very open person who spoke well. He said the man liked his own company and did not want any more time added to his sentence. The RMN was asked to see the man on two occasions regarding concerns about his mental health as he used to sit for long periods looking at the wall.

47. The man told the RMN that he liked to meditate and would face the wall, cover his head with his towel and feel that he would not get disturbed. He sat on the floor because that was how he liked to meditate. The RMN was of the opinion that the man was not suffering from mental illness.

48. One of the governors transferred to Stafford in October 2006 as an operational manager and the deputy head of residence. He had previously worked at HMP & YOI Brinsford. He had known the man from previous establishments over a number of years and met him again in segregation. The governor said they got on well and used to talk about Brinsford and the people they knew there. The governor said the man had decided for his own reasons that he did not want to return to normal location. The governor tried to persuade him to return but he refused without giving a reason.

49. The man’s second adjudication took place on 18 October in front of the Independent Adjudicator. The man received seven additional days imprisonment for failing to leave the segregation unit when ordered to do so by staff.

50. A segregation review board was held on 20 October chaired by the discipline governor. The man continued to refuse to leave. Those present had no concerns about his welfare.

51. On 22 October, the wing SO visited the man again to try to facilitate his return to C wing. He told the SO that he wanted to return. A further segregation review took place on 27 October when it was noted that the man refused to leave until he had been seen by an independent adjudicator. The man's personal officer went to see the man on 31 October and was told he was adamant that he would not return to normal location.

52. On 2 November, the man had a fight with a fellow prisoner whilst on exercise and sustained a light nose bleed. (The fellow prisoner declined to see the PPO investigator). The man was assessed by healthcare and placed on disciplinary report for fighting. The adjudication took place the following day and the adjudication governor imposed seven days' cellular confinement. The man said that he would not go back to normal location and did not want a transfer to another prison. He said that if he got a transfer he would go to the segregation unit wherever he was sent. A member of the IMB recalled him saying that he was content to spend his time in the segregation unit and did not want to go back to the wing. The IMB representative thought he seemed relaxed and cheerful.

53. Another C wing officer visited the man on 10 November. The officer recorded that the man was adamant that he would not return to C wing. An adjudication hearing was held later in the day regarding the man's refusal to obey an order to return to normal location.

54. The man was again visited in the segregation on 13 November by his personal officer. The man told him that he refused to return to normal location and wanted to stay in segregation. Later that day an Incentives and Earned Privilege review was carried out and the man was downgraded to basic regime. Targets were set for him, which would be reviewed in 28 days. If he met them beforehand an earlier review would be held.

55. On 14 November, a segregation review board was conducted by a second adjudication governor. The review identified no areas of concern. Another member of the IMB recalled that the man said he did not have any complaints and was being treated well. She said that his demeanour appeared calm and relaxed. The next day the man was informed that his application for parole had been refused by the Parole Board. It was recorded that he took the news well.

56. The wing SO visited the man again on 16 November and recorded that he still refused to return to normal location. The same day the man was present at his segregation review board which was chaired by a third adjudication governor. It was once more noted that the man refused to move to normal location. Four days later, the man told the prison officer that he wanted to remain on the unit, and was described as in good spirits. The man saw a member of the IMB on 22 November as part of her routine visit to the unit. He told her that he liked it in the unit, had no complaints and was treated well. She described his demeanour as calm and relaxed.

57. The segregation unit SO knew the man well and said that all the segregation unit staff spent time with him. He said that the man did not refuse to leave the unit in order to manipulate a transfer to another prison. The SO said that there were days when the man was talkative and others when he ignored the staff. He would often sit facing the back of his cell wall. The SO said the man regularly read library books and would leave the cell to make telephone calls, exercise and shower. The SO said the man was frightened of losing his temper and getting into more trouble, as he could not control himself at times. He thought that if he got into trouble again, he would have to appear before the judge and receive a further sentence.

58. A second prison officer spoke to the man on 24 November. The officer recorded that he felt the man had some mental health issues from misusing drugs which had made him paranoid and unable to be with other people. The officer told him that he would refer him to healthcare.

59. The man received a further 14 additional days from the independent adjudicator on 27 November for refusing a lawful order to return to normal location.

60. On 3 December, an entry in the man's wing history sheet described him as polite and amiable, but still insistent that he would not return to the wing. The next day the wing SO visited the man. Yet again, the man declined to return to normal location, preferring to stay where he was. Later that day, he attended his segregation review chaired by a governor. It was noted that the man had no behavioural problems and was clean and tidy, although still refused to return to normal location.

61. Two days later, the prison doctor assessed the man at the request of the governor who was concerned about his habit of sitting on the floor with a blanket over his head. The doctor said that the man nearly always sat in this position which he found more comfortable. The doctor described him as rational, making good eye contact, and as laughing with good humour. In interview, the prison doctor said that the man's behaviour was odd, but he was not psychotic or deluded.

62. The doctor asked one of the mental health nurses to assess the man and later that day the RMN saw him again. The man told the nurse that he was fine and was happy in segregation, although he would like to be closer to his mother's home so that it was not so far for her to visit. The nurse did not identify any mental health problems.

63. A third prison officer described the man as usually a very quiet, polite individual who liked his own company. He spent his time reading and exercised regularly. He complied with the rules about showers and cleaning his cell. A fourth prison officer said that the man asked for little from staff and was not generally considered a problem. However, the officer thought that the man's health had deteriorated. Because of his gluten free diet, he was supplied with fresh fruit which he stored in his cell. But the food had

rotted and the man had been told that he could not keep it. The fourth prison officer said that the man reacted by emptying his cell completely of all his property and became more withdrawn. He would only communicate with staff if he needed something and spent the majority of his day in the dark, sitting on the floor facing the back wall.

64. A fifth prison officer saw the man on 7 December and once more recorded that he did not want to go back on normal location. The man also talked about his mother not being able to visit because of her disability. The segregation unit SO described the man as very quiet and brooding that day.

65. When his cell was unlocked for him to collect his evening meal, he moved close to the SO's face telling him to leave him alone. The man punched the SO, catching him on his jaw and cutting his lip. The SO and the fourth and fifth prison officers used Control and Restraint techniques to restrain him and place him back in his cell. The assault was unexpected and staff did not anticipate having to deploy Control and Restraint.

66. As soon as the man was returned to his cell, the Segregation Unit SO said that he started to barricade himself in. He covered the observation panel to stop staff looking through, but the SO looked through the gap at the side of the door and saw the man set fire to his mattress. The SO immediately unscrewed the inundation point (which allows entry for a fire extinguisher) and let off four fire extinguishers to put the flames out. The fire brigade was called and attended. Further staff were summoned and opened the door outwards by which time the fire was out. The man had injured his head by banging it against the cell wall by the time the staff entered the cell.

67. The principal officer (PO) was the orderly officer (Oscar One) during the evening of 7 December and in operational charge of the prison. He attended the segregation unit and ensured that an ACCT document was opened. The man was to be observed five times an hour throughout the day and night. The man initially refused medical treatment to the cut on his head which was bleeding profusely, but subsequently was treated by the second RMN. The nurse thought that he and the man had a good interaction.

In the safer cell

68. The governor in charge of business management at Stafford and occasionally acts as duty governor, meaning that he is the senior manager in charge. He was duty governor on 7 December when the man set fire to his cell. He went to the segregation unit and authorised the man's removal to a safer cell. The duty governor also checked that he was subject to the ACCT plan. The man was allocated one of the gated cells on D2 landing.

69. At 5.30pm, the second PO recorded in the man's ACCT plan that he had been restrained for assaulting the SO in the segregation unit. He wrote that, after being restrained and relocated back into cell R1:06, the man decided to barricade and set fire to his cell. He then inflicted an injury to his

head by head butting the cell wall which caused bleeding to his forehead. The PO noted other concerns in that the man had been located in the segregation unit for several months and his behaviour and attitude had deteriorated.

70. An ACCT review was held two hours later at 7.35pm. It was noted that the man had refused treatment for the cut to his head, and appeared to be in shock which was likely to have been due to blood loss. The man had said that he did not want anyone playing with his head. He was moved to a safer cell for improved observation due to concerns about his mental health.

71. The safer custody manager and an ACCT assessor was told by the man that he felt pressurised by the segregation unit SO which was why he banged his head. He said he did not bang his head to harm himself. He told the officer that he did not want to go to work or return to normal location. He wanted to serve his sentence, but felt that the governor was trying to force him back to work and back to the mainstream prison system.

72. In interview, the SO was asked about the man's comment that he assaulted the SO because he felt pressurised by him. The SO described himself as a proactive manager, and said that every day he asked the man to comply with the rules and return to his wing.

73. A further ACCT review was held the following morning (8 December). The safer custody officer, the head of healthcare, an adjudication governor and the man's himself were present. The review recorded that there was a lot of discussion about the man's situation. It was recorded that the man was "manipulating the situation for his own benefit". He described himself as a loner who could not cope in the company of others. He was willing to serve a longer sentence rather than return to normal location. The review was aware that no mental illness had been diagnosed, but expressed concerns about his isolation.

74. The safer custody manager consulted the ACCT officer and recorded in the ACCT review that the man wanted to leave the safer cell and return to the segregation unit. However, the man also said that he would smash up and set fire to each segregation cell that he was put in. The SO recorded that he did not consider the man to be a threat to himself, but believed that he was trying to bend the rules to his advantage. It was recorded on the caremap that the man refused to participate in the assessment as he felt that he had no self harm problems. The review decided that the ACCT document should remain open and be reviewed on 11 December with the aim of closing it then.

75. At 4.10pm, a landing officer unlocked the man for a shower and clean clothing. The officer said that the man was compliant and showed no obvious signs of self harm. At 5.20pm, he was issued with adjudication paperwork for the assault on the segregation unit SO. It was noted that he appeared calm.

76. The man was present the same day at a review of his continued segregation which was chaired by the third adjudication governor and attended by the head of healthcare and the safer custody manager. The man still refused to return to normal location and the review panel had no other concerns about him.

77. The following day (9 December), the man refused to leave the safer cell to attend his review. It was recorded that he thought he was being bullied.

78. The chaplain met the man during her chaplaincy visits to D2 landing and asked him if he intended to harm himself again. The man told her that he had no more intentions of injuring himself.

79. The second RMN was on duty in the healthcare centre on Sunday 10 December and talked to the man, whom he had got to know well whilst he was in the safer cell. He took him out of the cell to the staff room where they chatted over tea and biscuits. The nurse allowed him to have a cigarette and to telephone his mother. They talked again before the man returned to his cell, but the interaction was not recorded.

80. On 11 December, the prison medical officer talked to the man in his cell. The man denied any more thought of harming himself. Later that day, his ACCT document was reviewed by the fourth adjudication governor, the staff nurse and the third adjudication officer. The man was also present. There were no concerns that he would harm himself and he was calm throughout the meeting. He talked about his anger problems and they discussed different ways of dealing with them. The review panel decided that he was no longer at risk of suicide or self harm and so the ACCT document was closed. The man was however to remain in the safer cell until the following day to make sure that he had no adverse reactions to the document being closed. He was offered the option of moving from the safer cell to either the vulnerable prisoners' wing or to normal location, but refused both suggestions.

81. The deputy head of residence prepared a care plan to manage the man's future prison movement following closure of the ACCT document. The plan was for the man to return to the segregation unit where staff would try to rebuild relationships with a view to eventually relocating him back to the mainstream population.

82. The next day (12 December), the wing SO spoke to the man in an attempt to persuade him to follow the plan and return to segregation. They talked through the cell gate and the man said that he refused to move. He threatened to use violence against any staff who attempted to move him, and then smash up and set fire to his cell.

83. The prison doctor spoke to the man and he said that he was okay, but repeated the threat to set fire to his cell if he was moved to the segregation unit. The doctor recorded that the man had a good rapport and was rational and calm. The doctor saw no evidence of psychosis.

84. Later in the day, the segregation unit SO visited the man to try to encourage him to return to the segregation unit. The man again refused to move. At 12.06pm, the SO reported to the PO that the man refused to move. The PO went to explain to the man that the ACCT document was closed and he had to return to the segregation unit. The man said that he was happy where he was in the safer cell and wanted to remain there. The PO warned him that he should move voluntarily or he would be moved by force.

Return to the segregation unit

85. The segregation Unit SO went back to the man and asked whether he was going to cooperate. The man refused again and was therefore forcibly removed to the segregation unit by the SO and three other officers. Because the move was pre-planned, a healthcare member of staff was present and it was filmed to ensure that only approved force was used.

86. The man was placed in cell R1:13 of the segregation unit and his clothes were cut off to check that he was not concealing any weapons. Because of his threats to smash his cell, the taps were turned off and he had no running water. The use of force forms have been examined by my investigator and appear to be in order. (However, the film of the man's removal to the segregation unit has been seized by the police and has not been seen by my investigator.) A segregation safety algorithm was completed. No medical reasons why he should not be located there were identified.

13 December

87. The third prison officer saw the man the following morning (13 December), and offered drinking water which he declined. The man said that he would not drink any more water. He asked the officer for a razor, which was refused.

88. Segregation unit staff asked the RMN to see the man that morning as they were concerned that his mood was low. The RMN spent some time with him, and he said that he felt victimised by staff because he was deprived of running water. He told the nurse that he thought staff were tampering with his food and drink, and said that he was going on hunger strike. The RMN's opinion was that the man displayed no obvious signs of mental illness and told him he would see him the following day.

89. The chaplain visited the man during the morning as part of her chaplaincy rounds. She said that he was standing in the cell and she tried to engage him in conversation. He told her he was fine. He had some books to read, and she did not notice anything in his demeanour which gave any indication that he intended to harm himself.

90. After lunch, the fourth prison officer and the second landing officer took a prisoner to the exercise yard. They returned at 3.10pm, and the second landing officer opened the flap to the man's cell door to check on him. The

officer could not see him and asked his colleagues in the segregation office where he was. He was told that the man was still in his cell.

91. The officers returned to the cell and opened the door. The second landing officer saw the man hanging at a low level, suspended by a bed sheet attached to the sink taps. He took the man's body weight, whilst the fourth prison office untied the ligature. They shouted for assistance, and the fourth prison officer activated his personal alarm on his radio but it did not work.

92. The wing officer entered the cell and managed to use the radio to inform the control room and request an ambulance. The fourth prison officer picked the man up and laid him on the floor in the main part of the cell. He checked the man's neck and wrist for a pulse, but could not find one. He was just about to start Cardio Pulmonary Resuscitation (CPR) when the RMN and the second wing SO arrived and took over. The RMN had collected the emergency first aid bag and defibrillator. (The defibrillator shows electrical stimulus from the heart, measures and analyses the information, and gives audible instructions.) The defibrillator showed that the man's heart still had an output and so they continued resuscitation.

93. The paramedics arrived and continued resuscitating the man who was then taken by ambulance to hospital. Stafford's control room log shows the ambulance was called at 3.41pm and arrived at 3.46pm. The ambulance left at 4.09pm. The man was not physically restrained, but prison officers accompanied him to hospital in accordance with prison protocol.

94. The deputy head of residence was the duty governor. He went to the segregation unit when he heard the radio call for medical assistance as a prisoner had been found hanging. He saw that a number of staff were distressed and in a state of shock, whilst others were carrying out resuscitation on the man.

95. The second adjudication governor was the governor in charge of resettlement and was notified that the man had been found hanging. He went to the control room to ensure that the emergency contingency plans were implemented and the prompt entry and exit of the ambulance was facilitated.

96. A hot-debrief of the staff involved in the resuscitation of the man and those implementing the prison contingency plans was held soon after the man was taken to hospital. At approximately 6.00pm, after the debrief, the chaplain telephoned the man's mother and arranged to meet her at the hospital. She was also able to offer emotional support.

97. Members of the man's family were in attendance at the hospital and made the decisions about his clinical care. The head of healthcare attended and spoke to the man's family and the prison staff. A C wing officer was assigned to bedwatch duties and he spoke to the man's mother who was concerned about the officers' presence. In interview, the officer said that

they kept a discreet distance and were conscious that it was a very emotional time for everybody concerned.

98. The deputy governor met the man's mother at the hospital at on the evening of 13 December. The mother asked how her son had hanged himself and the governor explained that he had torn up his bed sheet. She asked how her son was found and he told her that segregation unit staff had made a random check. Finally, she asked whether her son had been on a suicide and self harm monitoring watch. The deputy governor told her that he was not on a suicide watch, but was checked at irregular intervals throughout the day.

99. The man died in hospital on 5 December. He had not regained consciousness. His family were with him when he died.

100. The governor in charge of business management was appointed as family liaison officer to act as a contact with the man's mother and offer financial support for the man's funeral. He visited the man's mother and took a letter of condolences from the governing Governor. The family liaison officer returned the man's belongings and offered his mother the opportunity to visit the prison. He also provided a list of voluntary organisations which offer support and advice to bereaved families following a death in custody.

Post Mortem

101. The post mortem was carried out by a pathologist on 19 December 2006 at the hospital where he died. The cause of death was:

1a Bronchopneumonia
1b Cerebral oedema
1c Compression of neck structures

There was no evidence to suggest third party involvement. I understand the toxicology results have given the Coroner no cause for concern.

ISSUES CONSIDERED IN THE INVESTIGATION

Clinical Care

102. Healthcare staff saw the man as part of the healthcare reception screening process when he first arrived at Stafford. The screen highlighted that he was known to have coeliac disease for which he was prescribed a gluten free diet. In addition he was prescribed Complan. His records showed no other past medical history and no known disabilities. His mental health history highlighted that he had been prescribed medication for depression in 1997. During the man's reception screen at Stafford, he showed a neutral attitude and his mood and speech were described as normal. He appeared fully orientated to his surroundings and was neat and tidy in appearance. There was no evidence of mental illness.

103. It was also recorded in older parts of his medical records that he had a history of cannabis and illicit benzodiazepine abuse and that he had spent time in a rehabilitation unit. His medical records contain various initial reception health screens from previous periods of custody at other prisons. Significantly, it is documented consistently in each reception screen that he had no thoughts of suicide or self harm.

115. The man's physical health was affected by his coeliac disease. His medical record highlights a low Body Mass Index (BMI) and weight loss which was being monitored. However, his physical heath needs were addressed by prescribing specific gluten free products and nutritional supplements. When a member of staff recorded that he was only eating salad twice a day, action was taken to address this issue and ensure he received an adequate diet. In the opinion of the clinical reviewer, the care the man received for his physical health was appropriate to his identified needs.

104. There were occasions noted in the man's medical records when his behaviour resulted in interventions by nursing, medical and prison staff. The segregation safety algorithm did not highlight any medical reason why he should not be segregated.

105. The first suggestion of any deterioration in his stability appeared at the beginning of November 2006. He sustained a slight nosebleed following a fight with another prisoner and was restrained. The man was seen by the doctor who recorded that he had small abrasions to his left upper forehead and blood in his right nostril. Subsequent entries by nursing staff recorded no concerns.

106. On 5 December, the man was seen by the doctor as segregation staff were concerned about his 'odd behaviour'. The doctor assessed that he was perfectly well and quite rational, but took the precaution of asking a mental health nurse to assess him the following day. The nurse confirmed that there was no evidence that the man was mentally ill. The doctor concluded that the man's behaviour was odd but he was not psychotic or deluded. On

every occasion that he was seen by the mental health nurses, his actions were felt to be behavioural rather than psychotic.

107. The doctor considered that the man's behaviour did not cause sufficient concern to warrant a referral to mental health in reach services or to consider opening an ACCT document. At the time, the man was not threatening to harm himself and, as far as they were aware, he had never previously self harmed. The doctor felt that his behaviour was a result of him wanting to move to a prison nearer his mother, but the information was not passed on and did not result in any closer observations.

108. After the man assaulted the segregation unit SO on 7 December, he set fire to his cell and banged his head on the wall. He sustained a small cut to his forehead and initially declined stitches but accepted treatment later. When the doctor saw him four days later in the safer cell, he recorded that the man threatened to set fire to his cell if he was returned to segregation. The doctor believed that this was a reference to burning his cell rather than to harming himself, and found no evidence of psychosis.

109. Healthcare staff see segregation unit prisoners every day. The record for the visit to the man the following week noted that he said he was on hunger strike, was refusing food and accused staff of tampering with his meals. In interview, the nurse was asked whether he considered such allegations to be evidence of paranoid behaviour. He did not believe that they were, the man made good eye contact, was very open with him and showed no sign of hallucinations. The nurse did not review him again that day or refer him to mental health services because at that time he felt it was unnecessary. The man would receive the routine healthcare visit the next day. The nurse acknowledged in retrospect a further review might have been appropriate.

110. The clinical review found that, despite a limited reference in the reception health screen and the ACCT document, there is no record of a mental health assessment in the man's medical record. However, at the first clinical review meeting, the panel was presented with a document entitled 'Mental Health Assessment'. This assessment details the man's presenting problems, and states that he appeared unsurprised that a mental health assessment had been requested. The assessment shows that the man had no significant psychiatric history, and includes reference to his previous medical history, social history, and his appearance, mood and behaviour, thought control, and impression at the time of assessment. It also includes a plan for his future management.

111. There is a suggestion within this undated document that the man was unable to control his temper. It also records that there was no evidence of delusional ideas and that he denied any thought of harming himself. The document notes that there was no evidence of mental illness and the man was not suitable for referral to the mental health team. The intention was to persuade him to return to normal location and encourage him to engage with psychology for enhanced thinking skills and anger management.

112. The document was not referred to in any of the man's medical records, nor is there any suggestion that the actions were taken and a mental health assessment arranged. Furthermore, the document was undated although signed by one of the nurses.

The Primary Care Trust should carry out an audit of record keeping within HMP Stafford in accordance with PCT procedures based upon the Nursing and Midwifery Council Standards for Record Keeping, and a programme of regular audit and review should follow.

The Governor and Primary Care Trust should consider developing a communication strategy to ensure a better system of cross referencing between an ACCT document and a prisoner's medical record. This is particularly necessary where key nursing staff are documenting interactions with prisoners known to be at risk of self harm.

The man's stay in the segregation unit

113. The man was first sent to the segregation unit after he produced a positive drug test which showed that he had used opiates immediately before transferring to Stafford prison. His punishment of 14 days cellular confinement was severe but not excessively so. However, his stay in segregation continued from 22 September 2006 until his death nearly three months later, with the exception of a brief period in a safer cell. The length of his time in segregation was extended because of his repeated refusal to return to normal location.

114. The Governor has introduced a local policy with two aims: to reduce long term occupancy of the segregation unit, and to contain prisoners at Stafford rather than agreeing to transfer them elsewhere. Both of these objectives are proper ones. However, the man repeatedly said that he did not wish to transfer, but did want to remain in segregation as he preferred to be away from other prisoners. He had been bullied in Liverpool and been granted vulnerable prisoner status, and presumably did not wish to risk further intimidation.

115. Implementation of the Governor's policy was supported by the considerable efforts of wing staff who maintained contact with the man throughout his months in segregation. However, despite their best efforts (which were well documented), he refused to leave the unit. The man was also seen by segregation unit staff and attended segregation review boards. Throughout, he maintained his position. He did not want to return to normal location and made no applications for an alternative to segregation.

116. The man was frequently seen by members of the IMB, chaplaincy and healthcare teams, all of whom documented that he wished to remain segregated. In interview, the segregation unit SO said that the man was afraid of getting into trouble on normal location and of receiving further days added to his sentence. Although the man's mother did not believe her son

would request to stay segregated, the reality is that he refused to accept any alternatives.

Chaplains' access to the segregation unit

117. It is a fundamental safeguard for prisoners in segregation that they receive daily visits by people who are independent of the prison. Daily healthcare, IMB and chaplain's visits take place. However, I was concerned to learn that the chaplains' access had recently been curtailed. They no longer carry keys to the cells and are unable to have direct contact with prisoners without the intervention of other staff.

118. Restricting access may well have been implemented with the best of intentions. However, it is essential that the chaplains are fully aware of the rationale and involved in the decision. I am pleased to report that the chaplains now have access to cell keys.

The governor should review his decision not to allow the chaplains to hold keys to prisoners' cells.

Family involvement

119. The man's telephone calls to his mother were always positive and showed he was looking towards the future. She had spoken to him a few days before he was taken to hospital and said he had sounded fine on the telephone. The first his mother was aware that anything was wrong was when she was telephoned and told that her son had hanged himself. Only then did she find out about his previous self harm. The mother is concerned that she was not previously informed about it.

120. The ACCT guidance encourages prisons to include families wherever possible when support plans are being devised. This did not happen in this case. Although it is by no means certain that he would have consented to his mother being informed, it would have been good practice to have asked.

The governor should consider involving the families of prisoners monitored by the ACCT procedures in accordance with the ACCT guidance.

Return to the segregation unit

121. The man's mother was concerned that her son was assessed as fit to be moved back to the segregation unit so soon after harming himself. He was moved from a safer cell back to the segregation unit where he had resided since September.

122. I am satisfied that closure of the ACCT document was reasonable, and so location in the safer cell was no longer necessary. In the circumstances, I believe that delaying the man's return for 24 hours was a sensible

precaution but to leave him for any longer in a scarce resource, which offered reduced privacy, would have been inappropriate.

123. The decision that the man should return to segregation was made after he had been seen by a doctor and attended an ACCT review with two governors and a nurse, none of whom believed that he presented a further risk of self harm or suicide. However, the clinical review panel felt that the man's behaviour contradicted the documented opinion of healthcare staff and questioned whether returning him to segregation was appropriate. Their concern was reinforced by the entry for 13 December that he was seen in the segregation at the request of prison staff and was on hunger strike. The clinical review panel considered that a more detailed mental health assessment would have been appropriate at this stage.

The Primary Care Trust should raise the profile of available mental health services to all prisons within their area to ensure that prisoners can access additional mental health support. This should include clarification of the pathway to secondary mental health care services.

Parole Board

124. The man made an application for release on parole licence which was refused on 9 November. The Parole Board found that his time in custody had not been without incident. The man admitted he had a problem about being told what to do by people in authority and said there were times when he could not control his temper.

125. When he had previously been released on licence in 2005, he had lived with his mother which is where he intended to return on release from this sentence. He had a past history of alcohol and drug abuse. On balance the Board was not satisfied that his risk was manageable in the community over the available licence period, nor that the benefit of early release would outweigh the risks he presented.

126. The decisions of the Parole Board are outside my remit, but in any event I see nothing irrational in the Board's decision on the evidence before it.

Immediate response to the man's hanging

127. The clinical review panel has highlighted the good and immediate response by prison staff when the man was found hanging and by the nursing staff who subsequently attended to him. They also drew attention to the effectiveness of the prison's contingency plans in ensuring the quick entry and exit of the ambulance.

128. Although I am concerned that an officer's radio failed at the first attempt, a second officer successfully used the same piece of equipment and so I am satisfied that it was not faulty and make no recommendation.

Bedwatch

129. The man's mother has expressed concerns about the bedwatch arrangements after her son was taken to hospital. However, I am satisfied that the officers conducted themselves according to prison protocol and were properly monitored by the prison's managers. At no time was the man subject to physical restraint. The deputy governor attended the hospital the same day that the man was admitted and instructed the officers to maintain a discreet presence.

Press release

130. The man's mother asked what information was released by the prison to the press after her son was sent to the hospital. I have found that the basic details of the man's transfer to hospital and death were communicated to the Home Office, including his name, age, and the briefest of circumstances. The statement said:

> "A Prison Service Spokesperson said the man died in hospital on15 December, after being found hanging in his cell on Wednesday 13th Dec at HMP Stafford.
>
> "Every death in custody is a tragedy, and our sympathies are with the family and friends of the deceased at this time. The Police, Coroner and Next of Kin have been informed. As with all deaths in custody, the Prisons and Probation Ombudsman will conduct an investigation"

There is a proper public interest in any death occurring in custody and I see nothing to criticise in the contents of the press notice.

CONCLUSIONS

131. The man initially went to the segregation unit in September 2006 after being punished with 14 days cellular confinement for administering a controlled drug contrary to the Prison Rules. He had tested positive for opiates. Once in the segregation unit, and despite the best efforts of staff, he repeatedly declined to return to normal location and breached Prison Rules by repeatedly refusing to do so. His refusals resulted in further periods of punishment, as did a fight with a fellow prisoner.

132. Whilst in segregation, the man was regularly spoken to by members of healthcare, the management team, and the IMB, and by staff from his original wing as well as the segregation unit. His behaviour was recorded as odd. He was properly assessed by healthcare.

133. After three months in segregation, the man assaulted an officer on 7 December, was restrained and then set fire to his cell. He injured his head, was placed on ACCT and moved to a safer cell. A doctor and mental health nurse did not believe that he was suffering from a mental illness and no thought was apparently given to a further assessment by a psychiatrist.

134. Four days later (11 December), the man was no longer considered to be at risk of self harm and was removed from the ACCT plan. The following day, he was returned against his will to the segregation unit. The next day, he was found hanging and he died two days after being taken to hospital.

135. Stafford's prison and healthcare staff present as caring and concerned. Nevertheless, I wonder if more might have been done to help and assist (and challenge) the man given the length of time he had spent in segregation. Given that it is my unhappy duty to investigate all too many deaths that occur in segregation, I am all too aware of the special riskiness that attaches to it. In particular, was an opportunity missed to consult wider on any underlying physical or mental health issues that might have affected the man?

136. That said, the clinical review panel concluded that the man received a level of care equal to, if not higher than, that he would have received had he been a community patient experiencing similar undiagnosed difficulties. And on his enforced return to segregation once the ACCT form had been closed, no discipline staff or nursing staff, nor the chaplain, recognised any particular risk.

137. In hindsight, the man must have been suffering a greater level of distress than was apparent to any of the staff responsible for his care. However, while I am always anxious if prisoners spend protracted periods in segregation, I do not believe the actions leading to his death could reasonably have been anticipated.

RECOMMENDATIONS

1. **The Primary Care Trust should carry out an audit of record keeping within HMP Stafford in accordance with PCT procedures based upon the Nursing and Midwifery Council Standards for Record Keeping, and a programme of regular audit and review should follow. (Accepted)**

2. **The governor and Primary Care Trust should consider developing a communication strategy to ensure a better system of cross referencing between an ACCT document and a prisoner's medical record. This is particularly necessary where key nursing staff are documenting interactions with prisoners known to be at risk of self harm. (Accepted)**

3. **The governor should review his decision not to allow the chaplains to hold keys to prisoners' cells. (Accepted)**

4. **The governor should consider involving the families of prisoners monitored by the ACCT procedures in accordance with the ACCT guidance. (Accepted)**

5. **The Primary Care Trust should raise the profile of available mental health services to all prisons within their area to ensure that prisoners can access additional mental health support. This should include clarification of the pathway to secondary mental health care services. (Accepted)**