

**Investigation into the circumstances surrounding the  
death of a man at HMP Wakefield in June 2008**

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

**November 2009**

This is a report into the death of a man in June 2008 at HMP Wakefield. He was found hanging in his cell at 6.07am. The man was six and a half years into a life sentence and had been transferred to Wakefield from HMP Whitemoor in February 2008.

The investigation was led by one of my senior investigators. Her inquiries were extensive and conducted over several months, and she was assisted by my colleagues. My sympathies go to the man's family and I must apologise for the delay in issuing this report.

My investigator received excellent support from the Governor and his team in the Offender Management Unit. I would also like to thank the Governor of Wakefield for the time and resources that she and her staff gave to my investigation.

I am also grateful to the local Primary Care Trust for their appointment of the clinical reviewer to examine the medical care that the man received while he was at Wakefield. The clinical review is attached as the first annex.

The man had spent his six and a half years in custody moving around the Prison Service estate. He frequently made allegations that he was the subject of racism. I examine the way in which these allegations were investigated and am critical of the handling of some of his complaints.

The man received treatment for his mental health throughout his time in prison. At the time of his death, he was subject to an Appropriate Behaviour Compact (an agreement between staff and prisoners to manage disruptive conduct). As part of this investigation, I explore the management of the man's behaviour and the impact that this had on his mental health. I look at the decision to reduce the man's Incentives and Earned Privileges regime to basic, and criticise the process that led to that decision.

I make nine recommendations.

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

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

**November 2009**

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## SUMMARY

The man was serving a life sentence for a violent sexual offence. He struggled to adjust to a prison environment and was transferred between prisons 12 times during the six and a half years he was in custody. He was subject to suicide prevention measures on four separate occasions, the last time in 2006.

When the man was transferred from Whitemoor to Wakefield in February 2008, he was returned to a wing he had originally been on between 2003 and 2005. He became abusive to staff and was identified as a prisoner with challenging behaviour. Staff observed that the man would often speak to female staff in preference to male staff and female officers allegedly reported that he could be intimidating. An agreement was drawn up (known as an Appropriate Behaviour Compact) whereby the man was not permitted to approach female staff members. A daily record was kept of the man's conduct, with the aim of encouraging positive behaviour.

In the meantime, the man was seen by a mental health worker who spoke to him about the importance of taking his medication. (The man was taking anti-psychotic and anti-depressant medication.) The mental health worker understood that the man was not complying with wing rules and recommended that he be assessed by a consultant psychiatrist. The psychiatrist found no evidence that the man was at risk of self harm or suicide and did not adjust his medication.

The man reportedly found the terms of the compact difficult to stick to. Some staff and prisoners said that he was confused about when he was allowed to interact with female staff. His actions towards one female member of staff became "bizarre" and highly abusive. Other female staff were relaxed about speaking to him and did not challenge him when he approached them. However, the man's behaviour deteriorated and his privileges were eventually reduced to the basic level of the Incentives and Earned Privileges Scheme, but without the attendance of his personal officer at the review board.

While on the lowest level of privileges (which included loss of his television), the man became isolated and staff worried about his lack of interaction. Unbeknown to staff, he had ceased contact with his family. The acting wing manager contacted the mental health team and asked for their view on whether the man's television should be returned to him. An officer also asked the mental health team to consider whether the man should be supervised when taking his medication because she was concerned he was not taking the required dose. A different mental health worker visited the man and agreed that he should have his television given back to him. The mental health worker also felt that he had sufficient insight into the importance of taking his medication that he need not be supervised when taking it.

The man made one of many complaints on 28 May 2008. Although difficult to follow, he wrote "suicide is an option!" Two days later, the man returned to the standard level of privileges. As part of the response to his complaint, a

senior officer spoke to him on 31 May, but did not refer to his written suicide threat. He spoke to the man about general matters and concluded that he was not at risk of suicide or self harm. The senior officer's written response to the complaint was general and mentioned none of the specific issues that the man had raised. The senior officer did not consider initiating formal suicide prevention measures.

In the days before he died, two prisoners reported hearing the man shouting at officers that he was going to kill himself. The officers did not recollect this, and said in interview that they would have immediately spoken to him about any such threat and considered whether suicide prevention measures were necessary.

At the end of a night shift, at 6.07am in June, the man was found hanging in his cell. An urgent call for medical assistance was made over the radio and officers entered the cell and cut the ligature. The man's body was lowered to the ground but resuscitation was not possible due to the onset of rigor mortis. Paramedics arrived 20 minutes later and confirmed that the man had died.

In this report, I consider how the man's behaviour was managed at Wakefield and the decision to put him on the basic regime. I also examine his allegations of racism among staff at Wakefield (allegations that were echoed by other prisoners to whom the investigation team spoke, but which in aggregate terms have not been substantiated in an inspection by HM Chief Inspector of Prisons). I look at how the man's complaints were handled, and especially how the last complaint made on 28 May was dealt with.

The man's family raised a number of concerns about family liaison following his death, and I trust that these are also appropriately dealt with in the report.

## THE INVESTIGATION PROCESS

1. I appointed my investigator to lead the investigation into the man's death. A Governor arranged for the man's records to be copied and sent to her. My investigator sent notices to the prison, inviting staff and prisoners to contact her with information that they felt was relevant to the investigation. There were two responses from prisoners, both of whom my investigator contacted and interviewed.
2. My investigator and one of my Family Liaison Officers arranged to visit the man's family in London. I would like to thank the man's family for their valuable contribution to the investigation process. Among other things, they discussed their concerns about the contact they had with the prison after his death. I trust that I have addressed their concerns in my report. My investigator was also contacted by the family's legal representatives, who requested full disclosure of all documentation. In accordance with our disclosure policy, this was arranged.
3. My investigator went to Wakefield in August 2008 and met the clinical review team to conduct joint healthcare interviews. In October, my investigator was joined by the clinical reviewer and three other colleagues from my office to conduct further interviews. Investigators from my office conducted interviews with prisoners who had asked to speak to us in connection with the man's death. They also spoke to a prisoner who was subject to a basic regime. In total, the investigation team interviewed 24 members of staff and 13 prisoners. Notes of these interviews are annexed to the investigation report.
4. An Assistant Ombudsman joined my investigator and the clinical reviewer to interview staff over these three days in October. My investigator fed back her preliminary findings to the Governor of Wakefield after that visit. After further consideration of the evidence, my investigator returned to Wakefield at the end of November to carry out more staff interviews.
5. As part of the investigation, my investigator wrote to the Chair of the Independent Monitoring Board (IMB) to discuss their involvement in the man's care and their understanding of diversity at Wakefield. I am grateful for their response. She also spoke with another of my Assistant Ombudsmen who manages complaints from prisoners at Wakefield. My investigator also met and subsequently liaised with the lead of the team from Her Majesty's Inspectorate of Prisons who carried out a full announced inspection of Wakefield in December 2008.
6. My investigator returned to Wakefield for a final interview in February 2009. I am grateful to the Head of Offender Management and his team for providing my investigation team with excellent liaison throughout a complex investigation process.

## HMP WAKEFIELD

7. Wakefield is one of eight high security prisons in England and Wales. It accommodates up to 751 prisoners on four main wings. At the time of the most recently published report from HM Chief Inspector of Prisons (April 2005), 51 per cent of prisoners at Wakefield were accused or convicted of a sexual offence, making up the largest section of the population. Black or minority ethnic prisoners made up about 16 per cent of Wakefield's population at that time.
8. HM Chief Inspector further inspected Wakefield in December 2008, during the course of this investigation. My investigation team met with the Inspectorate to share findings. The Inspectorate report is not published at the time of issuing this draft so it cannot be explicitly referred to, but I am grateful to the Chief Inspector for her team's valuable contribution to my own investigation.
9. The Chief Inspector's 2005 report followed an unannounced inspection. She found that staff-prisoner relations still needed some development. However, the inspection team judged that the Governor at the time "demonstrated a commitment to promoting good race relations and tackling racist behaviour". Complaints about racist incidents were well investigated. But despite a significant population of black or minority ethnic prisoners, the inspection team found that "almost all staff were white" and "there was relatively little evidence of active, positive, promotion of cultural diversity". Three and a half years later, my investigation team were also concerned to find that there are almost no black or minority ethnic officers working on the wings at Wakefield. I will discuss this in more detail later in the report.
10. During the course of her investigation, my investigator was told that approximately 35 per cent of staff on the wing where the man was allocated were female. At that time, there was only one female senior officer on the wing. My investigator spoke to that senior officer and she acknowledged that her relationship with the man was difficult as the only female wing manager.
11. The Wakefield Independent Monitoring Board's (IMB's) annual report for 2008 found that there had been "excellent progress for all aspects of diversity, not just race equality". (Every prison has an IMB made up of members of the local community who monitor day-to-day life for prisoners and ensure that proper standards of care and decency are maintained.) The IMB raised no concerns about safer custody, and reported a "relaxed but secure relationship between staff and offenders throughout the establishment". My investigator wrote to the IMB to ask if there had been any contact between the man and any of its members and they confirmed that there had not.
12. In 2008, there were six deaths at Wakefield, four from natural causes and two apparently self-inflicted. Each death is investigated

separately, and there are few similarities between the circumstances of the man's death and those of the other prisoners.

### **Appropriate Behaviour Compact (ABC)**

13. An appropriate behaviour compact (known as an ABC) is a security strategy particular to Wakefield, designed to provide additional support to prisoners who have challenging behaviour that affects life on the wings. The prisoner and staff agree the aim of the ABC. Staff monitor the prisoner's behaviour, keeping an ongoing record of whether they are meeting the ABC's requirements. The ABC is reviewed at least monthly at a multi-disciplinary meeting attended by the Head of Residence. The man was subject to an ABC at the time of his death.

### **Incentives and Earned Privileges (IEP) scheme**

14. The Prison Service's Incentives and Earned Privilege (IEP) scheme is designed to encourage and reward positive behaviour. The scheme has three levels: standard, basic and enhanced. All prisoners have access to the standard regime when they first arrive at a prison. If a prisoner complies with the prison's regime and uses his time productively, he will earn extra privileges and become an enhanced prisoner. Basic is the most restricted regime and means less time out of cell and no television, among other restrictions. The man was on the basic regime between the end of April and the end of May 2008.
15. As a prisoner on the basic regime, the man was released from his cell for 20 minutes three times a day to collect his meal, make telephone calls and use the shower. He was entitled to two periods of association a week. The basic regime does not restrict access to education or employment, but the man attended neither and so spent long periods of time alone in his cell.

## KEY EVENTS

16. The man was remanded to HMP Pentonville at the end of January 2002. He moved to HMP Belmarsh just over a week later, where he stayed for two and a half months before he moved to HMP Brixton. In June the man was convicted and he was sentenced to life in prison two months later. He remained at Brixton for one and a half years. Between December 2002 and February 2003, the man was made subject to a F2052SH. (An F2052SH was the term used to describe suicide prevention measures that were used by the Prison Service before a new system, ACCT, was introduced in April 2005.) He told staff that “his long sentence causes him to have ups and downs he still gets depressed and feels at times he could be suicidal”. By February 2003, he reported feeling “well within himself” and the decision was made that he was no longer at risk and it was agreed to close the F2052SH.
17. When the man was first transferred to HMP Wakefield on 20 November 2003, he assaulted staff in reception. He remained at Wakefield on this occasion for about two years, apart from a one month period in HMP Whitemoor around July 2005. His time at Wakefield was marked by episodes of violent behaviour and accusations of racism against staff. A second F2052SH was put in place for a month between October and November 2004 after the man was allegedly racially abused by a prisoner on the wing. By November, the man was recorded as “forward looking and gave positive ideas”. The multidisciplinary review board agreed that the man was no longer at risk and closed the F2052SH.
18. Shortly after the man was moved to Frankland in November 2005, he asked to be permanently transferred to Whitemoor. The application was forwarded to the Population Management Unit for consideration.
19. The man told a nurse that he wanted to talk about his “funeral arrangements” on 27 May 2006. When challenged, he was confused about what his problems were, but they included not getting along with staff, lack of visits and lack of funds. An ACCT document was opened and remained open for two months. (Assessment, Care in Custody and Teamwork, or ACCT, is the system now used to identify, support and monitor prisoners at risk of self harm or suicide, and which replaced F2052SH.) It was closed on 26 June.
20. Three days later, the man rang his cell bell and told the officer who responded that he was suicidal because he was likely to be segregated the following morning. Another ACCT document was opened and remained open for one and a half months. The man was moved from the segregation unit to the healthcare centre where he remained for much of this time. He told staff that he did not want to be in Frankland because it was so far north and his family could not visit him easily. During his ACCT case reviews, he admitted that he was “probably

worrying too much about the adjudication". (An adjudication is a disciplinary hearing run by an independent adjudicator or a governor when a prisoner is alleged to have broken prison rules.) On 18 August, the man "categorically denied having any suicidal thoughts or intentions". He told staff that he felt "safe and secure on the wing" and the decision was taken to close his ACCT document. This was the last time that he was subject to suicide prevention monitoring.

21. After a year at Frankland, the man was transferred to Whitemoor in November 2006. In January 2007, he was assaulted by three prisoners and sustained a hand injury. Following the news of a close relative's death shortly afterwards, the man told staff that he could not sleep. When he was seen by a doctor from the mental health inreach team in March 2007, he said that he thought he had between six and seven breakdowns while he was in prison. He complained that the loss of his employment due to his hand injury meant that he had nothing to do, and the doctor agreed to speak to the physical education department to help him occupy his time. The man assured the doctor that he had no thoughts of harming himself at that time. He settled back into life at Whitemoor. The prison was closer to his friends and family and the man enjoyed more visits. However, the Vulnerable Prisoner Unit (VPU) closed and its prisoners were transferred to other high security prisons. (Some prisons have a VPU for prisoners who struggle to adapt to life on the wing, or who may be victimised. It is often the case that such units accommodate prisoners with a history of sexual offences.)
22. The man arrived at Wakefield for the second time on 15 February 2008. After the draft report was issued, the family asked my investigator to check whether his records arrived with him, and the prison said "to the best of our knowledge, all documentation arrived with the man on transfer". My investigator found no evidence to suggest that his records, including his previous ACCT documentation, did not come with him to Wakefield on that occasion. His Prisoner Escort Record (PER) indicated that he was a violent prisoner who had committed a sex offence, and also that he was vulnerable. (A Prisoner Escort Record is opened every time a prisoner is taken into custody to communicate the prisoner's level of risk between custodial agencies.) The following warning was recorded:

"The man is serving LIFE for RAPE, extreme violence was used, he is a volatile prisoner who is abusive to staff and prisoners, he especially singles out female staff. Racially abusive to staff and is deemed as a real threat to females ... Permanent transfer to Wakefield."
23. His cell sharing risk assessment was completed and the man was assessed as "low risk" of harming other prisoners. When he was located in his cell, he refused to speak with staff and prisoners and blocked his door with a cardboard box to prevent others from coming

into the cell. He told staff that he would go to the segregation unit and would respond to staff there. An Officer made an entry on the man's wing history sheet: "been on previous ABC compact, danger to staff. Previous ACCT documents. Mental health issues."

24. The next day, the man had an interview with a first night officer which was designed to identify any immediate needs. He told a second Officer that his next of kin was a girlfriend. (The woman was contacted by my Family Liaison Officer at the beginning of my investigation and she confirmed that she had only exchanged letters with the man.) During the reception procedures, he went on to say that he had no thoughts of suicide or self harm. He was told who his personal officers were at that time and he said he had no concerns about being at Wakefield. Although the man borrowed a Muslim prayer mat and headwear, there is no record of whether or not he was a Muslim in the records from his time at Whitemoor.
25. The man's first reception healthscreen was entered on his electronic record two days after it was carried out. The entry reads as follows: "He has reportedly self harmed in the past although I am unable to locate details of same and he states he has no history of self harming." As a result of the first reception healthscreen, he was referred for a mental health assessment.
26. The same day this entry was made (17 February 2008), the man approached a third Officer and asked whether the same female staff worked on B wing (the man was located on B wing on both occasions he was at Wakefield). The following day, the man had an altercation when he was collecting his food. His television was later found smashed on the floor of his cell. He told staff that it had fallen off the shelf. There is an unsigned entry in his clinical record from the same day, recording his allegation that he had been attacked in Whitemoor in January 2007 and that he was also "beaten" in Frankland. The entry also recorded that he had no thoughts of suicide at that time.
27. The man completed a self-referral for the disability department on 21 February. He was a diet-controlled diabetic and was signed up to the diabetes clinic. He was also recognised as having mental health problems. A Senior Officer (SO), the Disability Liaison Officer, explained in interview that there are no strict criteria for prisoners to qualify for support from the disability liaison team. Prisoners must identify themselves as disabled and will be offered additional support from her and her team on that basis.
28. On 26 February, the man told staff that "he wanted to go to the seg[regation] block because he was fed up with males sucking up to female [officers]." He was advised against this course of action. The same day, he made a complaint about female officers organising fights between staff and prisoners "using professionals and sports men". He wrote that he wanted "to stop the Irish mentality, to stop using me as a

meal ticket". He requested a transfer to Full Sutton. An SO received the complaint and referred the man to the mental health team.

29. The next day, the man asked a female officer if he had "come to bed eyes", which was recorded as a security matter. The senior officer on the wing was made aware and female staff were asked to be careful of the man approaching them. A fourth Officer wrote in the man's security record the following day:

"The man chooses only to speak to female staff. There can be any number of male staff, however, he chooses to bypass them and speak to females."

30. That same day (28 February), a mental health worker from the mental health inreach team made his initial assessment of the man's mental health needs. He recorded that he found the man to be orientated. The man told the nurse that he was only taking half of the Risperidone (an anti-psychotic) but, after an altercation with a member of staff, he resumed his full dosage. The mental health worker was told by staff that the altercation occurred when a male officer asked the man to stop following a female member of staff. The mental health assessment concluded that the man needed psychiatric input "as soon as possible". During interview, the mental health worker told my investigator that, given the man's presentation, it was routine for him to need to see a psychiatrist as soon as reasonably possible, but it was not a matter of special urgency:

"... obviously if he was having altercations with staff on the wing about following females, he had shown some non-compliance with his medication, that in itself would make me want to get him to come down and discuss whatever was happening with a consultant forensic psychiatrist as quickly as possible."

31. The man was placed on an ABC the following day. As the senior officer managing the wing that day, a second SO explained the decision to open the compact. She said that staff had complained to her that the man was watching a female Officer. The second SO told my investigators that, as a senior officer on the wing, she is responsible for the management of staff and the female Officer was not comfortable with the situation. During interview with the investigation team, the second SO recalled:

"... he would speak to her, he would probably home in on her, go past other staff to speak to her or he'd speak to, if she was on another landing, he would still go and speak to her, it was like ... unhealthy, and staff had raised concerns that they weren't comfortable ..."

32. In her interview, the female Officer did not recall speaking to any members of staff about concerns with the man's behaviour before his

ABC was put in place. She remembered, “he would approach me over staff that were in the nearer vicinity to him”, but thought that the ABC was opened because of more general concerns about his behaviour with female staff, rather than just with her.

33. The man was told that his behaviour towards female officers was inappropriate. The first target of the ABC was not to approach female officers at all. Once the man had achieved this target, the aim was to improve his behaviour so that appropriate interaction could take place. When the second SO was explaining the terms of his ABC to the man, he did not accept that he had acted inappropriately towards female members of staff. She made the following entry in his wing history:

“While being placed on ABC compact he refused to accept that his behaviour was not appropriate. When challenged he became bizarre to myself and I felt he was trying to intimidate me. He was showing inappropriate behaviour.”
34. The second SO explained to my investigation team what she meant by “bizarre” behaviour. She said that, during this exchange, the man leant over to her and stuck his tongue out at her while shouting. She said that a third SO was in the room so she did not feel threatened, but she perceived it as intimidating behaviour. The man was removed to the segregation unit for adjudication for his threats to the second SO.
35. While the man was in the segregation unit, security intelligence came to light suggesting that prisoners were scared of being assaulted by him. The intelligence also highlighted a risk that the man would be assaulted by other prisoners because of “his attitude towards some of the other prisoners”. The man returned from the segregation unit following his adjudication. His behaviour was monitored through the ABC and he had no difficulties complying with the terms of the compact. There were no recorded assaults involving the man.
36. On 12 March, the man approached the SO about his property at Whitemoor. The SO observed that he could get confused at times about where he was. The next day the SO reviewed the man’s ABC with him. The document was to stay open with the same restrictions.
37. The third SO intervened when he saw the man speaking to two female members of staff from another department on 15 March. The senior officer reminded him of the restrictions on his compact and he apologised for breaching those restrictions. The third SO then mediated between the man and the female members of staff.
38. Following the mental health worker’s recommendation that the man should be assessed by a psychiatrist, the psychiatrist had his first appointment with him on 18 March. During the review, the psychiatrist noted that the man was upset about the outcome of his recent appeal and that he had a “normal mental state”. He prescribed 37.5 milligrams

(mg) Venlafaxine (an anti-depressant) twice daily and three mg of Risperidone to be taken daily. The psychiatrist was aware that the man was on an ABC “not to speak to female officers”. He found no evidence of acute mood disorder or psychosis.

39. The next day, a fifth Officer spoke to the man. During interview, the fifth Officer said that she had not experienced the man’s inappropriate behaviour personally. She said that he would become very angry, but when challenged would quickly calm down. She was happy to speak to him without a male member of staff around, and often did so.
40. A sixth Officer observed the man watching a second female Officer on 21 March. He described the man as “not taking his eyes off” her. During interview, the sixth Officer said that he did not challenge the man about this behaviour or speak to the second female Officer about it. He explained that the ABC records intelligence about a prisoner’s unacceptable behaviour so that staff can work with the prisoner to encourage appropriate conduct.
41. A fourth SO had to remind the man of the terms of his compact two weeks later. The fourth SO did not normally work on the man’s landing but he was aware of the terms of his compact. The man told the fourth SO that he often spoke to female staff, and could not always find any male officers to speak to. The fourth SO encouraged him to try to find male officers to speak to. (The fourth SO estimated that about 35 per cent of officers on the wing are female, but with shift patterns it is difficult to guarantee that there will always be a male officer on duty.)
42. On 9 April, the man approached a female member of staff who did not work on the wing. He asked where she worked in the prison and she responded before going into the staff office. Other staff told her about his ABC, so she was then accompanied by a male officer off the wing, avoiding him. He was not spoken to about this incident and his reaction was not recorded.
43. The second SO had to reiterate the terms of the man’s compact again on 10 April. She told my investigators that she shared other officers’ concerns that he was using the compact to avoid going to education. Staff told him that this was “not good enough and he was to attend regardless”, saying that they would facilitate his attendance. The man asked to be moved to the segregation unit because he was concerned about his treatment on B wing.
44. The man repeated his request on 11 April to a seventh Officer, who made the following entry in his wing history:

“The man has requested to go to [the segregation unit] as he believes it is a black environment and that he was being hounded by homosexuals. At one point he followed a member of staff around and continually went into the wing office until he

was warned if he continued to follow this individual he would be placed behind his door.”

45. My investigation team spoke to the seventh Officer who said that, while there were no black or minority ethnic officers on B wing, there are none on the segregation unit either. My investigation team studied statistics of the prisoners who were segregated and found no statistical over-representation of black or minority ethnic prisoners. (I examine the issue of the man’s allegations of racism later in this report.) The fifth Officer spoke to him later that day and the man admitted that he had “behaved badly” and “did not do well under certain circumstances”.
46. The man’s medication was reviewed on 13 April and his anti-depressant was reduced. The following day, the prison doctor contacted the hepatology unit at St James’ Hospital to discuss the treatment of the man’s Hepatitis C. Arrangements were made for a hospital doctor to visit on 5 May. The man did not attend this medical appointment.
47. Smoking on a residential wing has been prohibited since a ban came into force in July 2007, although prisoners are still allowed to smoke in their cells. An eighth Officer found the man smoking on the wing on 19 April and she gave him a verbal warning, telling him that his IEP level would be reviewed. The eighth Officer challenged the man and thought that the matter was been dealt with, but he continued to speak with her. She reminded him that he should not speak to her because of the terms of his compact.
48. The Acting Principal Officer (PO) went over the restrictions of the man’s compact with him that afternoon. He told him that he could speak to female staff if he had their permission, but that he must not approach them. The man reacted by telling the Acting PO that “he is terminally ill, as he has Hepatitis C and he also came out with a statement that he is a good looking black man and I know what is happening”. The Acting PO asked the mental health team if the man’s behaviour was a symptom of mental illness. If not, staff were going to consider reducing his IEP status to basic.
49. In interview, a Nurse said that she was allocated the wing staff request for someone to speak to the man about his mental health. She said that she is not a mental health specialist but often dealt with primary mental health care needs. She made the following entry in his medical record:

“[Staff] were wishing to review his IEP status because he keeps breaching his compact expectations and approaching female staff. The wing staff wanted to know whether his behaviours were influenced by mental illness ... there appear to be a paranoid element to his pattern of thinking, though I do not think this would impact/impede on his ability to comply with the

compact. The wing staff are going to pursue the privilege being reduced.”

50. On 26 April, a PO was asked by the second SO to conduct an IEP board review of the man's status. The second SO told the PO that she thought the man's privilege level should be reduced to basic. My investigator spoke to the PO who recalled speaking to the second SO and reviewing the man's ABC. He said that he was satisfied that the second SO was a responsible senior officer and he trusted her judgement. He also thought that entries in the man's ABC sufficiently demonstrated that he was not complying with its terms.
51. Three Officers recall the PO asking whether they thought that the man's regime should be reduced to basic. The officers said that they did not think that he should be on the basic regime, and they were worried that reducing his incentives level would have an impact on his behaviour. (When he spoke to my investigation team, the PO could not recall this conversation.)
52. The PO, second SO and a ninth Officer carried out the IEP review. A tenth Officer was working on the wing that day and was the man's personal officer at the time, but he did not go to the board. The tenth Officer told my investigation team that he knew the man from his time at Frankland between 2005 and 2006, when he worked there as an officer. He said that he did not have many dealings with him at Wakefield. The PO said that the tenth Officer was asked to join the board as he was working on the landing where the board took place.
53. The PO did not remember the board very well, but he recalled that the man did not deny breaching his compact. The PO said that the man was upset at the outcome but seemed to understand the reasons his IEP status was being reduced to basic. The fifth Officer remembered that the man was angry when he returned to his cell after the board. However, once he had calmed down, he handed staff his personal belongings, including his television, and co-operated with the compact and regime. He was only released from his cell at meal times for 20 minutes at a time and had two periods of association each week. He could attend education, but refused because he was unsure whether he would breach his ABC in doing so. This meant that he spent a good deal of time alone in his cell.
54. Apart from a written warning about smoking on the wing, the man complied with his compact and the basic regime during the following few days. On 2 May, the IEP review concerning the man's smoking was held and the disability liaison officer attended at his request. She said that she had a good relationship with him and spoke to him daily without male officers present. She never experienced any inappropriate behaviour in her dealings with him. After the IEP review, the disability liaison officer made the following entry in his disability file:

“Today I attended an IEP review on the man. He is subject of an ABC compact and is also a basic prisoner. I have concerns about his mental state which appears unstable. Long periods locked in his cell is impounding [sic] the problem and he stated that he couldn't cope.”

55. The fourth SO chaired the review and acknowledged the positive comments about the man's behaviour in the ABC. However, the fourth SO said he had no choice but to keep him on the basic regime. He explained to my investigator that the review was in response to the man smoking on the wing. As smoking is prohibited, the fourth SO said it “would send the wrong message” to have been lenient under the circumstances.
56. Later that day, the man made two complaints about the second SO of a homophobic and racist nature. The second SO's colleague, the first SO, dealt with the complaint but found no evidence to support his allegation.
57. As noted above, the man did not attend the appointment arranged on 5 May to discuss his hepatitis. The disability liaison officer spoke to the man as promised and he told her that he was finding it “hard going” without a television. He said he was trying to improve his IEP status and looked forward to working because “being locked up for long periods makes him feel stressed”.
58. The man expected a further IEP review to be held on 9 May. The third SO explained to my investigator that, when the man was at Wakefield, basic prisoners had their first IEP review within seven days and the next review 28 days later, unless there was significant evidence that the status needed to be changed in the meantime. (This is in line with the requirements of Prison Service Order 4000 – Incentives and Earned Privileges. Prison Service Orders, or PSOs, are national instructions.)
59. The man was therefore not due an IEP review on 9 May. He was angry that a review was not going to be held and became abusive towards the third SO. He turned over a football table and threw a cup of tea across the landing before returning to his cell. He asked to speak to the fifth Officer about why his status had not been reviewed, although another prisoner's status had been upgraded from basic to standard. The fifth Officer said that he responded well when staff pointed out that he was being unreasonable. He calmed down, and she said that he understood that an IEP review was not due and apologised for his outburst.
60. The disability liaison officer spoke to the second SO that day about the man's request that she be invited to his next IEP review. The second SO questioned the logic of the senior disability liaison officer's attendance but the senior disability liaison officer reminded her that the

man had a clinical condition that meant he was disabled. When asked why she insisted on attending the review, the disability liaison officer explained to my investigator that she was “concerned” about him and he had asked her to help him. As she had known him “many years”, she was in a good position to contribute to the review and to support him.

61. The man saw the psychiatrist again on 10 May to discuss his ongoing mental health needs. During the psychiatric review, he told the psychiatrist that he felt singled out by staff, particularly a female officer, although he had no problems with other prisoners. He told the psychiatrist that it was “worth being alive”. The man’s medication was adjusted and the psychiatrist planned to see him within a month.
62. The fifth Officer had worked as a mental health nurse before being employed as a prison officer. She told my investigator that, due to his erratic presentation, she was concerned that the man was not taking his prescribed medication. On 11 May, she referred him to the mental health team to consider whether he should be supervised when taking his medication. The fifth Officer’s concerns were discussed the next day between the mental health team and wing staff and it was suggested that he might be “misusing his medication”.
63. An IEP review was held on 12 May. The third SO said that more reviews took place, although the man was not strictly entitled to them. The third SO chaired the review and decided that the man should remain on basic. He told my investigation team that he was aware of the man’s mental health issues. He explained that it is a difficult balance to judge whether to keep someone on the basic regime. When asked whether he thought that the man’s mental health was adversely affected by being on the basic regime, he told my investigator: “... maybe, but I think it would affect anybody’s mental state, wouldn’t it? You know, being locked up in their cells all the time.” The man attended the review but made no representations. According to the record of the review, he agreed with the outcome but refused to sign the document. There is no record that the disability liaison officer attended the IEP review on this occasion, despite her request to the second SO.
64. A second mental health worker carried out a mental health assessment on 13 May. According to his record, the man “did appear quite bored on the wing and admitted to finding it difficult to get on with certain staff members. Some paranoia evident.” He told the mental health nurse that he felt his “mental state deteriorated slightly due to his lack of activity since being placed on basic and a compact”. Although the man said that he had no thoughts of self harm, the second mental health worker recognised that the measures taken to improve his behaviour were not “conducive to his mental health at the moment though the need for it acknowledged”. As a result of the second mental health worker’s conversation with the man and wing staff, his television

was returned. An entry was made in the man's case history that he had been given his television "as long as he adheres to the compact".

65. Following the fifth Officer's communication with the healthcare department about supervised medication, the second mental health worker also spoke to the man about whether he was taking his medication. The man said that he did not think he needed to take it, so he had only been taking half the prescribed dose. The man told the second mental health worker that he just realised that taking the medication meant he was less angry, so he had started to take the full dose again. The second mental health worker was satisfied that the man had sufficient insight into the need to take his medication and its relation to his moods. They agreed that he could continue to take his medication unsupervised for the time being, although the situation would be reviewed. The second mental health worker arranged for an appointment with the psychiatrist for the following week.
66. After attending a diabetes clinic on 15 May, the man's diabetes medication was restarted.
67. Two days later, the man asked the eighth Officer whether he could be subject to ACCT measures so that "staff would watch him more", although he told her he had no intention of harming himself. The eighth Officer explained to him that increased supervision without any risk of suicide or self harm was not the purpose of the suicide prevention measures. In interview with my investigator, she said that she did not think that he was at any risk of suicide or harming himself, but was just trying to get more attention from staff.
68. The psychiatrist assessed the man on 21 May and recommended a change in medication. He told the psychiatrist that he was being targeted by one member of staff. A record of their meeting was written in his paper medical file, but was not copied in the electronic medical records used by the rest of the healthcare department.
69. The man made more complaints containing allegations of racism. Copies of all such complaints are passed to the Race Equality Principal Officer and she spoke to the man on 23 May. She noted his "perception that staff are racist as other offenders have told him that. The man was polite throughout the interview." The Race Equality Principal Officer held the meeting in an office on B wing and a male officer accompanied her because of the terms of the man's ABC.
70. A further complaint was submitted by the man on 28 May. It said:

"I have been convicted on circumstantial evidence. All my efforts to prove my innocence have failed. I was at the time a drug addict. I have not used in six years, but to no avail. I cope each day by begging. It's the joke of the prison. I want to leave and work and enjoy sporting activity while I still can. I am

terminally ill. I don't want treatment. I would like people to talk to me as someone, and not written off as mentally ill. I would like the Governor to stop laughing in my face, suicide is an option! I am only human; please stop treating me like an animal."

71. The man indicated that he had spoken to the third SO about the matters raised in his complaint. However, the third SO told my investigator that he had not seen the complaint before being interviewed after the man's death. He said that the man had spoken to him about his offence and appeal process, but they had not discussed anything else and he was not aware of his threat of suicide.
72. The prison doctor wrote to Leeds General Infirmary the following day to refer the man for "hepatitic surveillance". The doctor explained to my investigator that the man's condition was not serious at the time but could that it be fatal if left untreated. The man continued to refuse treatment for hepatitis, and so the prison doctor was concerned that he should be referred to the hospital and his condition monitored.
73. On 30 May, the third SO revised the man's ABC. The requirement of "no approach to any female member of staff" was amended to read that the man could approach female staff "to ask permission" and should be polite at all times. When asked about the alteration at interview, the third SO explained that he wanted to give the man more opportunity to talk to staff, although he believed that there was usually a male member of staff on duty. At the same time, the third SO reviewed the man's IEP status and increased it to standard. There is no formal record of the review, but the third SO made an entry in the wing history sheet. It is not possible to determine who else attended the review. When asked by my investigator about the decision to reinstate the man's standard regime, the third SO explained that it was difficult to balance the fact that he was no threat to staff with prisoners' complaints about his behaviour.
74. The man's complaint of 28 May was answered by a fifth SO on 31 May. The fifth SO normally works on A wing, but was covering B wing over a weekend. In interview, he said that he knew the man in passing. The fifth SO saw the complaint in the senior officer's office but was originally not going to deal with it as he saw the reference to the Governor and so thought that it was outside his own powers. The man then came into the office and spoke to the fifth SO about his canteen. (Canteen is the term for the prison shop where prisoners can spend their private cash.) His IEP status had been reviewed and he had been made a standard prisoner a few days earlier, but his income had not been altered. The senior officer looked at the man's canteen sheet, and agreed that he was entitled to more purchases and made the appropriate adjustment.

75. Following their brief conversation about his canteen, the fifth SO felt confident that he could deal with some elements of the man's complaint. The fifth SO thought that the man was happy about their exchange and he "did not register" the sentence "suicide is an option!". Even in retrospect, during interview for my investigation, he did not think he would have approached the complaint differently because he did not judge that the man was at risk of suicide or self harm. As a result, the fifth SO did not open an ACCT document. The fifth SO told my investigator that he thought that the allegation about the Governor would be raised automatically with the Head of Residence, as part of the complaint sifting system. The fifth SO's written response to the complaint was as follows:

"HM Prison Service has a duty of care to all offenders and am confident that your well being is being maintained. If you have any concerns over your mental health you should apply to see the mental health team."

76. Just before prisoners were locked in their cells for the lunchtime period on 2 June, the man approached the female Officer to ask for envelopes. The female Officer was assisting the sixth Officer and an eleventh Officer to lock prisoners in their cells. In interview, she said that the man was closer to the eleventh Officer and the sixth Officer (both male officers), but walked to the other end of the wing to speak to her. She asked the man to wait until the afternoon as she was in the middle of locking prisoners in their cells. He walked away and then returned with the same request and so she told him that he was in breach of his compact. The man called the female Officer a "racist bitch" and the other officers came to her support. The female Officer made an IEP referral following this episode.

77. The man went back to his cell but was angry and continued to shout through the cell door. One of the prisoners who spoke to my investigation team alleged that the man shouted through the cell door that he was going to kill himself. The prisoner said that the eleventh Officer told the man to "do it then". When my investigation team put this allegation to the eleventh Officer, he was adamant that this exchange had not taken place. He said that he would have taken such threats seriously and spoken to the man about it. The prisoner also said that the eighth Officer was present during the exchange. Again, the eighth Officer said that she had no recollection of hearing the man threaten to kill himself. She also said that, had she heard any such threat, she would have spoken to him about what he meant.

78. The next day, the man made a complaint about the female Officer's treatment. He alleged that her reply was "racist" and that she made the sixth Officer threaten him through his door. He went on to say, "I would like you to stop these staff having racist fun at my expense". The complaint was answered by the second SO, as follows:

“After speaking with all staff involved in the incident and found that you were in breach of your compact. Not allowed to approach female staff without permission. The sixth Officer challenged you appropriately and at no stage threatened you. I feel no necessity to take this any further.”

79. The sixth Officer told my investigation team that he had not been asked about the episode. The second SO said that she reviewed the paperwork and was satisfied that staff had acted appropriately. She did not speak to the man expressly about the complaint.
80. Another prisoner on the wing remembered seeing the man collect his dinner on the evening of 5 June. He said that the man seemed “stressed” about going back on the basic regime, but “otherwise he seemed okay”. A further prisoner also remembered speaking to the man that evening, and said he could tell something was wrong. He did not alert staff to his concerns.

### **June 2008**

81. In June, a Night Officer was coming to the end of his first week of nights at Wakefield. An experienced officer from HMP Leeds, he had been working at Wakefield for 18 months. The Night Officer received a hand-over from staff on evening duty and began his shift. He counted all the prisoners in their cells before the evening staff went off duty. In order to perform a roll count, the Night Officer walked around every cell and looked through the observation panel. He said that, if he could not see the prisoner because the cell was too dark, he would use the night light. (The switch for a night light is located on the wall outside the cell and the light is dimmer than the normal cell light.) Once he was satisfied that all the prisoners were accounted for, his roll check was complete and the evening staff went off duty. He was the only officer on B wing for the night shift, in line with normal staffing patterns.
82. Throughout the night, the Night Officer patrolled the landing. He responded to cell bells and checked category A prisoners (the highest security prisoners) and made the required ACCT checks on those identified as at risk of suicide or self harm. The man fell into neither category and so the Night Officer did not open his observation panel after the evening roll count.
83. At about 5.45am, the Night Officer started his morning roll count on the fourth landing. He arrived at the man’s cell at 6.04am. He looked through the observation panel. The Night Officer could only see the bottom of the man’s body. His upper body was behind a drawn curtain. He noticed that the man’s legs were at an angle and that his feet were not carrying his weight, so he realised that he was hanging. He made a radio call for immediate medical assistance, before shouting at staff in the area to help. The assist night orderly officer was working on the

centre (a small office based in the middle of the wings) and arrived within seconds. A second Night Officer was shortly behind him.

84. At night, only the most senior officers in charge of the prison carry a full set of keys. Officers carry a cell key in a sealed pouch for use in emergencies. The Night Officer broke his sealed pouch and unlocked the door. He had to kick it open because items (such as paper and a plastic knife) had been wedged in the frame. The Night Officer moved to the side and the assist night orderly officer went into the cell. He moved the curtain to reach the man's head and the ligature. The officers noticed that his tongue was swollen and his eyes were enlarged. The assist night orderly officer used his ligature knife to cut the bed sheet that was around the man's neck and attached to the window. The officers lowered him to the floor. The Night Officer explained to my investigation team that, due to the confined space, the man's body was too large to lay out completely with the three officers in the room. The assist night orderly officer checked the man for a pulse and found that there was none. He was not breathing and he was cold to the touch.
85. A Healthcare Senior Officer (HCSO) was in the healthcare centre at the time of the Night Officer's emergency call. He had no keys to get to B wing because the prison was still in a more secure night patrol state (where there are fewer staff and only the orderly officer in charge of the prison and dog handlers carry keys to main gates). The night orderly officer therefore collected the HCSO from the healthcare centre. The HCSO carried the defibrillator and emergency grab bag to the wing. He estimated that about three minutes had elapsed since the emergency call was raised. He found the man still leaning against the wall. He cradled the man's head and was assisted by the assist night orderly officer to lower his body to the floor. By this time, the Night Officer and the assist night orderly officer had left the cell. It was the HCSO's impression that the man had been dead for some time. He requested an ambulance and was told that one had already been called. The HCSO did not attempt resuscitation. He told my investigator that he was unable to insert an airway into the man's mouth.
86. When the Night Officer reported the medical emergency on B wing, the communications office automatically called an ambulance. The ambulance arrived and paramedics made their way to the man's cell. They searched for signs of life but found none. He was pronounced dead by the paramedics at 6.23am.
87. The prison chaplain was informed of the man's death. He was concerned because he believed the man was a Muslim and requested the prison imam go to his cell to carry out the appropriate rites. When the prison chaplain and the imam arrived at the man's cell, they found it was locked. The man was laid out on the floor with his hands by his

side. The imam said nothing else needed to be done with respect to his faith.

### **Family support**

88. A member of staff was appointed as the prison's family liaison officer and was telephoned on her way to work with the news that the man had died. When she arrived at the prison, the family liaison officer checked details of his latest correspondence and visits and noticed that he was most recently in touch with his mother. (In fact, he had listed another person as his next of kin.) Nevertheless, the family liaison officer telephoned the man's mother to break the news of his death. When asked by my investigator why she had chosen to break the news of his death over the telephone, she explained that the distance from London to Wakefield would have caused an unreasonable delay in notifying the man's family. I will examine the decision to break the news over the telephone later in this report.
89. The man's family were understandably upset by the news of his death, and the family liaison officer explained that she would contact them at a later time to arrange for them to visit the prison and look around his cell, if that was something they would find useful. She explained that the Governor had offered to pay for his funeral expenses, in accordance with national policy. The family were concerned with some aspects of this arrangement, which I also consider in more detail below.
90. The man's mother agreed to pass the news of his death on to the listed next of kin. In line with my procedure, my own Family Liaison Officer contacted the person listed as next of kin but, as noted earlier, she explained that she did not know the man very well, although she was sad to hear of his death from his mother. The person the man listed as his next of kin did not want to be involved any further with my investigation.

### **Support for prisoners**

91. The prisoners on B wing were told about the man's death a morning in June and Listeners were asked to make themselves available. (Listeners are prisoners trained by Samaritans to provide confidential emotional support to fellow prisoners in distress.) Staff told my investigation team that there was a lot of tension on the wing that day. The chaplaincy also arranged for at least two members of their team to be present to support the prisoners.
92. A collection was arranged so that prisoners could send flowers to the man's funeral. Originally, prisoners wanted to send flowers that spelled his name. However, insufficient money was raised and a bouquet of flowers was sent instead. Regrettably, this caused the family some anxiety. They had understood that the flower arrangement would be

sent by the prison and so had not arranged for flowers spelling the man's name themselves. They were disappointed to find that an arrangement with his name was not sent.

93. A memorial service was held in the prison chapel on 8 August. It was attended by 21 prisoners.

## ISSUES

### Clinical Care

94. I am grateful to Wakefield PCT for appointing a clinical reviewer to conduct the clinical review of the man's care. He attended the prison with my investigation team for three days in total and was present for all of the clinical interviews. He also visited the prison independently to speak to the psychology department about their input into ABCs. His review can be found at the first annex to this investigation report.
95. In his clinical review, the clinical reviewer finds that the man's physical health needs were dealt with appropriately while he was at Wakefield, including his diabetes. His mental health needs were dealt with by the mental health team promptly, and there was evidence of good liaison with residential staff. Despite the man's refusal to engage with treatment for hepatitis C, the clinical reviewer notes the prison doctor's continued efforts to refer him for treatment.
96. The man's family were particularly concerned about whether he was taking his medication. When he was in touch with them, they thought he was sometimes incoherent and were worried that he was not taking the required medication to manage his mental health. The fifth Officer, previously a mental health nurse, was concerned that some of his behaviour indicated that he was not taking his medication, and asked the mental health team to consider whether he could be supervised when he took it. The second mental health inreach worker assessed the man on 13 May. The man explained that he had reduced the amount of medication that he took, but then realised that it helped him and began to take it again. The second mental health inreach worker decided that the man had sufficient insight into the effects of his medication and did not require supervised medication. The second mental health inreach worker asked wing staff to let him know if they had further concerns and he would review the decision.
97. It may have been that the man was not taking his medication when his family last had contact with him in April 2008. However, the man assured the second mental health inreach worker that he was taking his medication properly again in May. In his clinical review, the clinical reviewer raises no concerns about the second mental health inreach worker's decision, and describes his assessment as "thorough".
98. The clinical reviewer makes three recommendations. One relates to mental health input in the ABC process and will be discussed below. The clinical reviewer also recommends that there should be an audit of mental health assessments at reception and improvements to the recording of mental health assessments on the electronic medical system. I endorse both his review and his recommendations.

## **Appropriate Behaviour Compacts**

99. According to PSO 1810 – Maintaining Order in Prisons:

“Governors must develop a Local Security Strategy for the management of prisoners whose behaviour is difficult or disruptive. Local strategies are to be agreed with Area Managers and must provide individual case management, the aim being that prisoners achieve an acceptable level of behaviour within the holding establishment.”

100. The ABC system is classified as a local security strategy and falls within the terms of this order. The system was developed by Wakefield in 2007. The Head of Residence explained its origins. Originally, the compact was called an Inappropriate Behaviour Compact and was to manage prisoners who proved particularly difficult and who did not respond to the IEP system. The Head of Residence explained that, when he took over the role of Head of Residence, such compacts were already in use. He “wanted to turn it round” and renamed the compacts Appropriate Behaviour Compacts to emphasise the encouragement of positive behaviour.

101. The Head of Residence outlined the system that underpins the use of the ABC. It is the wing manager’s responsibility to ensure the effectiveness of an ABC. The officers use the ABC to manage the prisoner on a day to day basis and contribute to it by monitoring and recording positive and negative behaviour. A multi-disciplinary review is held on the first Thursday of every month to discuss each of the open ABCs. The review should be attended by representatives of offender management, security, wing staff, safer prisons, healthcare, and the mental health inreach team if a prisoner has a mental health condition. As Head of Residence, he always attends the monthly reviews. The man was put on an ABC within two weeks of his arrival at Wakefield. The mental health team were invited to attend his reviews but could not do so due to workload pressures.

102. In his clinical review, the clinical reviewer acknowledges that the inreach team only had one member of staff for some of the time the man was at Wakefield. The second mental health inreach worker joined him at the beginning of May 2008. With such low staffing levels, it is not surprising that workload pressure prevented them attending the multi-disciplinary reviews. During a meeting with the Acting Healthcare Manager and the Head of Healthcare, the clinical reviewer was told that from June 2008 steps were being taken to increase the number of Registered Mental Nurses in employment at Wakefield. With this in mind, he makes the following recommendation, which I endorse:

**The Head of Healthcare and the Head of Residence should work together to ensure that, when a prisoner is on the caseload of the mental health inreach team, they should attend the initial review meeting to set up an ABC and also attend subsequent reviews.**

103. The circumstances surrounding the opening of the man's ABC are confusing. The second SO understood from other staff that the female Officer was uncomfortable with the man's dealings with her. The female Officer told my investigator that she had no problem with the man until he was on his compact. She understood that it was his more general behaviour towards female staff that was the problem.

**The Head of Residence should ensure that the reason for starting an ABC is clearly and specifically stated on the document and the reason is effectively communicated with the prisoner.**

104. For over a month of the ABC, the man was instructed not to approach female officers under any circumstance. Despite this strict condition, the disability liaison officer and fifth Officer were two of a number of female members of staff who spoke to the man without a male officer present. The fourth SO said that he could not guarantee that male officers would always be on duty, given the shift arrangements at Wakefield.
105. The eighth Officer breached the man for speaking back to her after she challenged him about smoking. During interview, she told my investigator that he started a conversation after she approached him about smoking on the landing. The female Officer also challenged him about asking for envelopes on the landing when two male officers were closer and could have been asked. She explained to the man that he had breached his compact yet he persisted in speaking to her.
106. Not only was the man's compact opened for unclear reasons, it was also applied inconsistently by staff members. Many of the prisoners interviewed by the investigation team were concerned that the ABC was being used by staff to control him. Staff told my investigator about the difficulty enforcing the terms of his compact. The eighth Officer told my investigator that she did not think that the man understood the terms of his compact. She said it was difficult for him to "differentiate" between female officers approaching him as opposed to him approaching a female officer. On receipt of the draft report, the family asked my investigator to clarify with the eighth Officer why she did not raise her concern about the man's confusion with another member of staff. In her written response, the eighth Officer said:

"At no time did I raise this issue with another member of staff as this was a personal opinion that I held. I felt and still feel that as I did interact with the man it may have added to his confusion."

107. The Governor explained that the ABC system provides flexibility when dealing with prisoners who are unable to cope with the strict discipline required on the wing. Rather than reducing their IEP status, she explained that staff are empowered to manage a prisoner's behaviour without depriving them of access to the regime.
108. However, the Head of Residence confirmed that a prisoner's IEP status is linked to their ABC because both relate to challenging negative behaviour. PSO 4000 – Incentives and Earned Privileges sets out how compacts should relate to the IEP scheme: "failure to comply with the terms of a compact does not constitute a disciplinary offence, unless it stems from behaviour that is in itself a breach of discipline." The Head of Residence said the man was abusive towards staff which constituted a breach of discipline, but merely talking to female staff rather than male staff would not constitute a breach of discipline.
109. I appreciate the principle behind the ABC but I am concerned about its application in the man's case. Staff told my investigation team that they were confused about how to enforce the terms of the compact. Prisoners and staff all thought that the man struggled to understand the terms of his compact. Some female staff strictly enforced the terms of the compact, but others happily spoke to him without a male member of staff being present. It is difficult to believe that such an inconsistent approach would best encourage him to interact appropriately with female staff. Although the third SO changed the terms of the man's compact on 30 May, by then he had experienced more than a month of being prevented from speaking to female officers.
110. In response to the draft report, the family asked whether there is a training package for ABCs. My investigator asked the prison how staff were trained in the use of ABCs and received the following response:

" ... there is no formal training package as it is not a national product but a local HMP Wakefield tool used to manage unacceptable behaviour. Staff on the wings become familiar with the documentation via the safer prisons team who oversee the process and terms of the compact. They are used in a very similar way to a national programme of security monitoring for some individuals and as such all residential staff are aware of their purpose and how to record information in them. The compact itself also has a clear description of why it is applicable to that particular offender at the front for all staff to read and discuss with the offender if required."

In their response, the prison also explained that the ABC system builds on staff's existing skills so no further training should be necessary. I appreciate staff learn the ABC process through its use, but I am surprised that there is no formal training package.

111. Although the ABC was subject to monthly discussions at the multi-disciplinary meetings, I am concerned that it was not working to encourage appropriate behaviour as intended. Consistency of approach and achievable aims must be central to the management of challenging behaviour.

**The Governor and the Head of Residence should consider introducing an audit and training package to accompany the ABC system.**

**Basic regime**

112. The decision to reduce the man's IEP status was taken by the PO, the second SO King and ninth Officer. The PO told my investigator that he had no reason not to trust the second SO's opinion that the man's status should be reduced to basic. He could not remember speaking to other officers, including the man's personal officer, for their views. The second SO had experienced abuse from the man personally and said that she had a problematic relationship with him as she was the only female senior officer on the wing.

113. The disability liaison officer for B wing, and tenth Officer, the man's personal officer, remembered that the PO asked their views about whether he should be on the basic regime. They said that, in their view, he responded well when challenged and reducing his IEP status would not improve his behaviour. They did not think that his IEP status should be reduced. Despite the fifth and tenth Officers having a good deal of contact with the man, neither was invited to attend the review. The ninth Officer was asked to attend with the PO and the second SO because he happened to be on the landing when the review was convened. In interview, he acknowledged that he knew little of the man.

114. I understand the man's perception, with that of other prisoners on the wing, that the decision about his IEP status was unfairly taken. As discussed above, the terms of his ABC were not consistently applied. The second SO opened the ABC and was also instrumental in the decision to place the man on the basic regime. Not all the officers agreed with the decision to reduce his IEP status, but it seems that their views were not considered during the review.

115. PSO 4000 requires that "the decision making mechanism must operate consistently and fairly" and "ideally this will be a formal board which includes the personal officer". I am surprised that the PO went to the trouble of consulting the man's personal officer but did not ensure that he attended. The PO was not usually based on B wing, but the second SO should have known that the tenth Officer was the man's personal officer and could have expressly invited him to the review.

116. I have no reason to distrust the view of the second SO that the man's behaviour was disruptive and that her experience of him was difficult. However, it is clear from conversations with other officers that there was a difference of opinion about whether the man should have been on the basic regime. I am concerned that the decision was made at a review without his personal officer or the disability liaison officer, both of whom were available and knew the man well. I understand the second SO's concerns about the man's poor behaviour towards her and persistent breaching of his compact. I do not conclude that the decision to reduce his IEP level was unreasonable (although others might equally reasonably have concluded that it should not be changed), but I am concerned about the way that it was reached.

**The Governor should remind staff that personal officers should be involved in IEP reviews when available.**

117. Following a consultation with the second mental health inreach worker, the man was given back his television as officers were concerned about the impact of the basic regime on his mental health. I am pleased that the mental health team were actively involved in the man's care and that staff were prepared to be flexible to safeguard his mental health.

118. The third SO returned the man's status to standard on 30 May. The investigation team have not seen a formal record of the review but there is a note in the man's wing history sheet to that effect. As there is no formal record, there is no way to determine who was involved in the decision to reinstate the standard regime. The third SO explained that the decision was a difficult balance. After a review of the ABC, the decision to reinstate the man to the standard regime fairly reflected the staff's overwhelmingly positive comments about his behaviour.

119. The man was on the basic regime from 26 April until 30 May. Following the draft report, his family told my investigator that they were concerned about the frequency with which his basic status was reviewed. The requirements for IEP reviews are set out in 4000. The man's IEP status was reduced on 26 April and a review was held within the required seven days, on 2 May. He was expecting a review a further seven days from that point, but he was mistaken to expect a second review so quickly. After the first IEP review, there does not have to be a review of a prisoner's IEP status for 28 days, as set out in PSO 4000. Staff responded to the man's concern and held an early review on 12 May, ten days after his previous review. A further IEP review was held on 30 May, 28 days after his first IEP review, in line with Wakefield's procedure. The investigation found that IEP reviews were held with the required regularity.

120. I am concerned at the impact of the basic regime on the man's mental state. He was on the basic regime from 26 April until 30 May, over a month of his time at Wakefield. Being on basic meant that he had 20

minutes every meal time to make a telephone call, collect a meal and take a shower. He was allowed association twice weekly, but otherwise spent his day alone in his cell. He elected not to go to education because he thought it might breach the terms of his ABC, despite staff assurance that it would not. My investigation team spoke to a fourth prisoner on the same wing as the man who was also subject to the basic regime. The fourth prisoner said that he too was allowed out of his cell for around half an hour three times a day and had two periods of association a week.

121. The man's last telephone contact with his family was 24 April. No staff were aware that he had stopped making calls. They reassured my investigator that he would have had the opportunity to use the telephone every day and that he must have chosen not to use it. Contact with friends and family is critical when a prisoner is otherwise isolated by being on basic. I accept that the man may have had the opportunity to use the telephone, and it may well be coincidental that he stopped contacting his family at the same time that his regime was reduced to basic. I trust that the Governor will reinforce the importance of prisoners on the basic regime maintaining contact with friends and family.

### **Racism**

122. The man made many allegations of racism against prison staff, not just at Wakefield, but at other prisons as well. Other prisoners alleged to my investigation team that there was a racist culture at Wakefield, and they were concerned that the man's treatment was affected because he was a black prisoner. On one occasion, the man asked to go to the segregation unit because it was a "black environment". When asked about this during interview, the seventh Officer was surprised that he thought that the segregation unit was a black environment. Although no black or minority ethnic officers worked on the wing, neither did any work in the segregation unit.
123. My investigation team spoke to the PO about her role as Race Equality Officer. She told the team that she was well supported and brought her concerns directly to the Deputy Governor or Governor who promoted the diversity agenda. Race equality meetings were held every month and were well attended. They were chaired by the Deputy Governor. (Although the IMB's role is to observe rather than participate in prison meetings, I was disappointed to discover that the Wakefield IMB had not attended any of the race equality meetings for which my investigation team were given minutes, in spite of being invited. I am assured that the appointment of another member of the IMB has reinforced their own commitment to the diversity agenda and they now attend every meeting.)
124. The Race Equality Officer explained the process by which she investigates allegations of racism. She explained that all complaints

with a racist element or marked by the prisoner as racist are brought to her attention. She said that each allegation is investigated: "it's a conversation, then you look for documented evidence and then formulate a recommendation or an outcome from the enquiries". I am reassured that, at the inspection in April 2005, HM Chief Inspector found that the process for investigating racist allegations was sound.

125. My own investigation team were also satisfied that the procedure for investigating complaints of racism was theoretically robust. However, as a consequence of the man's ABC, he could not speak with the Race Equality Principal Officer, a female member of staff, alone. A male member of staff had to be present, so that he did not breach of the conditions of his compact. The man's allegations were sensitive in nature and were about B wing officers. His meeting with the Race Equality Principal Officer took place in an office on B wing. Although she could not explicitly remember which male member of staff was present, and there is no record of his identity, I am concerned that it was likely to be a B wing officer. The Race Equality Principal Officer said that the man did not seem to be intimidated by the officer's presence and she believed that he spoke candidly about his perceived racial treatment.

**The Head of Residence should ensure that, where on rare occasions it is necessary for a racial investigation to be observed, it should be observed by someone independent, for example the IMB, and not by an officer from the same wing.**

126. The man said that he was frustrated he could not speak to a black officer about the racism he felt he was experiencing. In fact, he did speak once to a Diversity Officer who is himself black. However, he accused the Diversity Officer of being racist as well and would not speak to him again. When my investigation team asked the Race Equality Principal Officer about BME representation among the workforce at Wakefield, she said that the Prison Service's minimum required ethnic mix had been achieved. However, she acknowledged that almost all of the black or minority ethnic members of staff worked in roles without access to prisoners. In fact, she could only name two officers at Wakefield who were of a black or minority ethnic background. I am extremely concerned about the impact that this continues to have on a prison with a significant proportion of BME prisoners.
127. The Chief Inspector's report from April 2005 showed that 16 per cent of prisoners at Wakefield were black or minority ethnic. I do not underestimate the difficulty of recruiting a representative ethnic mix of officers and ensuring that they are front line staff. Indeed, when my investigation team put these findings to the Governor, she shared the concern. The Governor of Wakefield explained that there are a number of Operational Support Grades (OSGs – a grade below an officer and a non-contact grade) who are black or minority ethnic.

Additional support has been provided to help them through the required examination process to become officers.

128. My investigation team analysed figures for segregation, control and restraint and basic regime broken down by ethnic origin. From this crude assessment, they did not find an over-representation of BME prisoners. They also noticed that these figures were provided and discussed at every race equality meeting. The man told the psychiatrist that he felt “singled out” by staff and he alleged that staff were racist on many occasions. My investigation found no evidence of overt racism at Wakefield. However, it is difficult to rebut the man’s perception, shared by others, that the needs of BME prisoners are not sufficiently appreciated by an overwhelmingly white workforce.

**The Prison Service should ensure as far as possible that there is an appropriate ethnic mix of staff working with prisoners at Wakefield.**

129. During the investigation process, my investigator met the team from HM Inspectorate of Prisons carrying out a further inspection in December 2008. By this time, my investigator was concerned about the number of allegations of racism she had received from prisoners at Wakefield, in addition to those made by the man. The inspection team routinely looks at the treatment of black and other minority ethnic prisoners and their perception of that treatment. Although the inspection report remains unpublished at the time of issuing this draft, my investigator has received informal feedback of the outcome. The inspectorate has indeed found that black or minority ethnic prisoners perceive that they are treated unfairly as a result of their race. However, the inspectorate’s own examination of the treatment of prisoners broken down by race (for example, access to courses, IEP status, likelihood of segregation, use of restraint) found no discernible differences.
130. I understand that black and other minority ethnic prisoners may feel that they are unfairly treated as a result of their ethnicity. I am concerned that there are insufficient role models on the wing to promote cultural diversity. However, I am confident that the systems in place to investigate allegations of racism are robust when appropriately employed. I am also pleased to learn that HM Inspectorate of Prisons has not found that prisoners are not treated differently according to their ethnicity. Nevertheless, the Governor will wish to improve BME prisoners’ perception of their treatment at Wakefield, and I suggest that a better balanced staffing mix would be an important step in achieving that aim.

### **Complaints procedure**

131. I am concerned about the man’s experience of the complaints procedure. My role as Prisons and Probation Ombudsman is to

investigate prisoners' complaints that cannot be resolved under the internal procedures. I maintain a good working relationship with Wakefield while dealing with such complaints. I cannot sensibly compare one prison's handling of complaints with another because there are too many varying factors, such as the make-up of the each prison's population. However, I can say that I have had no reason to doubt the effectiveness of Wakefield's complaints structure in general, and I only examine the man's own experience.

132. PSO 2510 – Prisoner's Request and Complaints Procedure governs the way that Prison Service staff answer complaints made by prisoners. There are three stages to escalate a complaint. First, the complaint goes to a frontline officer. The PSO suggests that most complaints should be resolved at this stage. Secondly, if the prisoner is not content with the response received after the first stage, they can submit the complaint to a Governor for consideration. The final stage within the establishment is for the complaint to be submitted to the Governing Governor for consideration. If the complaint cannot be resolved after the third stage, the prisoner may approach my office. In total, the man made eight complaints during his last time at Wakefield, some of which remained unanswered when he died. Of those that were answered, he received an initial reply within the required three working days.
133. According to Chapter 11 of PSO 2510, "any written allegation against a member of staff must be investigated". The matter must first be referred to the staff member's line manager and an investigation conducted. The PSO goes on to say:

"A prisoner who has made an allegation against a member of staff which, on investigation, has been deemed to be unfounded should be given a written warning not to repeat the allegation, followed where necessary by a formal order."
134. All of the man's complaints made during his most recent time at Wakefield were allegations about members of staff. The first mentions "female officers" and then he moves on to being more specific, repeatedly complaining about the second SO and also the Governor and the female Officer. When my investigation team spoke to the Governor about how complaints of this nature are dealt with at Wakefield, she explained that she expected complaints to be dealt with at the lowest possible level. That would mean that a complaint about a senior officer should be dealt with by a principal officer, and so on.
135. In fact, most of the man's complaints were dealt with by staff senior to those named in the complaint. However, he made a complaint on 26 April when he accused the second SO of being "racist" and stopping his wages "without good reason". The SO responded to that complaint, as follows: "in relation to the issue of pay, you were not and will not be paid for periods where you have failed to attend for labour". During

interview with my investigation team, the second SO could not recall whether the SO spoke to her about this complaint. Due to the allegation of racism, the complaint was also referred to the Race Equality Principal Officer and dealt with under the prison's race equality procedures, as explained above. Again, the second SO did not specifically remember speaking to the race equality team in relation to this complaint.

136. The man's complaints were not always coherent. Staff responses were brief and frequently asked him to be clearer about what he was complaining about. After the man's exchange with the female Officer on 2 June, he made a complaint about her, alleging that she was racist. The second SO responded, without recording that she had spoken to the staff involved or to the man about what had happened. The second SO said that staff may not recall her speaking to them about the complaint because she did not do so formally, but discussed matters raised in the complaint in a general way.
137. I have been disappointed to learn of the lack of contact between the IMB and a prisoner of the man's profile. He was well known to staff and routinely complained about his treatment at Wakefield. Despite his mental health problems, he was subject to an ABC and placed on the basic regime. However, the only complaint that the IMB responded to involved them speaking to staff and not seeking out the man. When the man was complaining about his treatment by staff, it is surprising that the IMB did not speak to him as well as to the staff involved. I have chosen not to make a formal recommendation but will send a copy of my report to the Chair of the Board for their consideration.
138. When my investigation team asked the Governor about the operational level at which complaints are routinely dealt with at Wakefield, she said it was to empower wing staff to resolve matters locally. In this way, the Governor hopes to promote communication among staff and prisoners. This is laudable, and I share the view that grievances should wherever possible be resolved at the lowest level possible. However, I am concerned that, in practice, staff dealing with matters in which they or their close colleagues are involved may not approach their task with the appropriate degree of rigour and detachment. There is more than one example of the man's complaints being answered without staff speaking either to him or to the staff mentioned in the complaint.

**The Governor should review the operation of the complaints system to ensure that responses to complaints are sufficiently rigorous and evidence-based.**

#### **The man's complaint of 28 May**

139. The man's complaint written on 28 May was answered by the fifth SO three days later. The complaint mentioned the Governor, who the man accused of "laughing in his face". When my investigation team spoke

to the fifth SO, he explained that, when he first looked at the complaint, he did not think he could deal with it because it was about a governor and it would have to be referred to someone more senior.

140. In this complaint, the man also asked that “someone independent” deal with the matter. The fifth SO was not intending to deal with the complaint, but the man came into the wing office while he was there. The fifth SO spoke to him about another matter, which he resolved. After that conversation, the fifth SO thought that he was in a position to deal with the issues the man had brought up in the complaint. In fact, he had not spoken to him about anything contained in the complaint. He told my investigators that he was worried that, by asking the man about his complaint, the conversation would last a long time.
141. The complaint contained two possible warnings of the man’s thoughts of self harm. He wrote “suicide is an option!” and that he was dying and did not want treatment. I accept that the wording of the complaint was confused, but it is disappointing that the fifth SO did not recognise either indication of possible suicidal ideation. When asked during interview, the fifth SO said that he “did not register” the sentence about suicide being an option. When offered the opportunity to review the complaint and his response by my investigator during interview, the fifth SO remained of the view that he would not have handled it differently even with the benefit of hindsight. He told my investigator that he had assessed the man’s presentation during their conversation and had not judged that he was at risk of self harm. The fifth SO said he was confident in ACCT procedures and would have opened one if he felt it was necessary.
142. My investigator was sufficiently concerned about the fifth SO’s approach to this complaint that she brought it to the attention of the Governor following his interview. The Governor took a copy of the complaint and agreed to take the matter forward. Nevertheless, I make the following recommendation:

**The Governor should remind all staff that, if a complaint mentions thoughts of suicide or self harm, staff must speak to the prisoner as a matter of urgency and consider opening an ACCT document.**

#### **Suicide threat**

143. Staff and prisoners told my investigation team that they were surprised that the man took his life. So far as I have discovered, he had not spoken to any prisoner about suicide or self harm. Moreover, the fifth SO did not register his written threat, judging it as a manifestation of the man’s frustration rather than as a serious intent to kill himself.
144. One prisoner recalled overhearing the man shouting at the eleventh Officer that he wanted to kill himself the night before he took his life. However, the eleventh Officer was not actually working on B wing that

evening. He was involved in the incident with the man on 2 June, when he shouted through his door following his altercation with the female Officer. The prisoner alleged that the eleventh Officer responded to the man's suicide threat by telling him to "do it then". My investigation team put the allegation to the eleventh Officer. The eleventh Officer said that he would have taken any threat from the man seriously and would not have responded in such a way. He said that he might have waited until he calmed down, but would have spoken to him about any such statement to establish whether it was true.

145. My investigation team could not discover any more evidence either to support or refute the allegation. During the eleventh Officer's interview, there was good evidence that he had built up a rapport with the man. There is also evidence that the man was a challenging prisoner and would have been frustrating for staff to deal with. I trust that the exchange did not take place as the prisoner recalled it, and I trust that the Governor will remind her staff to take every suicide threat seriously.

### **Emergency response**

146. The man was found during the morning roll check. A radio call was made and an ambulance called without delay. As the prison was in a night patrol state, the healthcare response had to wait to be collected from the healthcare centre. Nevertheless, the HCSO estimated he took only three minutes to reach the cell.
147. After consideration of the emergency medical response on the morning of 6 June in his clinical review, the clinical reviewer concludes:
- "The nurse responded quickly and appropriately. There were no life signs and very clear signs of rigor mortis and therefore quite rightly no resuscitation was attempted as the man appears to have been dead for some time."
148. The HCSO remembered that, when he reached the cell, the man was still in a seated position leaning against the wall. The Night Duty Officer recalled that the man's size and the stiffness of his condition meant that there was some difficulty lowering him to the ground. The Night Officer explained that the dimensions of the cell made it hard to find the space, and they may have still been trying to lay the man down ready for resuscitation when the HCSO arrived. I am bound to say that I am surprised it took more than the three minutes before the HCSO's arrival to move the man into an appropriate position for resuscitation. However, if there was a delay it would plainly not have changed the outcome given the onset of rigor mortis.
149. The family were concerned whether the man sustained a head injury as part of the resuscitation efforts. The HCSO remembered taking over lowering the man's body and described "cradling" his head as he was brought to the ground. I trust that such care was taken and the

resuscitation was carried out in an appropriately respectful manner. Certainly the staff interviewed spoke respectfully about the man and seem to have had regard for his dignity.

### **Family liaison concerns**

150. During my investigator's meeting with the family, they raised several concerns about their liaison with the prison in the weeks following the man's death. I have dealt with their concerns about his care in the previous sections. Here, I consider the problems they described with the family liaison arrangements.
151. The officer who was appointed as family liaison officer by the prison is one of five family liaison officers at Wakefield. She undertook the Prison Service Family Liaison Officer training in November 2004 and has been the appointed family liaison officer for other families following deaths of Wakefield prisoners.
152. The family asked the family liaison officer whether the man was receiving his medication. The family liaison officer knew that he was on medication for diabetes because she saw the medication being removed from his cell by the police. However, the family liaison officer did not know that the man had a mental health condition. During interview, she said she would not expect wing staff to know whether he was on medication for his mental health:

"No, it's medical in confidence. The wing staff might be aware that the man goes to the medical hatch to collect his medication, but that would be the only thing they know."
153. The family liaison officer also mentioned a previous self harm attempt to the family during their visit to the prison. From their discussion that day, the family understood the man's attempt to harm himself had taken place not long before his death. They were concerned that they had not been told of this previously. My investigator asked the family liaison officer which self harm incident she was referring to in their discussion, and she responded that she mentioned when the man harmed himself in 2006, while he was at Whitemoor. When asked whether she knew of any later attempts to harm himself, she responded, "None whatsoever, not while he was within our prison."
154. Every prisoner arriving in custody nominates who they consider to be next of kin. The details are recorded in the prisoner's core record and on a national computer system. The man did not name a relative, but nominated someone he was corresponding with. Strictly speaking, the family liaison officer should have contacted the listed next of kin before consulting the man's telephone and visits records to determine who he appeared to be in contact with. However, on this occasion, the family liaison officer contacted those closest to the man and appropriately maintained contact with them.

155. PSO 2710 - Follow up to Deaths in Custody governs the Prison Service's obligations to family after a prisoner has died in their custody. It requires that the prison:

"Arrange notification to the next-of-kin and any other person reasonably nominated by the prisoner as soon as possible in a suitable manner giving an accurate factual account of what has happened."

156. The related guidance to family liaison officers has more detail of what is expected following a death in custody and suggests that face-to-face notification is best. The family liaison officer explained to my investigator that she wanted to break the news of the man's death to his family by telephone because they lived over 180 miles from the prison. She said that she thought the family should know as soon as possible, and to tell them in person would have meant hours of delay. The guidance in fact suggests that the "using the telephone is too impersonal to use in delivering news of a death to the family and should be used only as a last resort". When distance is a problem, the guidance suggests, "a dedicated Family Liaison Officer or chaplain based in the area nearest the family home could inform the family face to face." I understand that the family liaison officer made the decision to break the news to the family over the telephone with their best interests in mind, but she was not working within Prison Service guidelines.

**The Head of Safer Custody should remind all family liaison officers at Wakefield of the contents of Prison Service guidance for liaison with bereaved families.**

157. In accordance with the guidance, the man's family was invited to visit Wakefield and look around the cell where he died. PSO 2710 also requires the prison to "hand over personal possessions and monies to the appropriate person in a suitable manner". The family told my investigator that they were invited to Wakefield and were grateful to the prison for arranging their transport. However, they were concerned that the man's cell had been "staged" for their benefit. They described shower gel in his cell that was not his, and bedding that did not belong to him. My investigator put their concerns to the family liaison officer who explained:

"I mean I feel quite upset that the family have actually said that, they felt it was staged, it sort of took me a bit by surprise really. The property that was left in the cell was toiletries and other bits and pieces that were actually, belonged to the prison, that we give out to offenders in prison, sort of bars of soap, flask, the television. The cell when the man died was sealed obviously until [the police] said we could have the cell back. When I knew the family were coming I asked the wing staff to do a cell

clearance which they did and take out the man's personal belongings, and I asked them to leave the cell as it was found on the morning ... I didn't want the cell to look bare and empty, I wanted them to leave some things in that were in the cell, but take out the man's personal belongings so I could give them back to the family on the day, and as far as I understood it, that's what they'd done. When I went into the cell with the family, there was still bits and pieces, like his flask in the cell, and the bed was made on the day when he died anyway, so nothing was changed, the cell had not been altered at any stage, as far as I'm concerned, it was as it was when the man died apart from his personal belongings taken out."

158. The man used a bed sheet to make the ligature that he used to suspend himself. The family were concerned that they could not then understand how his bed was made when they visited the cell, especially as the family liaison officer told them that the bed was left as it was from when he was discovered. Upon questioning by my investigator, the family liaison officer explained that a prisoner could have a spare set of sheets in their cells. Therefore, she thought that the man must have used the second set of sheets to make the ligature. (I cannot confirm or deny this.)
159. During the family's visit to his cell, they also noticed that the cell next door had been taped, using yellow and black stripy tape across the observation panel and on the door of the cell, as if it were a scene of crime. The family were worried that, given their other concerns about the "staging" of the cell, the cell next door was actually the cell where the man died and they were being misled by the prison. My investigator asked the family liaison officer about this matter in interview, but she could not recall the tape on the door. When she visited the wing, my investigator noticed that the tape was still on the neighbouring cell. An officer explained that a prisoner had set a fire in that cell and it was yet to be released for use by other prisoners. I trust that this allays the family's suspicions.
160. The family told my investigator that the prison had offered to pay for the funeral but that they felt they had no control over the funeral arrangements. They said that the prison had selected cheaper options, for example a lower standard of coffin. When my investigator asked the family liaison officer to explain the prison's involvement in funeral arrangements during interview, she said:

"I've contacted the Funeral Directors and they've sent the bill directly to us, so the bill wouldn't go to the family, the bill is on my desk at this moment in time ... Any arrangements to do with the funeral is done by the family. All I ask for is the bill and say you know, as long as it's reasonable you know, we will pay the cost, that's all ..."

161. Clearly, the Prison Service must not restrict what the family may arrange for the funeral of someone who has died in their custody. However, if these arrangements result in costs beyond those reasonably incurred, the family should pay the balance. The man's family told my investigator that they would have been happy to do this. The family liaison officer assured my investigator that the prison gave the funeral director no specification for the funeral but simply arranged for payment to go through the prison. Supplementary guidance to family liaison officers alongside PSO 2710 suggests that the prison should offer to pay a reasonable sum, around £3,000, and should liaise directly with the funeral director to arrange payment. The family liaison officer discharged the prison's obligation in this respect. However, there seems to have been some miscommunication between the family, the funeral director and the prison. This is most regrettable, and I hope that the Governor will work with the appointed family liaison officers to ensure that such a misunderstanding does not arise in the future.
162. Following receipt of the draft report, the man's family were concerned that suicide prevention measures were not put in place before he died. The investigation team considered the assessment of his risk throughout the process. I am careful not to apply the benefit of hindsight in my investigations. In interviews, staff assured my investigator that that they were trained and confident in ACCT procedures and would have opened an ACCT document if they thought that the man was at risk of self harm. The man's behaviour and mood was being monitored through the ABC. Any concerns about risk of self harm or suicide would have been recorded in that ongoing record and checked by duty governors. There is no evidence of any such concern. Staff told my investigation team that they did not think that the man was at risk of self harm. All staff were surprised by his death. His low mood was attributed to being on the basic regime, and staff took measures to improve his wellbeing. Still, they did not think that he was at risk of self harm. Given the information available to staff at the time of their judgements, I do not think it was unreasonable for staff not to have opened an ACCT document.

## CONCLUSION

163. The man was not alone amongst BME prisoners in his view that he was being treated unfairly at Wakefield. However, as HM Inspectorate of Prisons has found in its most recent inspection, this perception of unfair treatment is not borne out by an analysis of access to courses, IEP status, likelihood of segregation, use of restraint, etc. Nevertheless, it is clear that more must be done to improve the persuade BME prisoners that Wakefield lives up to the Prison Service's vision of treating all prisoners fairly and with respect for their diversity. I have suggested that an important step would be by increasing the proportion of frontline staff from a BME background.
164. While the decision to place the man on an ABC was not improper, staff's use of the compact was flawed. Neither the man nor officers fully understood the reason the ABC was opened and the terms of the ABC were difficult to enforce. They were also ignored by some female staff, which undoubtedly added to the man's confusion.
165. Equally, given his abusive behaviour and apparent targeting of staff, the decision to reduce the man to the basic regime may not have been unreasonable. However, the process followed was not satisfactory, and this investigation has revealed that some staff thought the decision itself was wrong. In practice, the man responded badly to the downgrading and isolated himself from his family.
166. The man made numerous complaints about how staff treated him. The complaints were 'investigated' without speaking to the people involved. This did nothing to reassure him that his treatment at Wakefield was fair.
167. The man was undoubtedly both a challenging prisoner and a vulnerable man himself. However, while I have criticised aspects of his treatment, I also wish to acknowledge that many staff appear to have worked well with him.
168. I agree with the clinical reviewer that the actions taken on the morning that he was discovered were appropriate and timely.

## RECOMMENDATIONS

1. The Head of Healthcare and the Head of Residence should work together to ensure that, when a prisoner is on the caseload of the mental health inreach team, they should attend the initial review meeting to set up an ABC and also attend subsequent reviews.

The prison accepted this recommendation, with the following response:

“Mental Health team to be invited as regular attendee to ABC meetings. Mental Health Team co-ordinator to be informed of anyone being considered for ABC before meeting to ensure current caseload offenders are flagged up as such.”

2. The Head of Residence should ensure that the reason for starting an ABC is clearly and specifically stated on the document and the reason is effectively communicated with the prisoner.

Following the issue of the draft report, the prison accepted this recommendation. In response, they wrote:

“ABC document to be reviewed at next ABC meeting (November 09) to ensure reasons are clear and written document is given to all offenders subject to ABC outlining why the document has been opened and ensure wing rep attending meeting or wing manager/safer prisons manager speaks directly to offenders to explain the process and outcome when they are placed on ABC.”

3. The Governor and the Head of Residence should consider introducing an audit and training package to accompany the ABC system.

The prison only partially accepted this recommendation.

“Safer Prisons awareness package can be altered to include ABC awareness. Performance unit to be asked to look at feasibility of an internal audit protocol for ABCs.”

4. The Governor should remind staff that personal officers should be involved in IEP reviews when available.

The prison accepted this recommendation and issued a notice to staff to remind them of the involvement of personal officers in IEP reviews.

5. The Head of Residence should ensure that, where on rare occasions it is necessary for a racial investigation to be observed, it should be observed by someone independent, for example the IMB, and not by an officer from the same wing.

The prison accepted this recommendation, with the following response:

“Any investigations such as this go via Race Equality Officer who may task their assist staff to pursue the enquiry. To discuss with REO using staff from wings/areas other than originating unit to carry out this work. IMB to be invited to discuss this proposal with REO and Residential manager with oversight for equalities issues.”

6. The Prison Service should ensure as far as possible that there is an appropriate ethnic mix of staff working with prisoners at Wakefield.

The Prison Service is yet to respond to this recommendation.

7. The Governor should review the operation of the complaints system to ensure that responses to complaints are sufficiently rigorous and evidence-based.

The prison accepted this recommendation and undertook to take the following action:

“An advice document will be compiled and made available to all staff, with particular focus on managers. This will include clear guidance on how to respond to a complaint that has an inclusion of suicidal or self harm related issues, as well as general guidance on making through and evidence based responses.”

8. The Governor should remind all staff that, if a complaint mentions thoughts of suicide or self harm, staff must speak to the prisoner as a matter of urgency and consider opening an ACCT document.

The Governor accepted this recommendation and reissued a notice to remind staff of their obligations following any threat of self harm.

9. The Head of Healthcare and the Chaplain should remind all family liaison officers at Wakefield of the contents of Prison Service guidance for liaison with bereaved families.

The prison accepted this recommendation and reminded all FLOs at Wakefield of the importance of the Prison Service guidance for liaison with bereaved families.