



A Report by the
Prisons and
Probation
Ombudsman
Nigel Newcomen CBE

**Investigation into the death of a man
in November 2014 at HMP Featherstone**

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 investigation report into the death of a man, who was found hanged in his cell at HMP Featherstone on 5 November 2014. He was 28 years old. I offer my condolences to the man's family and friends.

An investigator was appointed. A clinical reviewer reviewed the man's clinical care and treatment. The prison cooperated fully with the investigation.

The man received a five year prison sentence in June 2013 and had been at Featherstone since October 2013. This was not his first time in prison. The man was prescribed medication for depression shortly after he arrived at Featherstone. He said that he had never harmed himself or attempted suicide before and no one had any concerns that he was at risk.

Initially the man appeared to settle well, but staff began to have some concerns about him and they suspected he was using drugs. In March and August 2014, the man was assaulted by other prisoners and said that there were people in the prison who were out to get him because of a grudge from outside. In October, he told an officer that he had been pressured into holding some unauthorised items for other prisoners. The man was reluctant to say much about the incidents because of fear of reprisals, which were not fully investigated.

On 4 November, the man appeared to overreact to a minor reprimand for smoking where this was not allowed. The man denied he had been smoking, smashed the contents of his cell and threatened staff. He later calmed down and agreed to move to a new cell. His behaviour was out of character, but no one discussed with him whether anything else lay behind it. The man appeared to settle and the staff had no concerns about him that evening. Early the next morning, a night patrol officer found the man hanged in his cell. It was apparent that he had died.

Despite the man's extreme reaction to events on 4 November, there was little to indicate that he was at heightened risk of suicide and I consider that it would have been difficult for staff to have predicted his actions or prevented his death. However, I am concerned that Featherstone did not take effective action to monitor or address the man's suspected drug use or investigate thoroughly when there were clear signs that he was the victim of bullying.

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

July 2015

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SUMMARY

1. In June 2013, the man was sentenced to five years imprisonment. He transferred to Featherstone in October 2013. When he arrived, the man said he had no physical or mental health problems and had never tried to harm himself. Six weeks later, the man told a doctor he felt depressed and the doctor prescribed an antidepressant, which he continued to take until he died.
2. Staff, who considered the man to be a model prisoner, began to notice a change in his behaviour. He was involved in two fights and, at the end of January, staff monitored him under violence reduction procedures for two weeks. Throughout 2014, there was intelligence indicating that the man took drugs, but no action was taken.
3. In March 2014, the man reported that a prisoner had assaulted him but did not know who the assailant was. He said that he felt threatened but staff took no action. Another prisoner assaulted him again in August but staff took no action.
4. On 16 October, the man told staff that he had been pressured into holding steroid tablets, drug paraphernalia and a mobile phone in his cell. He asked officers to search his cell, confiscate the items and place him on a disciplinary charge so that it would not appear that he informed them of this. The man said that he did not want to be monitored under violence reduction procedures. Nothing further was done to investigate his claims and the man was waiting for a disciplinary hearing at the time he died.
5. On the morning of 4 November, the man was working in the kitchen and he and another prisoner were reprimanded for smoking in the kitchen toilets. The man denied smoking and became angry and aggressive. He later smashed the furniture and fittings in his cell and threatened staff. However, he quickly calmed down and moved to another cell. Managers told him he would be charged with a disciplinary offence, but no one discussed with him whether anything else lay behind his violent outburst, which was out of character. There is no record that anyone considered whether his risk of suicide or self-harm was raised as a result.
6. At 6.39am on 5 November, the night patrol officer found the man hanged in his cell. He was clearly dead and staff did not attempt to resuscitate him.
7. We are concerned that Featherstone did not respond effectively to intelligence that the man was using drugs or use violence reduction procedures effectively to support him and investigate the evident threats against him. This might have helped identify his underlying distress. However, despite the man's extreme reaction to being warned about smoking on 4 November, we recognise that it would have been difficult for staff to have predicted his actions or prevented his death. We make two recommendations.

THE INVESTIGATION PROCESS

8. The investigator issued notices to staff and prisoners at HMP Featherstone informing them of the investigation and inviting them to contact her if they had relevant information. No one responded.
9. The investigator obtained copies of the man's prison and healthcare records and interviewed 12 members of staff and one prisoner at Featherstone.
10. The investigator informed HM Coroner for Staffordshire (South) of the investigation and we have sent him a copy of this report. The coroner sent us the post-mortem examination report.
11. NHS England (Shropshire and Staffordshire) appointed a clinical reviewer to review the man's clinical care at Featherstone.
12. One of the Ombudsman's family liaison officers contacted the man's mother who asked why her son had smashed the contents of his cell on 4 November 2014. She thought this behaviour was out of character and an extreme reaction to having been caught smoking in the wrong area. The man's mother also said that Featherstone had not given her all of the man's letters and photographs. Staff checked and assured us that they had returned all of the man's belongings to his mother. The man's mother did not comment on the draft report.

HMP FEATHERSTONE

13. HMP Featherstone is a medium secure prison in the West Midlands. It holds up to 687 men in seven house blocks. Staffordshire and Stoke on Trent Partnership NHS Trust run healthcare services.

HM Inspectorate of Prisons

14. The most recent inspection of Featherstone was in October 2013. Inspectors noted that although the prison was generally safe, debt to other prisoners was a clear problem for a significant minority of prisoners, which was linked to the availability of drugs and tradable medicines. This was partly responsible for many of the violent incidents and bullying in the prison. Investigations were not always recorded well. Support for victims was inadequate and they accounted for a significant proportion of those who self-harmed. In their survey, the inspectorate noted that more prisoners than at comparator establishments said that it was easy to get illegal drugs at the prison. Drug testing on grounds of suspicion was not always completed on time.
15. Inspectors found that safer custody arrangements were good. Staff identified prisoners at risk of suicide and self-harm and appeared caring.

Independent Monitoring Board

16. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help ensure that prisoners are treated fairly and decently. In its annual report for the period to 31 October 2014, the Board was concerned about the amount of illegal substances in the prison and the effect it had on prisoners' behaviour, with debt and subsequent bullying.

Previous deaths

17. There has been one other self-inflicted death at Featherstone since 2012. There are no similar issues with the man's death.

KEY EVENTS

2013

18. On 11 June 2013, the man was sentenced to five years imprisonment for possession of a firearm and having a blade in a public place. He began his sentence at HMP Hewell and transferred to Featherstone on 2 October 2013.
19. At a health screen when he arrived at Featherstone, the man told the nurse that he had no concerns about his mental or physical health and was not currently taking any medication. He said that, before his sentence, he had used £70 of heroin daily, but had completed a methadone detoxification programme at Hewell and did not need any more support for drug problems. The nurse noted that the man said that he had never harmed himself before and he had no thoughts of doing so.
20. On 12 October, an officer introduced himself as the man's personal officer. He noted in his prison record that he appeared to have settled in well on Houseblock 1 and had no concerns. The man said that he had no thoughts of suicide or self-harm. (Subsequent entries between 26 October and 12 January 2014 from the personal officer, and two other officers noted that the man was well behaved and a 'model prisoner'.)
21. On 27 November, a doctor examined the man who said he had groin pain from an old injury, when he had injected heroin. The doctor found no cause for concern, but prescribed the man meloxicam (an anti-inflammatory and pain relief medication). The man was unhappy as he had wanted to be prescribed tramadol (a strong opioid painkiller often traded and misused in prisons).
22. The man told the doctor that he had been feeling tearful and depressed. He said that he had no thoughts of harming himself or of suicide, but had previously been prescribed mirtazapine (an antidepressant). The doctor prescribed the man one month's supply of mirtazapine tablets, to be issued to the man a week at a time. The man continued to be dispensed mirtazapine weekly until he died.

2014

23. On 10 January 2014, staff doing a random check of mail, read one of the man's letters, in which he wrote that he had been 'smashed' all day. The security department advised staff on the man's houseblock to monitor him for signs that he was taking illicit drugs and report any findings to them.
24. On 16 January, officers had to separate the man and another prisoner when they were fighting. The man said that he knew the prisoner from outside prison and that they had fought because the other prisoner was criticising him to mutual acquaintances at Featherstone. A nurse examined the man and noted that he had superficial scratches on his neck. Both prisoners were placed on level 2 (known as VR2) of Featherstone's violence reduction

monitoring scheme. They were both charged with a disciplinary offence under Prison Rules. The man's disciplinary hearing was suspended for him to get legal advice from his solicitor, but the case was never dealt with. Featherstone could not explain this.

25. Under VR2 (which was used when there was clear evidence of violence or anti-social behaviour), staff monitored the man's behaviour and made daily entries in his violence reduction support and management plan. While on VR2, the man was not allowed a television in his cell and spent more time locked in his cell than normal.
26. Later on 16 January, staff read another of the man's letters during random mail monitoring. The letter suggested that the man might be involved in trafficking unauthorised items into the prison during visits. Security staff suggested that the man's incoming post should be monitored, but there is no record that this was done.
27. After the fight, in line with the violence reduction monitoring scheme, the Senior Officer (SO) reviewed the man's Incentives and Earned Privileges (IEP) scheme status. (The IEP scheme aims to encourage and reward responsible behaviour. Under the scheme, prisoners can earn additional privileges such as extra visits, more time out of cell, the ability to earn more money in prison jobs and to wear their own clothes. There are three levels, basic, standard and enhanced.) The SO placed the man on the basic regime until 30 January, when he returned to standard level.
28. The SO completed a violence reduction review on 30 January, and noted that the man had not been involved in any other incidents and could move to VR1, the lowest level of monitoring under the violence reduction policy. Another SO reviewed this on 6 February, and as the man's behaviour had been good, ended the monitoring.
29. On 22 February, an officer noted that the man's behaviour had deteriorated (although she did not record how) and that he had become friends with another prisoner who had a negative attitude. The officer wrote that she had warned the man about his behaviour and he had seemed to accept her advice.
30. On 26 March, the man told an officer that an unknown prisoner had attacked him from behind. A nurse treated him for a three inch cut on his face. The next day, the man told a member of staff that he had heard there was a contract out on him because of things he had done outside prison. The man said that he was scared and asked to move to another houseblock or the segregation unit. Staff told him this was not possible, but they would monitor him. Security staff asked houseblock officers to investigate the assault and report back to them.
31. According to Featherstone's violence reduction policy, the incident should have resulted in an investigation being completed within 72 hours. The outcome of the investigation should have been noted in the man's prison

record. The policy also directed that the victim of anti-social behaviour should be supported and consideration given to, among other things, whether they should be moved to another houseblock and/or to another work placement. There is no evidence of any further investigation or that staff supported the man in line with the policy.

32. On 25 April, as part of random mail monitoring, staff read a letter the man had written to a prisoner at HMP Birmingham, in which he said that he was stealing things from the kitchen, where he had just started working. Security staff advised that he should be removed from the job immediately, but this did not happen. In May, staff noted some further minor concerns about the man's behaviour on the wing and at work in the kitchen.
33. On 4 June, staff read another of the man's letters to his friend in Birmingham, in which he said that his kitchen job was not well paid but that he did not mind as he enjoyed working there and stole items to sell to other prisoners. He said that he was using illicit drugs and had been smoking a lot of mamba (a synthetic cannabis substitute). The security department advised kitchen staff to search the man thoroughly, when he arrived and left for work. This did not always happen.
34. On 10 July, staff read a letter the man had written to a friend at HMP Hewell, in which he said that he had taken pregabalin (an anticonvulsant also used for neuropathic pain and often traded in prison), which he was not prescribed, and had smoked a 'spliff'. The security department instructed staff to monitor the man's mail for further information and for him to be drug tested. The man was never tested for drugs while he was at Featherstone.
35. On 17 July, Instructional officer gave the man a 'Work Effort Warning' because he was not working well in the kitchen. The man had been seen trying to steal a large packet of biscuits and was given an IEP warning. The man was sacked from his kitchen job the next day as he had received three IEP warnings. However, because of an administrative error, two of the IEP warnings had to be revoked and the man went back to work in the kitchen.
36. On 13 August, the man and another prisoner were found fighting on the houseblock. A healthcare assistant examined the man and noted that he had scratches on one side of his neck and a bruise under his right eye, although he said he was not in any pain. CCTV showed that the other prisoner had assaulted the man. This prisoner was placed on report, violence reduction monitoring and received an adjudication award of 28 days loss of privileges, suspended for three months.
37. In September and October, supervising staff in the kitchen caught the man trying to steal items and he received IEP warnings. An officer gave him another IEP warning after she found pieces of silver foil (a prohibited item associated with drug taking) in his cell. On 7 October, an officer reviewed the man's IEP status and lowered him to the basic regime for seven days as he had received three IEP warnings. (On 12 October, he received another

negative entry in his record, so he remained on the basic regime until 21 October.)

38. On 16 October, the man told the Supervising Officer (SO) that another prisoner (who he refused to name) was making him keep a mobile telephone and steroid tablets in his cell. The man asked if an SO could arrange for his cell to be searched and the items discovered. He said that he would rather face a disciplinary hearing than have other prisoners think that he had willingly given staff the information. He indicated that he might be prepared to tell the Governor (or whoever chaired the disciplinary hearing) who had asked him to hold the items. The man said he was not in debt, but had been threatened. We found no evidence that the man was in debt at Featherstone.
39. The man told the SO that he did not think the other prisoner would cause any further problems if the items were found during a cell search. He said that he did not want staff to monitor him under violence reduction procedures or have any other kind of support, as other prisoners might discover that he had informed staff. The man mentioned that he was still waiting for his mirtazapine tablets that week. (The SO chased this up and the man received his medication on 20 October.)
40. The SO and the houseblock manager, arranged for the man's cell to be searched that day. Staff found and confiscated a number of white tablets (which were later identified as steroids), some glass vials, a mobile phone and a charger. The man was charged with a disciplinary offence for possession of unauthorised items.
41. The SO referred the man for a mental health assessment, as he was concerned that the man had been bullied into holding the items and because there had been a break in him taking his antidepressants. On 17 October, a nurse completed a Threshold Assessment Grid (TAG) to assess the man's mental health. The man scored four out of a possible 24, indicating that there were no concerns about him being at risk of self-harm or suicide and he was low risk. The nurse noted that, although the man was at low risk of self-harm, he was at risk of abuse or exploitation by others and made a routine referral for the man to see a mental health nurse.
42. On 18 October, the man's disciplinary hearing (for the prohibited items found in his cell) was referred to the Independent Adjudicator (a district judge). (The man died before the hearing.)
43. On 31 October, the man told the mental health nurse that he did not know why he had been referred and had no problems. The mental health nurse recorded that the man appeared bleary eyed and a little sedated or intoxicated. The man denied any substance misuse and said that he had not slept well for several nights, and that he sometimes had trouble sleeping for no particular reason. The mental health nurse accepted this. The man did not want any mental health support so the mental health nurse discharged him from the mental health team caseload.

4 November 2014

44. On the morning of 4 November, the man worked in the kitchen. A catering assistant, told the investigator that the man had initially seemed his usual self. During the morning, the man and another prisoner went into the kitchen toilets. The assistant said that he shouted to them not to smoke in the toilets, as this was prohibited.
45. After a minute or two, the assistant followed them. He found the man and the other prisoner in one cubicle, with smoke coming out. The assistant said that he told them that he had already warned them about smoking and walked out of the toilets. The other prisoner followed the assistant out and blew smoke in his face as he passed him. The assistant told both men that he would give them an IEP warning. The assistant said that the other prisoner was annoyed, but walked off. The man then went to see another catering manager, to challenge the assistant's decision, but the manager agreed with the assistant.
46. The man left the manager's office visibly annoyed. He threw a cup he was holding against the wall and became very angry. The assistant pressed an alarm bell and officers came to escort the man back to his cell.
47. A prisoner and friend of the man, told the investigator that the man was not happy working in the kitchen and felt that the staff there did not like him. The man's friend said that the kitchen toilets always smelt of tobacco and that the assistant had no proof that the man had been smoking. The man's friend said that the man sometimes smoked spice (another synthetic cannabis substitute), but when he did so, he became relaxed and calm rather than angry.
48. It was approximately 11.00am when officers took the man back to his cell and the man's friend went to see him. He said that the man was swearing and said that kitchen staff had 'stitched him up'. The man's friend said that he told the man to calm down and passed him a cigarette under the door. The man said that he would have accepted the IEP warning if he had been smoking, but that he had not. The man's friend said the man alternated between quietly smoking a cigarette and kicking the furniture. The man then began to smash the contents of his cell and the man's friend described him as 'going crazy'.
49. Staff heard the commotion and went to the man's cell, but when they reached it, the man had covered his observation panel. As the man's cell was on the ground floor, a houseblock manager went outside and looked through the window. The man had broken the window and smashed his toilet, sink and furniture. The houseblock manager reported what she could see a senior manager. The man threatened to harm staff if they tried to come into the cell. He had stripped to his underpants and trainers and covered his body in shampoo and shower gel, to make it difficult for staff to restrain him.
50. The senior manager, the houseblock manager and another manager, and houseblock officers discussed what to do to keep the man safe. They tried to

persuade the man to let them into the cell and, although he refused, he agreed to uncover the observation panel. The houseblock manager organised and briefed the intervention team and returned to the man's cell door speak to him. The man agreed to dry himself and get dressed and, a few minutes later, he agreed to leave the cell voluntarily. The cell was badly damaged. The senior manager decided to move the man to another cell on the houseblock rather than to the segregation unit.

51. The manager and the houseblock manager went to speak to the man in the new cell. He told them he was fine and would not repeat his earlier behaviour. The man said his only issue was working in the kitchen. They briefly discussed a job change. The manager told the investigator that the man did not seem emotional or upset. He could not remember whether he had asked the man if he had any thoughts of suicide or self-harm but said that he generally would do in such situations. The houseblock manager and the manager told the man that he would face a disciplinary hearing for destroying his cell but could stay in the new cell now he had calmed down. Officers checked the man frequently throughout the afternoon. No one recorded any concerns about the man or his risk to himself.
52. At 4.30pm, an officer asked the man if he was all right. The man was lying on his bed, awake with his eyes open, but he did not reply. Half an hour later, the officer and a prisoner took the man his evening meal. The officer opened the cell door and the man got up from the bed and walked over to take his dinner. The prisoner asked the man if he was all right and the man said he was. The man made good eye contact and the officer had no concerns about him. At some point during the evening, an unidentified officer brought the man some belongings from his original cell, including photographs of his children and writing material.
53. At 5.55pm, the man's friend passed the man some tobacco under the cell door. An officer gave him some blankets. The man's friend spoke to the man at 6.05pm and said he seemed drained. The officer saw the man at 6.30pm, just before he went off duty. He said the man seemed fine at the time.
54. At 8.20pm, the officer put a written IEP warning for smoking in the kitchen toilets that morning under the man's door. He said that the man thanked him. The officer handed over to night staff and explained the man's situation. Records show that the man did not press his cell bell that night.

5 November 2014

55. The night patrol officer on duty on Houseblock 1 on the night of 4-5 November said it was a very quiet night and he did not remember having to respond to any cell bells. (The system log shows that the last cell bell on Houseblock 1 was pressed at 6.30pm on 4 November.)
56. At 6.35am, the night patrol officer began an early morning check of prisoners and reached the man's cell at 6.39am. While patrolling the houseblock during the night, the night patrol officer had noticed that the man's cell light was on

all night as he could see the light through a gap around the cell door. The night patrol officer said that this had not concerned him, as prisoners often kept their lights on. He did not check the man during the night

57. The night patrol officer opened the door observation panel and saw that the man was hanging from the end of his upturned bed, with a piece of torn sheet around his neck. His feet were off the floor. At 6.39am, the night patrol officer radioed an emergency code blue (which signifies circumstances such as when a prisoner is unconscious or not breathing). Control room staff called an ambulance immediately.
58. The night patrol officer said that the man's limbs looked stiff, as if rigor mortis had set in, and it was clear from blood pooling in his extremities and other physical signs that the man had been dead for some time. The night patrol officer had no doubt about this, so decided not to go into the man's cell until other staff arrived, as he would not be able to cut the ligature and manage the man's body in a respectful way by himself. We are satisfied that this was appropriate. A manager and an officer arrived within a minute and the manager unlocked the cell door. The manager cut the ligature from the man's neck and he and an officer lowered the man to the mattress on the floor.
59. The manager, a first aider, checked for a pulse but knew there would be none. He said he knew the man could not be resuscitated as soon as he saw him. The man felt cold and stiff and there was evidence of rigor mortis. He was certain from this and the other physical signs, that there was no doubt the man was dead. The manager said his aim was to preserve the evidence and treat the man's body with dignity and respect. The manager and an officer locked the cell while they waited for the ambulance. Paramedics arrived at the cell at 6.53am. They examined the man and very quickly confirmed that he had died.
60. The man had left two letters in his cell. He wrote that he could not carry on like this, that he did not feel like himself anymore and that he was a 'waster'. He said that he was sorry for his actions but that he had a dangerous side that he could not control, and he was worried he would do something he regretted.

Contact with the man's family

61. When he arrived at Featherstone, the man had listed his former girlfriend as his next of kin and her address as a probation approved premises. Prison staff checked with the approved premises but she no longer lived there and they did not have her current address. Prison staff found some details for the man's adopted parents in Wales, but then found that they had not lived there for many years.
62. The prison asked the police to help them trace the man's next of kin. In the meantime, staff noticed that one of the letters the man had left in his cell was addressed to 'Dad'. The Reverend and the deputy governor, went to the address on the man's letter at 11.45am. The occupier told them that he was not the man's father, although the man had called him dad. He said that he

had not heard from the man for a long time and not in touch with any of the man's family or friends.

63. The Reverend and deputy governor phoned the prison and learnt that the police had found an address for the man's mother. They arrived at her house at 12.45pm and broke the news of the man's death to her and her family. The man's mother later visited the prison and met some of his friends.
64. The man's funeral was held on 19 November. Featherstone paid funeral expenses, in line with national guidance.

Support for prisoners and staff

65. Staff broke the news of the man's death to prisoners during the morning of 5 November. The Governor issued a note, which explained what had happened and the support available. Prisoners were invited to attend a memorial service held in the prison.
66. A senior officer spoke to some of the staff involved in the emergency response, after the man's death, but there was no formal debrief for all the staff involved, as national instructions require.

Post-mortem report

67. The post-mortem examination found that the man had died from hanging. There were no other injuries. Traces of gabapentin (an anticonvulsant and pain relief medication), which the man was not prescribed, were detected. There was no trace of mirtazapine, which the man had been prescribed.

ISSUES

The man's risk of suicide and self-harm

68. When the man arrived at Featherstone in early October 2013, he said that he had never harmed himself or attempted suicide before. In November 2013, he told a doctor that he felt depressed and the doctor prescribed antidepressants, which he continued to take until his death. No one had any concerns that the man was at risk of suicide and self-harm or considered that he needed to be monitored under Prison Service suicide and self-harm prevention procedures.
69. On 4 November, the man reacted angrily to receiving an IEP warning and smashed up his cell and threatened staff. Subsequently, he calmed down and the staff had no further concerns about him. The man's extreme and out of character reaction to, what appears to have been, a relatively minor event, might have indicated a more serious underlying issue and it is unfortunate that no one seems to have discussed with him whether there was anything else that was particularly concerning him. However, during the afternoon and evening of 4 November, the man told staff that he was all right and gave them no reason to consider that he needed closer monitoring.
70. We are satisfied that in the hours leading up to the man's death, there was little to suggest to staff that he was at imminent risk of suicide. We do not consider that staff could reasonably have been expected to predict his actions and prevent his death.

Substance misuse

71. It is apparent from letters that the man wrote to other prisoners, evidence from the man's friend, and the results of the post-mortem examination that the man sometimes used illicit substances (including synthetic cannabinoids and other prisoners' prescribed medication). Staff reported the evidence and concerns to the security department, but there is little evidence that the prison took action to investigate the extent of the man's substance misuse or his involvement in trading or supplying drugs. The man's cell was searched only twice (and one of those occasions was at his request). He was not tested for drugs, although the security department had advised that this should be done. We note that, at the inspection of Featherstone in 2013, inspectors noted that not all suspicion testing was completed on time. While we do not know whether the man's death was associated with illicit drug use, it is a factor that can increase a prisoner's vulnerability. We make the following recommendation:

The Governor should ensure that there is an effective and timely response to security information indicating a prisoner is using or trading illegal drugs or diverted prescribed medication.

Violence reduction

72. We have some concerns about the operation of the violence reduction procedures at Featherstone. On 16 January, the man was involved in a fight and monitored under violence reduction procedures until 6 February. On 26 March, when the man told staff he had been assaulted from behind by an unknown prisoner, no one investigated the attack any further and there is no evidence that staff supported the man afterwards. The next day, he appears to have been so worried that other prisoners were intending to harm him that he asked to move to the segregation unit or another houseblock. Staff told him that this was not possible, although Featherstone's violence reduction policy specifically requires this to be considered. The man was attacked again on 13 August, but still staff took no further action. Prison Service Instruction (PSI) 64/2011 instructs that '*Victims of violence must be provided with an appropriate level of support according to the hurt or injury they suffer. Victims must be informed of the outcome of actions taken as a result of the violence.*'
73. In October, when the man reported that he had been pressured into holding unauthorised items in his cell for another prisoner, he asked for his cell to be searched and the items confiscated. The man said that he preferred to face a disciplinary hearing than for other prisoners think he was an informant. He indicated that he might be prepared to tell the manager conducting his disciplinary hearing, who the other prisoner was, but there is no record that a manager spoke to him about this and the charge was referred to the Independent Adjudicator and not heard before his death. This was a missed opportunity for prison staff to investigate further. Although the man said that he did not want to be monitored under violence reduction procedures, there is no evidence that staff considered ways of supporting him, such as moving him to a different houseblock.
74. As with the use of drugs, there is no evidence of any direct link between the violence and intimidation that the man experienced and his death. However, being the victim of bullying and intimidation can increase the risk of suicide and self-harm. We do not consider that Featherstone properly investigated these incidents or supported the man effectively, in line with national instructions or the prison's local violence reduction policy. We make the following recommendation:

The Governor should ensure that all information indicating violence, bullying and intimidation is fully coordinated and investigated and that apparent victims are effectively supported and protected.

Clinical care

75. A clinical reviewer reviewed the standard of physical and mental healthcare the man received at Featherstone. The clinical reviewer concluded that, apart from eight days when the man did not receive his antidepressant medication, the care he received was equivalent to the care he could have expected to receive in the community.

RECOMMENDATIONS

1. The Governor should ensure that there is an effective and timely response to security information indicating a prisoner is using or trading illegal drugs or diverted prescribed medication.
2. The Governor should ensure that all information indicating violence, bullying and intimidation is fully coordinated and investigated and that apparent victims are effectively supported and protected.

Action Plan					
No	Recommendation	Accepted/Not Accepted	Response	Target date for completion and function responsible	Progress (to be updated after 6 months)
1	The Governor should ensure that there is an effective and timely response to security information indicating a prisoner is using or trading illegal drugs or diverted prescribed medication.	Accepted	PSO 3601 Mandatory Drug Testing states that prisoners must be tested within 72 hours of submission of intelligence. Where staff are profiled to this task, we will always endeavour to test prisoners who are suspected of taking any illicit drugs or medication within the required timescales. The use of suspicion testing is monitored at Senior Management Team meetings and the Security Committee.	Completed Head of Security	
2	The Governor should ensure that all information indicating violence, bullying and intimidation is fully coordinated and investigated and that apparent victims are effectively supported and protected.	Accepted	All information received by security regarding violence, bullying and intimidation is sent to Safer Custody via a Request for Information Form (RFI). This is then distributed to the appropriate residential Senior Officer for investigation, which should take place within 72 hours. All RFI's are now up to date. A Notice to Staff has been issued to remind staff about the investigative process regarding violence and bullying and the importance of adhering to the	Completed Head of Safer Custody & Equalities	

Action Plan					
No	Recommendation	Accepted/Not Accepted	Response	Target date for completion and function responsible	Progress (to be updated after 6 months)
			<p>timeframes.</p> <p>All support for victims is set out in the Violence Reduction Policy. This is to be resent to all staff by 31/5/15 to remind them of the options available to protect and support apparent victims.</p>		