

A Report by the  
Prisons and  
Probation  
Ombudsman  
Nigel Newcomen CBE

---

**Investigation into the death of a man at  
HMP Isle of Wight in April 2010**

## ***Our Vision***

*To be a leading, independent investigatory body,  
a model to others, that makes a significant contribution  
to safer, fairer custody and offender supervision.*

This is the report into the circumstances surrounding the death of a man. He was discovered hanging in his cell at HMP Isle of Wight in April 2010. He was 23 years old. I offer my condolences to the man's family and friends for their loss.

The investigation was carried out by one of my investigators. A clinical review of the man's healthcare was undertaken by a doctor on behalf of Isle of Wight Primary Care Trust. HMP Isle of Wight cooperated fully with investigation. I apologise for the length of time it has taken to issue this report.

The man had a history of self-harm. In the five months in custody before arriving at the Isle of Wight, he took an overdose of medication and also tried to hang himself on four occasions. After he was sentenced, he moved to the Camp Hill site of HMP Isle of Wight but the escort documents completed by staff at his previous prison, HMP Winchester, did not provide any information about these incidents of self-harm. This was a serious omission, about which we make a recommendation, but the investigation does not find that this affected the eventual outcome.

The man had a range of problems and was frequently in trouble at Camp Hill, most often for having a mobile phone, which he seems to have used to speak to his children. He missed his family and had tried, without success, to get a move nearer to them, not helped by the mishandling of his application by the prison. In a disproportionate response to a child protection issue, he was banned for some time from seeing his children, although by the time of his death these visits had resumed. According to other prisoners, in the weeks before his death, a senior manager was unduly pressurising him about the source of his mobile phones. The manager firmly denied anything untoward. He also had several outstanding disciplinary hearings, including one the day before his death.

In spite of all these issues, neither staff nor prisoners saw any signs that the man intended to harm himself and the investigation was not able to establish what led to his actions. A number of recommendations are made to address areas of concern raised by this man's sad case.

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.

**Nigel Newcomen CBE**  
**Prisons and Probation Ombudsman**

**June 2013**

## **CONTENTS**

Summary	5
The investigation process	7
HMP Isle of Wight	8
Glossary	9
Key events	10
Issues	22
Conclusion	30
Recommendations	31

## SUMMARY

1. On 26 March 2009, the man was remanded into custody at HMP Winchester. Four days later, he took an overdose of medication. After a brief stay in hospital when he refused treatment, he was transferred to the prison healthcare centre and monitoring and support measures were put in place. He told staff that everything had overwhelmed him. The monitoring and support measures remained in place until 7 April.
2. Three days later, the man was transferred to HMP Bullingdon. Over the next four months, staff found him hanging on four occasions, and in one of these incidents he became unconscious. The reasons he gave for harming himself were frustration with various prison procedures. He was subject to monitoring and support measures because of his risk of suicide and self harm.
3. The man returned to Winchester in August and, eventually, the support measures were withdrawn. Several entries in his prison records refer to him breaking prison rules and wanting to make telephone calls at time when prisoners were locked up. .
4. The man was sentenced to 30 months imprisonment in October and transferred to Camp Hill. On his arrival, the nurse in reception noted the overdose because it was in his medical records. However, the nurse did not know about the attempted hangings and the man did not tell him.
5. The following month, the man was put onto the basic level of the Incentives and Earned Privileges (IEP) scheme after staff judged that his behaviour did not meet the required standards. The next day, staff reported their concerns about the man's behaviour with his young children during a visit and he was banned from having contact with them, or any children, for three months. Staff also saw him with a mobile phone and he was put on closed visits for three months.
6. The man was often found with a mobile phone in his possession. At the time of his death, he had two outstanding disciplinary hearings for having a mobile phone, as well as one for assaulting a prisoner. A disciplinary hearing for having a mobile phone was held on the morning of his death. The previous day, he had refused to co-operate with staff who wanted to search him and his cellmate for a phone. He had tried to brush past one of the officers. Staff restrained and then took him to the segregation unit. When he arrived, a routine medical examination found no injuries.
7. The duty governor adjourned the hearing until the officer who first restrained the man could be present. He then returned to the wing. At lunchtime, he told his cellmate that the head of operations and security (who was also the duty governor that day) had questioned him about where he had been obtaining the mobiles phones. After lunch, he spoke to two other prisoners and again complained about the governor putting pressure on him about the source of his mobiles phones.

8. The man was locked in his cell on St Thomas's wing sometime after returning there between 3.00pm and 3.30 pm on an afternoon in April as he did not have work or education that day. The officer who unlocked cells at 4.30pm did not see that anyone was in the cell and so did not open the door. When his cellmate returned at 4.45pm, he saw the man lying almost on the floor, hanging from the window bars. He alerted staff who cut the man down and made resuscitation attempts. An ambulance was called but neither the staff nor paramedics could resuscitate him. The prison doctor certified his death at 5.14pm.
9. Prison managers activated their death in custody plans and offered support to prisoners, especially the man's friends, and to the staff involved. They discussed how to break the news to his family and then asked the police in the family's home area to send a family liaison officer to their home in Bedfordshire. Family members later visited the prison to see the cell and talk to some of their relative's friends.
10. There were no obvious signs that the man would attempt to harm himself at Camp Hill and the investigation has not been able to discover why he took this action. The head of security and operations denied putting him under undue pressure about the source of his mobile phones. We make seven recommendations on weaknesses that were found during the investigation. These relate to health matters, checking cells, emergency equipment and procedures and liaison with families after a death.

## THE INVESTIGATION PROCESS

11. This office was notified of the man's death on 21 April 2010. The investigation was opened five days later when the investigator visited the prison. She spoke to the head of the Camp Hill site of the Isle of Wight prison, members of the Independent Monitoring Board (IMB) and representatives of the Prison Officers' Association. She also visited the man's cell and collected his prison records.
12. Notices were issued to staff and prisoners informing them of the investigation and inviting anyone who had relevant information to contact the investigator. There were no responses. The long delay in issuing this report is regretted. This was due to the extended absence of the investigator and a backlog of cases during the course of the investigation.
13. The investigator asked Isle of Wight Primary Care Trust (PCT) to commission an independent review of the clinical care the man received at the prison.
14. The investigator and the clinical reviewer visited the prison to interview healthcare staff. The investigator returned twice more to interview a number of staff and several prisoners. She also attended the clinical review panel meeting.
15. One of the Prisons and Probation Ombudsman's family liaison officers contacted the man's family to ask if they had any questions or issues they wished to discuss. She and the investigator later met his father and solicitor. His father set out the family's concerns. These covered why he was not watched more closely as he was suffering from depression, events in the days leading up to his death, the manager who was pressurising him, why his children were prevented from visiting him, why he was refused a transfer to another prison, why his nose appeared broken after death and not all of his property being returned to the family.
16. At the end of the investigation stage, the investigator met the Governor to discuss the findings.
17. After the man's family read the draft report, they contacted our office through their solicitor to make a number of observations. They believe they were treated disrespectfully as members of the gypsy community. Staff spoke to them rudely, lost documents they sent to Camp Hill and destroyed some of their relative's property without consulting his parents. They are deeply concerned to learn of their relative's attempts to hang himself at Bullingdon and are shocked that this information was not made available to them or staff at Camp Hill when he transferred. The actions of a senior officer in describing the man's self-harm as "attention seeking" also caused them concern. The final concern is that, on one occasion staff shouted at him and required him to go to his cell when he was in the middle of a conversation with his solicitor despite him explaining this to them .

## HMP ISLE OF WIGHT - CAMP HILL

18. HMP Isle of Wight was established on 1 April 2009, following a merger of Albany, Parkhurst and Camp Hill prisons and has approximately 1,700 prisoners on the three sites. Each site has its own director who reports to the Governor.
19. Camp Hill was built in the early years of the 20<sup>th</sup> century. It is a category C training prison holding adult men on short, medium and long sentences, received from the local prisons of Winchester, Lewes and the London area. (Prisoners are risk assessed when they go into prison and given a category based on their offence and the risk that they pose to the public should they escape. Category C prisoners are those who cannot be trusted in open conditions but who would not have the ability or resources to make a determined escape.) The prison has nine residential units. Because of the difficulty and expense of travelling to the Isle of Wight, the prison can be particularly unpopular some most prisoners and their families.
20. Health services at HMP Isle of Wight are commissioned by the Isle of Wight NHS Primary Care Trust. The prison's healthcare is clustered with Albany and is provided by Parkhurst. Parkhurst provides healthcare to the 1500 or so prisoners from the three parts of the prison and has a 12 bed in-patient facility (mainly providing psychiatric treatment). Prisoners' medical needs are dealt with by an out-patients department and primary nursing cover during the day. There is no overnight healthcare facility at Camp Hill.
21. Each prison has an Independent Monitoring Board (IMB) made up of members of the community. The Board's role is to monitor the operation of the prison and check that prisoners are treated fairly and decently. Each Board produces an annual report. The IMB report published in July 2009, identified prisoners having mobile phones as a particular problem.
22. HM Inspectorate of Prisons conducted an unannounced full follow-up inspection of Camp Hill in February 2009, 14 months before the man's death. (Another inspection has been carried out since.) Inspectors considered that the prison was not performing to an acceptable standard in any of the key areas. In particular, they found that suicide and self-harm prevention procedures were poorly implemented. Recommendations made following previous deaths in custody had not led to improvements in the use of anti-bullying and violence reduction measures. Staff-prisoner relationships were mixed, there was insufficient purposeful activity and too little strategic focus on resettlement.
23. Camp Hill has had seven deaths since 2004, when this office began investigating deaths in custody. We have considered whether there are any similarities between this death and the others but have found none of significance. To be clear which part of Isle of Wight prison is involved, the prison is referred to as Camp Hill in the main sections of the report.

## **GLOSSARY**

### **Assessment, Care in Custody and Teamwork (ACCT)**

24. ACCT operates in all prisons to monitor and support prisoners assessed as at risk of suicide or self-harm. Once placed on ACCT, the prisoner is subject to regular case reviews that should direct observations/conversations to be carried out at intervals determined by their perceived level of risk and check whether identified actions to support the prisoner have been achieved.

### **Control and restraint (C&R)**

25. C&R is the only approved method by staff to restrain prisoners by force. It involves using physical holds to control the movement of the prisoner. Staff have to complete records for each incident. All prisoners should be examined by a nurse, and if necessary a doctor, following the use of force. A member of healthcare must be present during a planned use of force intervention. Ratchet handcuffs may be applied temporarily if, necessary to move a prisoner and to prevent injury or escalation of the incident.

### **Cellular confinement (CC)**

26. A prisoner can be confined to his cell as a punishment if found guilty at a disciplinary hearing, known as an adjudication. Often the punishment will also remove much of the in-cell activities that a prisoner has at his/her disposal: their radio, books, and magazines etc. The Ombudsman does not agree with the removal of all of these things. To leave prisoners confined to a cell with nothing to occupy them is too harsh and could be detrimental to their health and well-being.

### **Defibrillator**

27. A defibrillator is a machine that treats victims of sudden cardiac arrest by delivering a shock to the heart.

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

28. The Incentives and Earned Privileges scheme is designed to encourage and reward good behaviour in prisons. The scheme has three levels, basic, standard and enhanced. Prisoners move between levels according to their behaviour and performance. The higher the level, the more privileges a prisoner is allowed. Basic regime can be imposed for a number of reasons, usually involving a pattern of bad behaviour.

## KEY EVENTS

29. On 26 March 2009, the man was remanded into custody at HMP Winchester to await trial on a number of offences.
30. Four days later, at approximately 10.00pm, his cellmate told staff that the man had taken three to four boxes of citalopram (an antidepressant used to treat depression, anxiety and panic disorder) and was unconscious. Staff took him to hospital where he recovered consciousness. He declined treatment and discharged himself, so staff took him back to prison. They admitted him to the healthcare centre and put in place ACCT measures to give him additional support.
31. During an interview with the ACCT assessor on the morning of 31 March, the man said that “everything got on top of him”. He had not planned anything but had gone to take his tablets and had just decided to take them all. However, somewhat at odds with this statement is the fact that he had taken the time to write a note to his family. He also told the assessor that he had wanted to die but “Today is glad he didn’t die”.
32. The man remained subject to ACCT monitoring until 7 April and staff scheduled a post-closure review for the following week. On 10 April, he transferred to HMP Bullingdon and staff decided to give him time to settle in before holding the review. The ACCT post-closure review meeting had not been held when, on 20 April, staff re-opened the ACCT measures after he smashed up his cell and then tried to hang himself from the window bars. Staff cut him down, and moved him to a cell in the healthcare centre under constant supervision. (Constant Supervision is where a member of staff supervises a prisoner on a one to one basis, remaining within eyesight at all times and within a suitable distance to be able to physically intervene quickly.) He had also cut his neck several times with a razor.
33. The man told staff that he did not want to die but was frustrated because his visitors had been refused entry to the prison. The reason why his visitors were not permitted to meet him is unclear as three different explanations are mentioned in his records. Such lack of clarity is unhelpful and the man’s frustration is understandable. It is even more unfortunate that he had only recently been transferred and was still in the post-closure period of the ACCT process. Staff arranged for him to telephone his family and organised a visit for the following day. They continued to monitor him until 11 May when the ACCT was closed.
34. On 23 July, the man was found guilty of breaking prison rules by being “In possession of unauthorised article”. He was charged with possessing a mobile phone. A few days later he told the ACCT assessor that he had been found in possession of cannabis which belonged to his cellmate. His punishment was ten days cellular confinement (in the Segregation Unit) with no association, television, gym and loss of privileges.

35. On 25 July, an officer checking on the man saw him with a length of torn sheet around his neck, which he was trying to attach to the bed. The officer stopped him and then started the procedure for ACCT monitoring. A senior officer, an ACCT assessor, interviewed the man less than an hour later. He said that he was unhappy at having closed visits imposed but had no thoughts of suicide or self-harm. He had been made subject to closed visits after he told staff that cannabis they had found in his cell was his. (Prisoners or their visitors may be subject to a period of closed visits usually due to suspected, attempted or actual smuggling of contraband. During closed visits, a transparent screen separates the prisoner and their visitors and there is no physical contact.) The SO/ACCT assessor made the following note in the ACCT:

“[The man] has been at HMP Bullingdon before and healthcare have informed me he has done this before to manipulate staff to getting his CC’s [cellular confinement] done in healthcare rather than SSCU [Separation, Support and Challenge Unit as the segregation unit is known at Bullingdon.] [He] is a [sic] attention seeker when he breaks the rules will manipulate at the earliest opportunity. Risk appears low.”

36. At the case review the following day, the man told staff that he had kept some cannabis out of fear of his cellmate. Staff said that when he had completed his cellular confinement, they would transfer him to a different wing, away from the cellmate. They then closed the ACCT procedures.
37. Two days later on 27 July, having been alerted by the prisoner in the next cell, staff found the man hanging from the window bars. They cut him down and healthcare staff arrived and treated him. Staff then moved him from the segregation unit to the constant observation suite in the healthcare centre and opened an ACCT. The following day, after an ACCT case review, he moved to a normal cell in healthcare and the observations were reduced to half-hourly. They were further reduced to hourly and then one per shift but the dates are not recorded on the front of the ACCT booklet.
38. The man completed the ten days of cellular confinement but on the afternoon of 7 August, staff again found him with a noose around his neck which he had tied to the light fitting. He was unconscious and had to be cut down. Healthcare staff gave him oxygen. He was again put on constant supervision. A registered mental nurse wrote a long entry in the man’s wing record, including:

“When conscious became very angry, stating he would refuse to be admitted to inpatients and then started kicking the furniture. [He] then became distressed crying etc - saying that being in HCC [Healthcare Centre] was the reason why he tried to hang himself...he refused to walk to inpatients ... We were informed that [he] had secreted a razor blade which he intended to use on himself.”

Two days later, staff stopped the constant supervision and he moved to a normal cell in the healthcare unit.

39. On 18 August, the man moved back to HMP Winchester. He was still subject to the ACCT procedures. The monitoring eventually ended on 25 August and the post-closure review was held on 17 September.
40. Several entries in the man's record, by staff at Winchester, show that he was often in trouble because of alleged breaches of prison rules. Staff complained that he repeatedly asked to be allowed out of his cell to make telephone calls at times when all prisoners were locked up.

### **Events at HMP Isle of Wight – Camp Hill**

41. The man was convicted on 2 October 2009 and sentenced to a total of 30 months imprisonment for conspiracy to rob and handling stolen goods. On 19 October, he transferred to Camp Hill on the Isle of Wight. Staff at Winchester filled in a Person Escort Record (PER) form as is required when a prisoner transfers from one prison to another but not all the sections were completed in accordance with the guidance.
42. The second page of the form has space for information on any risks the prisoner may present to himself and others. The first category on the list is suicide/self harm. As the man had recently and frequently self-harmed, this section should have contained a summary of his actions and the ACCT Monitoring. Instead, the officer put a small diagonal line through the box which appeared to indicate that there were no issues of self-harm.
43. A nurse interviewed the man at Camp Hill as part of the normal reception process. He read the man's medical record and noted that, seven months earlier, he had taken an overdose of citalopram, an antidepressant medication. He did not tell the nurse about the occasions when he had attempted to hang himself. When asked, he said that he had no thoughts of suicide or self-harm. He told the nurse that he suffered from asthma but was not on any medication for it. The medical records do not state whether he was prescribed anti-depressants on his arrival at Camp Hill. When he arrived at Camp Hill, the medical records were changing from a paper based to computerised system. His notes before 3 December 2009 were not put onto the computer and were unavailable for our investigation.
44. The nurse discussed the man's overdose with one of his colleagues, a community psychiatric nurse (CPN). He told the CPN that he had no concerns about him at that time. The nurse told the investigator that the CPN's opinion was that, because the man's condition was not acute (severe) he would not be taken onto the CPN's caseload. The nurse also flagged up the information about the overdose on the medical record system, so that other members of healthcare department could see it.
45. The following day, 20 October, a member of staff copied an entry of 30 September from the man's offender assessment into the man's electronic case notes where all the wing staff could read it. It said:

“[The man] told me that he overdosed on sleeping tablets when he was first remanded and had to be taken to hospital as a result. He also reported suffering from depression but stated that he did not feel suicidal at the moment.”

46. The man applied several times to work in the kitchens at Camp Hill. On each occasion his request was refused, with one officer writing:

“I do not recommend him at the moment due to his poor attitude and his immature nature. He needs to apply at later [sic] date, such as when he gets his Enhanced Status and can show a more mature side to himself.”
47. On 4 November, the man applied for a transfer to another prison on compassionate grounds, saying that his father was not well enough to travel to the island. He named The Mount, Coldingley and Onley prisons in his application, all of them on the mainland. An SO refused the request, saying that the man had not been at Camp Hill long enough. He treated the request as a “progressive transfer application” rather than looking into any reasons why he might have grounds for a compassionate move. The records do not indicate why he did so. Progressive transfers are usually only allowed after 12 months.
48. The man continued asking staff about being given a compassionate transfer throughout the next few months. Staff told him that the medical information in support of the application had been lost and he arranged to have another copy sent. However, there is no evidence in his records that the application progressed at all.
49. The rest of the month was not a good one for the man. Staff suspected him of having a mobile phone but he was not found with one. He fought twice with another prisoner and both men had cuts and bruises treated. The fights led to him receiving an IEP warning. In the middle of the month, he started work in one of the textile workshops but did not reach the required standard of work and lost the job.
50. An SO explained to the investigator how the IEP scheme worked while the man was at Camp Hill. Throughout the month, staff mark prisoners on different subjects such as their work, cleanliness of cell and attitude to the prison. If a prisoner is on standard level and getting ten points or less, they are considered to fall into basic scores. In these circumstances, staff would issue an oral warning. During November, staff gave the man an IEP warning because of low scores and warned him that unless he improved, he risked being moved to the basic level.
51. As the man had low IEP scores in October and November he was moved to basic level. A major consequence of being on basic level is that the prisoner is not allowed a television in the cell. Normally this would have meant the man moving cells to share with another prisoner on basic but his cellmate volunteered to remain with him, even though this meant that he would not

have a television either. He said that he had asked to continue sharing as he knew that the man had had previous thoughts of self-harm. An SO agreed to keep the two men together.

52. On 23 November, the man's mother and his young children visited him. After the session was over, staff who had supervised the visits told managers that they had seen him teaching his two-year old daughter to swear. Staff in the Public Protection Unit at the prison emailed the probation office in Bedfordshire and Bedfordshire social services asking for advice and any relevant information they held on him.
53. The following day, the head of security at Camp Hill put the man onto closed visits for a minimum of three months. Staff had seen him using a mobile phone in his cell and told him to give it to them but he had flushed it down the toilet. Throughout his time in prison, the man often had access to mobile phones and staff in the security department tried to discover where he was getting them. This is discussed more fully later in the report. An SO told the man of the decision to put him on closed visits on 2 December and the man signed to say he had been told the reason why.
54. Meanwhile, staff in the Public Protection Unit (PPU) assessed the information from the visits staff and decided that the man's actions put his daughter at risk. As a result of this, they put him onto level one of the public protection measures. This meant that he could no longer have visits from, or contact with, any children, including his own. On 4 December, the man signed a note to say he had been informed of the decision and the reasons for it. PPU staff reviewed the decision after three months and, on 5 March 2010, they decided to remove him from level one. This meant that he could again have visits from his children.
55. The man completed a period of 28 days on the basic level of IEP and returned to standard level on 4 January 2010. A week later, staff placed him on report for having a mobile phone. (Staff had suspected him and his cellmate of having a mobile phone in their cell on 17 December but had insufficient proof to take any action.)
56. On 15 January, the man had an appointment with a doctor for a rash on his face. After prescribing antibiotics, the doctor asked him how he was doing generally. She told the investigator that she did this after seeing from his notes that he was being treated for depression. He told her that he was feeling "run down". The doctor noted that he was on a low dose of an antidepressant, so she increased the dose to 30mg and arranged to review him later.
57. The man returned to the doctor on 29 January complaining of an itchy rash on his back. He asked her to complete a prison form that would allow him, for medical reasons, to wear his own clothes or have his own bedding. She explained to him that, as all prison bedding is washed in non-biological powder, it was not the cause of his rash. She told him to speak to wing staff about using his own bedding.

58. The man saw one of the other doctors on 19 February, complaining of lower back pain after lifting weights. Three days later, at another doctor's appointment, he said that co-codamol helped reduce the pain but he had run out of tablets. The doctor prescribed more pain killers. He again asked the doctor to certify that he should be allowed to wear his own clothes for medical reasons. The doctor repeated that the prison doctors did not do that. On 24 March, he saw a further doctor who prescribed more co-codamol tablets for back pain.
59. On 8 April at about 5.15pm, an officer looked through the observation hatch of the man's cell. He saw the man lying on the bottom bunk bed, talking on a mobile phone. He and three other officers went into the cell and recovered the phone. Two days later, he had an adjudication hearing at which the duty governor referred the matter to an independent adjudicator (a judge who hears more serious charges.) He advised the man to consider speaking to his solicitor about the charges.
60. On 10 April, officers said they saw the man assault another prisoner by punching him on the head and face. An SO and an officer escorted him to the segregation unit, where staff searched him. They noted that he had no injuries and the man, when asked, reported none. Twenty minutes later, a member of the healthcare team examined him and assessed that he was fit to be held in the segregation unit. The matter was passed to the police to investigate.
61. At 10.30am the following morning, the man attended an adjudication hearing. The duty governor who held the hearing decided that the man would remain in the segregation unit until the police carried out their investigation. He was also placed on stage two of the anti-bullying procedures. This meant that for 28 days staff were required to monitor him more closely, particularly when interacting with other prisoners. On 14 April, a doctor again saw the man in the segregation unit. He told the doctor that the pain killers were no longer very effective. The doctor then prescribed tramadol, another painkiller. Throughout this time, doctors continued to prescribe antidepressants.
62. On 16 April, the man moved from the segregation unit to St Thomas's wing. A note in his records stated, "Happy to be here." The following day another entry recorded that he moved cells so that he was with a cellmate who was about his own age and that there were no problems with this. The only other entry of note was on 19 April. An officer wrote that the man went to the healthcare centre for his morning medication and attempted to return at lunchtime to collect his "in-possession" medication. When the officer checked with healthcare staff, they said that he had no such medication to collect.

### **The day before the man's death**

63. At lunchtime the day before his death, the man telephoned his offender manager (probation officer). At the time of the call, he was locked in his cell during the staff lunch break. He used a mobile phone, the possession of

which was contrary to prison rules. The offender manager immediately passed the information to the prison's security department who, in turn, told officers on St Thomas's wing.

64. At 1.30pm, four officers went to the cell which the man shared with his cellmate to search for the mobile phone. Two of those officers went into the cell and explained to the two men that they were looking for a mobile phone and they were going to strip search each of the men. The man's cellmate told the investigator that the man walked towards the officers, saying they were not going to search him. He added that, while the officers' attention was on his cellmate, he threw the phone out of the window. (Staff later found a mobile phone on the grass outside, fairly close to the man's cell window.) The two officers stayed in the cell to search the man's cellmate and the two remaining officers took the man out onto the landing to wait his turn.
65. One of the officers who took the man out onto the landing told the investigator in interview that, while waiting, the man became "more and more agitated". He tried to walk along the landing but the officers called him back. He told the officers that they were not going to search him and they insisted they were. He continued to pace for a few minutes. Then the officer reported he said, "I've got to get out of here; I'm getting out of here." He tried to walk away but the officer stood in his path and blocked him.
66. According to the officers' account, for a short while the two officers moved from side to side as the man tried to slip past one of them. One of them put his arms out to prevent this and the man attempted to push past. As he did so, the officer held onto his arm and shouted for staff to assist him. They fell to the floor and the officer held the man's left arm in an arm lock. Other officers came to his assistance and restrained the man using Control and Restraint (C&R) procedures. The other officer out on the landing took control of his head and another officer came out of the cell and took his right arm. Other staff arrived and put handcuffs on the man.
67. The man stopped struggling and calmed down, according to one of the officers who was situated out on the landing. Staff helped him stand up and gave him a pat-down search. Then two officers walked him to the segregation unit. On the way, they met a nurse, who had been called to accompany them, as is usual when a prisoner is taken to the segregation unit.
68. Once in the segregation unit, staff removed the handcuffs and the nurse asked the man if he had any injuries from being removed from the wing. He reported none and she did not see any sign of injuries either. She completed the medical form stating that the man was fit to be held in the segregation unit.
69. One of the officers involved in the search for the mobile phone completed a report of the incident, which he sent to the segregation unit staff. They then charged the man with assault and arranged to hold an adjudication the next day. He remained in the segregation unit overnight.

## The day of the man's death

70. The following morning, the duty governor that day held the adjudication and recorded that the man said he was not guilty, did not want to call witnesses and did not want legal assistance or representation. He then adjourned the hearing until an officer could be present. The duty governor also wrote a note on the form that said, "[The man] requested a compassionate transfer told how to go about this."
71. When the hearing ended, the man was released from the segregation unit to return to St Thomas's wing. At that time of the morning, prisoners were free to move around certain areas of the prison. There is no record of what the man did or where he went. When the investigators interviewed the duty governor, he told them that the segregation unit SO unlocked the door for the man. Afterwards, the SO told the duty governor that a prisoner was "waiting for" the man there.
72. Later in the morning, an officer was checking where all the St Thomas's prisoners were. He could not account for the man, who should have been in his cell because he was not assigned to work or education. This ties in with information from the man's cellmate who told the investigator that he met the man as he was returning to the wing at the end of the morning's work. He said that they laughed about getting rid of the phone the previous day.
73. Once the man was back in his cell, an officer spoke to him through the observation hatch in the cell door. He told the investigator that the man talked about the adjudication (he had been charged with assaulting this officer):
- "... he [the man] did ask me about the report, what was going on. And I did say, 'Well, I'll just make sure the governor knows' because the report said he was being done for assault. Now to a lot of prisoners that sounds bad, that he's actually punched someone or something like that. But I did explain to him through the door that I would make it perfectly clear to the governor that it was pushing, you didn't thump me or anything like that or you didn't use a weapon. He was quite happy with that. I can't remember if he said thank you or anything like that, he was not particularly upset in any way."
74. During lunchtime, the man told his cellmate about meeting the duty governor. He said that the duty governor had questioned him about where he had been obtaining the mobile phones. His cellmate told the investigator that the man said that the duty governor had said:
- "Tell me who it is and I'll leave you alone.' ... And he said, 'If you did assault [name of officer], I think, yes [name of officer], 'then I am going to come down on you like a ton of bricks,' and all that. Proper angry with him I think. How [the man] was sounding, it was like he was proper angry with him."

75. When interviewed, the duty governor said that no such conversation had taken place. After the adjudication hearing ended, he said he had discussed the possibility of a transfer to another prison with him. He pointed out that it might be difficult to persuade another prison to take him because of his record of having mobile phones. However, he denied questioning him or making any threats.
76. The duty governor said that he saw the man, very briefly, outside the administration block shortly after lunch. The man and another prisoner were standing outside and the man asked to speak to him. The duty governor asked if it was urgent and then said he would get a senior officer to speak to him. He estimated that the conversation lasted only a few seconds.
77. Another prisoner told the investigator that he and the man talked for about half an hour from 1.45pm. He said that they often talked together and, on previous occasions, the man had cried once or twice when referring to his problems. The prisoner said that the man's only real issue was pressure he was getting from the duty governor about mobile phones and the threats he was making to keep him from seeing his family. Their conversation on this occasion was also about, "his feelings, his thoughts, his worries..." He recalled that the man was "extremely upset and he was finding it hard..."
78. An officer told the investigator that he saw the man on the telephone on the ground floor, sometime between 2.15pm and 2.45pm. The records from the prisoner telephone system show that at 2.15 pm, he telephoned his solicitor and the call lasted 90 seconds. According to his solicitor, an officer shouted to his client to finish his call and get into his cell.
79. Another prisoner told the investigators that not long after (he estimated between 3.00 and 3.30 pm) he met the man and they walked back to St Thomas's together. He said that the man told him that he had been called down to the bottom part of the prison, to the visits hall or gate, the prisoner could not say which. He said that the man complained that the duty governor and another person, who he did not name, had been putting pressure on him to give them information.
80. The normal routine is that prisoners have their tea, the last meal of the day about 4.30 or 4.45pm. Staff go round each landing and unlock the prisoners who have spent the afternoon in their cells. If a cell is empty because the prisoner or prisoners are at work or some other activity, the cell remains locked. As prisoners return from work, they ask the officer on the landing to unlock their doors.
81. An officer and an SO started to unlock cells on the second floor at about 4.30pm. The officer took the cells on one half of the landing and the SO went round the other side. The officer looked through the observation hatch on each door and, when he saw a prisoner in the cell, unlocked the door for him to get his meal.

82. The man was in one of the cells the officer checked but the officer did not unlock the door. He told the investigator that he could not say for certain that he had looked through the hatch but he was sure that, assuming he had, he had not seen the man.
83. The layout of the cells means that prisoners cannot always be seen clearly when they are watching television. Another officer described the cells when interviewed. He said:
- “...the way the cells are designed the prisoners can’t watch their TV from their beds and most of them put their cabinets in front of the door and put the TV on the cabinet so they can watch it from their bed and this was blocking the door so whoever had gone down before then and looked through wouldn’t have seen anything in the cell.”
84. The investigator checked this during one of her visits and found that it was difficult to see past the locker into the cell. The locker is about four feet tall and when it is behind the door, the view from the observation hatch is partially obscured.
85. The man’s cellmate returned from work at approximately 4.45 pm and the officer opened his cell door. The man’s cellmate looked into the cell and saw the man at the back of the room. He had a sheet around his neck and attached to the window bars. He backed away from the door and called the officer over. The officer looked around the locker. He saw the man so he went into the cell, moving with difficulty past the locker. He was slumped, almost on the floor, under the window. The officer used his cut-down tool (a special knife which prison officers carry) to cut the sheet and lowered him onto the floor.
86. An officer and the duty governor were outside St Thomas’s wing when the duty governor’s radio sounded, raising the alarm. He ran and his colleague followed him onto the wing and up to the man’s cell. The duty senior officer assigned to respond to emergency calls that day told the investigator that he was called to St Thomas’s at “approximately 4.48pm”. When he arrived, the duty governor was outside the cell and the officer was just going into the cell. He told a fellow officer to keep a record of who entered the cell and at what time.
87. The officer entered the cell with difficulty, because of the position of the locker, to assist the man. He asked staff outside the cell to remove some of the furniture to give him more room. The duty senior officer organised that and checked that an ambulance had been called, which it had, at 4.51 pm. The officer checked the man for breathing and a pulse. When he found neither, he started chest compressions in an attempt to resuscitate him.
88. Two nurses were in the healthcare centre when they received a call for assistance at St Thomas’s wing. They were not given any other details, so took a bag of emergency equipment but not a defibrillator. They arrived at the cell a few minutes after the officer. At the cell, one of the nurses gave the

man oxygen through a mask while his colleague examined the man. She noted that his pupils were dilated, he was not breathing, had no pulse, was grey in colour and cold. She checked that staff had called an ambulance and asked for a defibrillator to be brought to the scene. When this arrived at 5.04pm, she attached it to the man but it said not to apply a shock.

89. The nurses and the officer continued with cardio pulmonary resuscitation (CPR) and the ambulance staff arrived at 5.06pm. The paramedics attached their heart monitor and examined the man. Six minutes later, one of the prison doctors arrived. She examined him and then, with the agreement of the nurses and paramedics decided not to continue with CPR. At 5.14pm, the doctor certified that the man had died.
90. After the staff went into the cell to assist the man, his cellmate walked down the stairs and met another prisoner whom he told what had happened. They sat outside the wing, in shock, while the other prisoners on the wing were locked in their cells. When staff realised that they were outside, they moved the two men to the exercise yard at the back of the building. They offered them the Listeners' service (Listeners are Samaritan trained prisoners who provide confidential support to other prisoners) and arranged for the man's cellmate to move into a friend's cell.
91. Prison managers held a "hot debrief" for the staff who were involved in finding and attempting to resuscitate the man. The aim of such meetings is to focus on reassurance, information sharing and how staff can support each other. It gives staff an opportunity to raise issues and the duty SO assigned to respond to emergency calls told the investigator that he had raised two matters, discussed later in this report. At the meeting, staff were offered the support of the care team.
92. After the man's death, prison managers discussed how to break the news to his family. Prison Service guidance recommends that prison staff meet the family in person to do this, if possible. One of the prison's managers considered the time it would take to drive to the family home. He was very aware that any delay in breaking the news risked the family being told unofficially rather than by prison managers. He also spoke to the police local to where the family lived. Taking account of the information they gave him and the distance, he asked the police to contact the family. A police family liaison officer then went to the family home and told them of their relative's death.
93. The prison manager then arranged for family members to visit the prison, see their relative's cell and talk to some of his friends. During the visit, he offered help with the funeral expenses, which was declined. He gave the family much of their relative's property and his cash. The man's father suddenly became unwell, bringing the visit to an unexpected end. The manager told the investigator that, at that time, he had discussed other items, such as bedding, with the family friend who had accompanied the man's father and was told that the items were not needed. However, the family later asked this office for

help in recovering the property, indicating that they wanted everything that belonged to him to be returned to them.

## ISSUES

### Information about previous self-harm

94. The Person Escort Record (PER) completed on transfer should summarise important information about the prisoner for the benefit of staff at the new prison. The second page of the form has space for information on possible risks the prisoner presents to himself and others. The first category on the list is suicide/self harm and the guidance notes state:

“To be completed if the [sic]:  
Has or has attempted to self-harm  
Is at known risk of self-harm (e.g. has threatened self-harm/on open ACCT plan  
Has recently been at risk of self-harm (e.g. post-closure phase of ACCT plan/PNC [Police National Computer] suicide/self-harm warning marker in the last six months ...”

95. As the man had taken an overdose and had had four incidents of self-harm by tying ligatures, staff at Winchester should have put this information on the PER form in October 2009 when he transferred to Camp Hill. (His most recent ACCT plan had been closed in August and the post-closure review was held in September.) They did not, so staff at Camp Hill did not have this critical information when he arrived. We make the following recommendation:

**The Governor of Winchester should ensure that reception staff enter all relevant information about prisoners on the PER form, especially relating to previous and current risk of self-harm.**

96. The nurse in Camp Hill reception noted that the man had previously taken an overdose of medication and flagged this up in his medical record. He did not know about the previous episodes of attempted hanging and use of ligatures and the man did not tell him. He discussed the man with a CPN colleague, indicating that he had no concerns about him at that time. As a result, the CPN decided not to include him in the mental health team's caseload.
97. It is not possible to say whether, if the two nurses had known about all the previous incidents of self harm, their decision would have been different. However, there is a great deal of difference between a single act of self-harm five months earlier and a series of five incidents spread over five months and only recently ended.
98. It should also be noted that the man was cared for by the prison doctors who saw him fairly regularly and prescribed antidepressants. As already noted, his computerised medical records begin on 3 December 2009 and earlier records were not available for the investigation. Therefore it is not possible to say whether he was prescribed anti-depressants when he transferred to, and during his early days at Camp Hill. However, a prison doctor examined him on 15 January 2010 and noted that he was on a low dose of an anti-depressant. So he must have been prescribed the medication before that but

we are unable to say when that began. It is also worth noting that, before his death, the man spent six months at Camp Hill without any incident of self-harm.

### **Mobile phones and the management of security**

99. The man appears to have been able to obtain a number of mobile phones in prison. Several of the prisoners told the investigator this and he had a number of adjudication hearings for possession of a phone which is contrary to prison rules. One of his cellmates said that he used the mobiles to call his family every day.
100. The fact that the man was able to obtain a succession of phones brought him to the attention of the security department and the Head of Operations and Security at Camp Hill. As with all security governors in prison, it was part of his responsibilities to try to prevent phones, drugs and other forbidden items from being brought into the prison.
101. Other prisoners told the investigator that the Head of Operations and Security spoke several times to the man asking him about the phones. They said that the man had told them this and that he was upset as a result. One prisoner said that he often chatted to the man. During the six to eight weeks before his death he said that he often mentioned the Head of Security and Operations. He said:

“[The Head of Operations and Security] was extremely proactive in persecuting and discriminating towards [man] continually and making his life hard for him, little comments here and there, I will catch you, I will make your life hell, stupid little things like this, if you carry on I will make sure you don't see your family.”

102. The prisoner said that the man cried once or twice as they discussed this. He said it had quite an effect on the man and his response was:

“a mixture of aggression, hate and sadness. Obviously, he was annoyed that he'd allowed him to get to him as much as [Head of Security and Operations] did. He broke down [the man's] walls and [he] was quite a strong fellow.”

103. The man's cellmate recalled the conversation they had at lunchtime on the day of the man's death when the man said that the Head of Operations and Security was “really pressuring him“ to say where he was getting the phones. A further prisoner used the same phrase when he described meeting the man about 3.00pm that day. After his death, a prisoner told staff that the Head of Operations and Security had been bullying the man. The man did not make any formal complaint about this.
104. The Head of Operations and Security was interviewed during the investigation. The investigator went through the list of allegations against him and he denied them all. He was clear that he had not discussed where the

man was obtaining his phones, nor had he made any threats. When told of the questions the man said he had asked him, the Head of Operations and Security said:

“It’s quite ironic in a way these questions [where he was getting the mobiles from and was an officer bringing the mobile phones in] because they are sort of questions I would ask to be honest. That is the sort of questions I would ask with somebody with his background activity. But I don’t ever recall being involved in that dialogue with him.”

105. The Head of Operations and Security was very firm that he did not bully the man or threaten him. He said that, while he did sometimes point out to prisoners the consequences of their actions, he did not ever threaten anyone. There is a fine line between being very clear with prisoners about what might or will happen if they break the rules and bullying. He was adamant that he did not overstep the mark. One of his colleagues mentioned in passing to the investigator that he was a very effective head of security when judged by the number of contraband items seized. The Head of Operations and Security suggested that the allegations of bullying were made in an attempt to have him removed from the prison.
106. On the other hand, the man told his cellmate and other prisoners that the Head of Operations and Security was putting pressure on him and making threats. Such contradictory evidence cannot be reconciled but it seems unlikely that an active security manager would not at least have questioned the man about the source of his mobile phones. Ultimately it is not possible to be sure what actually happened. However, it is important to include the information given by those who knew the man as an indication of any concerns and his state of mind in the period leading up to his death.
107. None of the prisoners who spoke to the investigator had any concerns that the man was so affected by what he described as the Head of Operations and Security’s threats that he would harm himself. Even a fellow prisoner, who described him as tearful, said that he did not see any signs that the man would take the action he did.

### **The man’s requests for a transfer to a prison on the mainland**

108. Staff told the investigator that many prisoners do not like being imprisoned on the Isle of Wight and a lot of them request a transfer. The man asked to be transferred to a prison on the mainland on a number of occasions, citing family reasons for doing so. He first asked not long after arriving on the island and asked the Head of Operations and Security on the day of his death whether a transfer was possible. The prison’s policy was that a move to a mainland prison had to be part of a prisoner’s normal sentence progression and could only take place after he had been at the Isle of Wight for twelve months. When the man arrived at Camp Hill, he had less than 12 months left to serve so would not have been regarded as eligible for such a move.

109. The man also applied for a transfer on compassionate grounds. However, when he asked about the progress of the application, staff said that they could not find the paperwork and the medical information in support of the application had been lost. He then provided them with a copy. He also raised the issue at an adjudication hearing with the Head of Operations and Security on the morning of his death. By that time his release date was only ten weeks away. It is apparent that his request was not dealt with properly or efficiently, even when he made repeated requests to try to find out what was happening. Contact with his family was very important to him and it is unacceptable that his request for a transfer was not properly considered and he never received a reply.

**The Governor should ensure that requests for compassionate transfers are promptly and properly considered.**

### **The decision to ban the man from all contact with children**

110. In November 2009, visits staff reported concerns about the man's behaviour towards his children during visits. They said he had been teaching his two year old daughter to spit and swear. Staff in the PPU asked for advice and information from his offender manager in Bedfordshire Probation Trust and Bedfordshire Social Services. The prison's public protection file indicates that at that stage he was put on level one public protection measures. This barred him from having any contact with children and meant that he could not have visits from his own children or even talk to them using the telephones in the prison. (His cellmate told the investigator that the man used mobile phones to talk to his daughter and say goodnight to her each day.)
111. The records indicate that PPU staff did not receive a reply from the local probation office or social services at that time, but on 5 March 2010 there is a note to say "I have spoken to the relevant depts and they have no concerns relating to the incident on visits. He will now be warned of his behaviour and the consequence of any repeat."
112. While the original concern and referral for advice is understandable, the decision to ban all contact, even in a supervised setting, was a disproportionate response to the situation. Leaving the ban in place for three months was an unacceptably long period to prevent a father's contact with his children.

**The Governor should ensure that child protection decisions are based on solid evidence, proportionate and regularly reviewed.**

### **Health**

113. The clinical reviewer concludes that the clinical care the man received was equivalent to that which he would have been given in the community. Throughout his time at Camp Hill, he was seen regularly by members of the healthcare staff. His doctors' appointments were concerned with acne, back

pain and depression and for each condition, he was prescribed medication. When he was in the segregation unit, a doctor or nurse visited each day.

#### *In-possession medication*

114. In the medical records, some entries made by doctors indicated that they were prescribing large quantities of medication at one time which the man was able to have in his possession. As he had taken an overdose of his medication in the early part of his sentence, this was of concern to the investigator and clinical reviewer.
115. The clinical reviewer discussed the issue with the senior doctor at Camp Hill. She explained that even if the notes stated 200 tablets, no prisoner would be issued with more than a week's supply at a time (a maximum of 56 tablets). At the time of the clinical review meeting, the healthcare department had drafted the policy for staff to carry out risk assessments as to whether a prisoner would be allowed to have certain medications in his possession. The prison doctor also suggested that, once the policy was in use, it should be monitored. The meeting agreed that the draft policy should be approved by the end of 2010 and an audit of the procedures carried out by the middle of 2011.

#### **Emergency response**

116. When staff discovered the man hanging, they called for healthcare staff to give medical assistance. The two nurses who went to St Thomas's wing had not been given the detail of the emergency and did not know what they would find at the cell. They took emergency equipment but not a defibrillator, which a member of staff had to bring subsequently. One of the nurses told the investigator that it was only when he saw a prisoner crying, that he realised the seriousness of the situation.
117. In many prisons and in other parts of Isle of Wight prison, staff use radio codes to alert healthcare staff to the type of emergency that has arisen. This allows them some mental preparation and helps ensure that they take the emergency equipment they are likely to need.
118. The issue was discussed at the clinical review meeting held at the prison on 9 September 2010. The panel recommended that codes be used at Camp Hill and, in common with the other sites of the prison, Code Red for situations where blood was involved and Code Blue for breathing difficulties. The prison governor responsible for healthcare agreed to introduce the codes at Camp Hill within two months of the meeting. During his interview with the investigator, the Head of Operations and Security said that he had introduced the use of the codes earlier that week. The investigator has checked with Camp Hill and been assured that healthcare staff now routinely take a defibrillator in response to a Code Blue call.

#### **Unlocking cells and checking prisoners**

119. As described earlier in the report, prisoners at Camp Hill organised the cell furniture to make it more comfortable and practical to watch television from the beds. The site of the electrical socket in the cells means that they have to pull a cupboard into the centre of the room and that, with a television on top of it, this partly obscures the sight line from the observation panel in the door.
120. An officer explained that staff did not unlock every cell at around 4.30pm. He unlocked the door only if he saw someone in the cell when he looked in. Prisoners were usually locked up in the afternoon if they do not have a job. However, they could be unlocked for several reasons; for example to collect medication from the healthcare centre (as the man often did), go to the gym or library. He does not remember specifically looking into the man's cell. Officers spend a lot of time each day checking cells and locking and unlocking doors. There is nothing inherently questionable about the officer being unable to remember checking that particular cell at that particular time.
121. The man was in the cell when the officer initially went round the landing but it appears he did not see him. When the cell was unlocked about 20 minutes later, he was found hanging. The last known movement of the man was when he and a fellow prisoner walked up the hill to St Thomas's wing some time after 3.00pm. It is not possible to say at what point between 3.00pm and 4.48pm the man tied the ligature. Nor is there any evidence as to his intentions when he did so. However, he had been at Camp Hill long enough to expect an officer to unlock him for tea at about 4.30pm.
122. The arrangement of the cupboard and television is significant because it restricts how much of the cell an officer can see when he or she looks in. The two obvious solutions are to move the electrical sockets or to forbid the prisoners from moving the cupboard across the door. Neither of these options seems practical. Rewiring would be very costly and forbidding prisoners to move their cupboards would have a disproportionately negative impact on their daily lives, especially for those who have to spend many hours locked in their cells because of a lack of activity places in the prison. It would add considerably to staff burdens and would cause resentment across the wings. We therefore recommend:

**The Governor should ensure that staff exercise due diligence and view the entire area of a cell when checking whether it is occupied or not.**

### **Bruising to face**

123. When the man's family saw him after his death, they were concerned about the bruising to his face and possibly a broken nose. The day before his death, he had been restrained and moved to the segregation unit. However, the nurse who examined him after he arrived in the segregation unit saw no signs of injury and noted that he told her that he had no injuries.

124. The investigator also raised these concerns at the clinical review panel meeting and also read the post mortem report. The panel members discussed the matter and the clinical reviewer summarised their conclusions:

“[The senior prison doctor] commented that due to asphyxiation [man’s] appearance would have been very different to that which his family remembered. It was also noted that resuscitation can be very physical and bruising may well have been due to that. The pathologist’s report clearly states that [man] had not been the victim of an attack. It was discussed that the pathologist is well respected in his field and is always looking for signs of assault when examining prisoners.”

125. The post mortem report describes in great detail the marks on the man’s body. The pathologist concluded that, “There were no features to suggest that [the man] had been the victim of attack or restraint by any other person.” We are therefore satisfied that the bruising was not due to any actions before [his] death.

### **Issues raised at the hot debrief**

126. The duty SO assigned to respond to emergency calls that day told the investigator that he had raised two issues at the hot debrief. Neither impacted on the treatment the man received but were about ways to improve the procedures for managing such emergencies. Firstly, he had not been able to speak directly to the Head of Operations and Security over his radio because the location of St Thomas’s wing disrupted the signal. He told the investigator that technical staff at the prison were looking at how to solve that problem.
127. His second point was that prisoners were unlocked for association when the police team and the man’s body were still in cell. This meant that some prisoners had to walk past the open cell to reach the stairs. He stood in the doorway, trying to block the scene as much as possible but would have preferred a privacy screen to put across the door to block it from public view. We agree that the lack of privacy was unfortunate.

**The Governor should ensure that there is sufficient privacy at the scene of a death or serious incident to maintain the dignity of the victim.**

128. When the debrief began, two of the staff who played a major part in the attempted resuscitation were still being interviewed by the police. Their absence meant that those present did not hear directly from them and they themselves did not benefit from sharing what had happened.

**The Governor should ensure that all key staff involved are invited to and able to attend hot debriefs after a serious incident.**

### **The man’s property**

129. Prison staff returned some items of property to the man’s family. As his father was taken ill during a visit to the prison after his death, staff consulted a family

friend who had accompanied him, about what to do with the remainder. The friend indicated that it was not required. However, the family later said that they wanted all of his belongings returned. By then, the remaining items had been destroyed. Staff assumed the family friend who had come with the man's father had a representative role during the visit, but it would have been better practice to have raised the issue again directly with the family before destroying the man's bedding and other personal items. We therefore make the following recommendation:

**The Governor should ensure that, following the death of a prisoner, staff fully consult family members about the return of all outstanding property before destroying any of it.**

## CONCLUSION

130. This was a young man who had only ten weeks left to serve in prison at the time of his death. During the first five months of his imprisonment, he harmed himself five times, once so seriously that he had become unconscious. In response to this, staff supported him under the suicide and self-harm prevention measures for a significant length of time. Information about these risk factors should have been passed on when he transferred from Winchester prison but from the time of his arrival at Camp Hill until his death, he did not harm himself and gave no indication that he was a risk. He saw prison doctors often and they prescribed him antidepressant medication.
131. In the months before his death, the man faced a number of problems. For three months he had only closed visits and was not allowed to see his children. He had a number of disciplinary hearings, for possessing mobile phones and two for assaulting a prisoner and an officer. His application for a compassionate transfer to a prison closer to his family was not properly considered. The lack of contact with his family was particularly stressful for the man who placed great importance on this.
132. The perspective of the prisoners who spoke to the investigator was that his greatest problem was being pressured by a prison manager. Several said that he had complained to them for weeks before his death about being threatened if he did not reveal the source of his mobile phones. The governor involved firmly denied putting any pressure on him beyond pointing out the negative consequences of having a reputation for having mobile phones in prison.
133. While it is regrettable and poor practice that information about his previous incidents of self harm was not passed on when he moved to Camp Hill, there is little indication that this affected the eventual outcome. The man gave staff and other prisoners at Camp Hill no reason to believe that he had any thoughts of self-harm or that he would take such action. He did not leave a note explaining his actions so it is not possible to know his thoughts or intention at the time. .

## RECOMMENDATIONS

1. The Governor of Winchester should ensure that reception staff enter all relevant information about prisoners on the PER form, especially relating to previous and current risk of self-harm.

This recommendation was accepted. The Prison Service responded:

“The Head of Operations ensures that all reception and security department staff that complete PERs enter all relevant information about prisoners on the PER form, especially relating to previous and current risk of self-harm.” To be reviewed for compliance in June 2012.

2. The Governor should ensure that requests for compassionate transfers are promptly and properly considered.

This recommendation was accepted. The Prison Service responded:

“It is the intention of HMP Isle Of Wight to treat each Compassionate Transfer Application with the respect that such a request deserves. The system requires that the offender submits a Transfer Application stating the reason for a ‘Compassionate’ rather than a ‘Progressive’ transfer. Supporting evidence is required of the reason for the transfer. The prisoner’s Offender Supervisor (OS) will conduct checks on the authenticity of the evidence and make recommendations to Population Management, who then process the transfer. Often, the OS will be aware of serious family issues and is best placed to confirm the compassionate transfer progresses. The system employed operates effectively in most cases. Requests are accommodated as soon as practicable but we are restricted by population pressures. If the situation was considered urgent, then the Head of Resettlement would contact appropriate establishments direct in an attempt to facilitate a transfer. The system can fail if an offender cannot or is not willing to provide evidence of compassionate reasons.”

3. The Governor should ensure that child protection decisions are based on solid evidence, proportionate and regularly reviewed.

This recommendation was accepted. The Prison Service responded:

“HMP Isle of Wight is conscious there have been occasions that the child protection decisions at the Camp Hill site may have been “over cautious”. A process will be put in place to ensure that an operational manager with the responsibility for public protection reviews all child protection decisions at Camp Hill site.” To be completed in July 2012.

4. The Governor should ensure that staff exercise due diligence and view the entire area of a cell when checking whether it is occupied or not.

This recommendation was accepted. The Prison Service responded:

“An operational instruction is to be issued to ensure that all staff are aware of the diligence required when checking a cell for occupancy.” To be completed in June 2012

5. The Governor should ensure that there is sufficient privacy at the scene of a death or serious incident to maintain the dignity of the victim.

This recommendation was accepted. The Prison Service responded:

“The local policy on the management of prisoners at risk of harm to self to others and from others outlines the necessity for the First on Scene and the Orderly Officer to ensure that either the deceased or injured party are provided with sufficient privacy to uphold their dignity when undergoing treatment.”

6. The Governor should ensure that all key staff involved are invited to and able to attend hot debriefs after a serious incident.

This recommendation was accepted. The Prison Service responded:

“The local policy on the management of prisoners at risk of harm to self to others and from others, outlines that all key staff involved in a serious incident should attend the hot debrief. A reminder has been sent out to all operational Manager F's and above relating to this subject matter.”

7. The Governor should ensure that, following the death of a prisoner, staff fully consult family members about the return of all outstanding property before destroying any of it.

“The local policy on the management of prisoners at risk of harm to self to others and from others, details what should happen with a deceased prisoner's property. The responsibility to ensure the correct procedure is followed is with the appointed Investigation & Inquest Liaison Officer (IILO).”