

# Learning lessons bulletin

## Fatal incident investigations issue 8

# Segregation

This Learning Lessons Bulletin examines learning from investigations into the self-inflicted deaths of prisoners being held in segregation conditions at the time of death.

Segregation is an extreme and isolating form of custody used for prisoners who have misbehaved or who cannot be kept safely in normal prison accommodation. It inherently reduces protective factors against suicide and self-harm, such as activity and interaction with others, and should only be used in exceptional circumstances for those known to be at risk of taking their own life.

Worryingly, in 2013/14 eight prisoners killed themselves in prison segregation units, four of whom had been assessed as at risk of suicide and self-harm. This is the highest number of deaths in these settings since 2004/5. These eight deaths accounted for 9% of all self-inflicted deaths in prison that year. Unfortunately, there are no centralised records of the number of prisoners segregated at any one time across the prison estate, so it is not possible to generalise about the use of segregation or whether this number of deaths in segregation was disproportionate.

What we do know, however, is that the Prison Service's own instructions recognise the potentially damaging effect of segregation on those who may be at risk of suicide and self-harm. Similarly, in my 2013/14 annual report, I raised concerns about the number of deaths of prisoners who were known by staff to be vulnerable and at risk of harming themselves, yet were still held in segregation conditions.

This bulletin explores these concerns further and is intended to encourage learning from these deaths, reduce the inappropriate use of segregation for the vulnerable, support safe practice and, ultimately, contribute to the prevention of future deaths.



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## Introduction

Segregation is a process by which a prisoner is removed from association with other prisoners, under Prison Rule 45. This can be for reasons of good order and discipline, when prison managers consider that keeping a prisoner on a standard prison wing would be disruptive, difficult to manage or unsafe for others. A prisoner might also be segregated for their own protection and safety, when there is reason to believe that they might be under threat from other prisoners. Additionally, a prisoner can spend time in a segregation unit when serving a punishment of cellular confinement after being found guilty of a disciplinary offence, or in the period between an alleged offence and an initial hearing.

Most prisons have a dedicated segregation unit, sometimes known as the care and separation unit or CSU, which allows prisoners to be moved to a location completely separate from the main residential wings. In segregation units, prisoners will generally spend most of the time alone in their cell, leaving only to shower, use the telephone and exercise for a short period. They will not usually have much of their personal property with them and are unlikely to have televisions. Segregated conditions are also sometimes applied outside of segregation units. Prisoners can be kept on the wing, but locked in their cells for the most of the day, and taken to shower and exercise separately from other prisoners on the wing.

## Segregation rules and procedures

There are a number of rules about segregating prisoners, which prison staff are required to follow. These are mostly set out in detail in Prison Service Order (PSO) 1700, Segregation. In addition, Prison Service Instruction (PSI) 64/2011, Safer Custody, sets out the policy on the use of segregation for prisoners at risk of suicide and self-harm, and advises against the segregation of such prisoners where possible. When prison staff do not know these rules or do not put them into practice appropriately, prisoner safety can be compromised with potentially fatal consequences.

## Case study 1

Mr A was taken to the segregation unit after staff found him in a part of the prison where he should not have been, and in possession of a long strip of cloth which they suspected he was using to bring illegal items into the prison. The staff who found him reported that he seemed very frightened and was shaking. Once he reached the segregation unit, Mr A quickly began to protest about his situation and said that his cell was dirty and smelly. He became disruptive and banged and kicked the cell door. Shortly afterwards, he harmed himself by cutting his wrist with a plastic knife. Staff began Prison Service suicide and self-harm prevention procedures (known as ACCT) but did not consider whether it was necessary to move him to another location because of his actions.

A nurse assessed Mr A as fit for segregation. This angered him and he threatened to smash up his cell and harm himself again, if he was not moved elsewhere. Prison staff responded by removing all non-fixed furniture from his cell, leaving him with only a mattress. All his clothing and standard bedding were removed, and he was given a tear-resistant tunic and blanket.

When furniture is removed from a cell, Prison Service procedures require that the cell should be regarded as 'Special Accommodation' – the most austere and extreme form of custody requiring special protective arrangements. PSO 1700 makes it clear that those in Special Accommodation should be observed a minimum of five times an hour, and that staff should make every effort to engage with them. After removing the furniture from his cell, the staff in the segregation unit observed Mr A just twice an hour and not the required five times. The investigation also raised uncertainty about how thoroughly the checks were carried out and found little evidence that staff had any meaningful interaction with Mr A. In addition, the instructions in PSO 1700 require that when alternative clothing is used, an enhanced case review should be held immediately. No review was held. Later that evening, Mr A was found hanged in his cell, after he had managed to make a ligature from his tear-resistant blanket.

Our investigation into Mr A's death uncovered numerous procedural, organisational and management failings in the prison's segregation unit. In addition to the failings mentioned above, no one seems to have acknowledged that using Special Accommodation and protective clothing are measures of last resort and should be used for as short a period as possible. PSO 1700 specifies that:

“Every effort must be made to keep the time a prisoner is held in Special Accommodation to a minimum, i.e. minutes rather than hours or days”.

In Mr A's case, managers and staff resorted to extreme measures very quickly and seemed to be unaware that their actions amounted to the use of Special Accommodation. As a result, they did not apply the procedures designed to protect prisoners in such circumstances. There was no exit plan and Mr A spent over two hours in Special Accommodation in protective clothing before he was found dead. These measures should be used only in extreme situations when absolutely necessary to keep the prisoner or others safe. Planning of how to move the prisoner to an alternative location and to return their normal clothes and bedding to them should begin immediately.

The investigation into Mr A's death identified numerous faults with the operation of the segregation unit as a whole. There were considerable gaps in the unit's records in the month leading up to the incident, and some days were completely blank. On 13 out of 30 days that month, managers did not record that they had carried out daily management checks of the segregation unit, which are mandatory. We found weaknesses in handover procedures and on the night of Mr A's death, there was confusion about which officer and senior manager had been allocated to the unit.

Many of the staff had little awareness or understanding about the procedural requirements for running the segregation unit, although most of them were regular segregation unit staff. The senior operational manager responsible for the segregation unit and overall safer custody procedures admitted to the investigator that he had not read the Prison Service Instruction about Safer Custody (64/2011) and was unaware of some of the procedures it contained.

The investigation into Mr A's case identified such serious failures to comply with mandatory instructions that we recommended a disciplinary investigation into the actions of some of the staff involved.

Prison Service Orders and Instructions include mandatory procedures designed to help ensure that segregation units are run effectively and that prisoners and staff are kept safe. It is essential that managers and staff working in segregation units fully understand their special responsibilities, and are aware of and follow the required mandatory procedures. Managers need to ensure that all staff working in segregation units are competent, qualified and trained to carry out their duties. Segregation is an extreme form of imprisonment and mistakes can have potentially tragic consequences.

## Eligibility for segregation

Challenging prisoners, particularly those suffering from mental health issues, may also have significant vulnerabilities which may be worsened by segregation. Staff may naturally be focused on the challenging behaviour rather than the vulnerabilities, so to help counter any threat to a prisoner's wellbeing, PSO 1700, Segregation, specifies that an Initial Segregation Health Screen must be conducted within the first two hours of a prisoner being placed in segregation. The primary purpose of this screen is to assess a prisoner's ability to cope with the effects of being segregated. If the decision is made to segregate a prisoner, regular Segregation Review Boards should then take place throughout the period that the prisoner continues to be segregated. These should be multi-disciplinary, attended by both prison and healthcare staff. Their purpose is to consider how well the prisoner is coping and if segregation continues to be suitable.

At the Initial Segregation Health Screen, and subsequent Segregation Review Boards, prison and healthcare staff need to consider a prisoner's mental health history and any current circumstances that could increase their vulnerability, before making a decision that a prisoner is fit to be segregated or to remain in segregation. Such circumstances could be far reaching, ranging from substance misuse or debts to other prisoners, to events outside the prison such

as a family grievance or relationship breakdown. It is important that decisions are not based simply on a prisoner's current demeanour and their assurance that they are coping. An outwardly positive persona can mask underlying problems and does not always represent a true picture of an individual's mental health state and coping abilities<sup>1</sup>.

## Case study 2

Mr B was identified as being part of a group who allegedly seriously assaulted another prisoner. After the incident, prison staff moved him to a different wing and placed him on the basic regime. The next day he refused to return to his cell and said that other prisoners on the wing were threatening him. A manager decided that he should remain in his cell on the wing, but under segregated conditions. He was locked in his cell for most of the day, and taken to the segregation unit for exercise and to shower and make phone calls.

At the initial segregation healthcare screen, a nurse deemed Mr B fit for segregation and raised no concerns. Two days later, at a segregation review, Mr B reported that he was happy with the current situation. The review did not identify any concerns about his segregation.

Before he came to prison, Mr B had been receiving treatment for depression. He had taken an overdose four months earlier, and had cut his wrists several years before. There is no evidence that anyone took into account these factors when the decision was made that he was fit for segregation, either at the initial screen or at the review.

As well as being segregated, Mr B had been placed on the basic regime because of his alleged involvement in the attack on the other prisoner. This had left him with no TV and little to occupy himself. On the night after the segregation review assessed him as fit for segregation, Mr B asked another prisoner if he could borrow a radio, but did not manage to get one. He also asked an officer for a book to help occupy him. As the prison was in 'night state' (when officers are not allowed to open cell doors without authority unless in an emergency), the officer told him he would have to wait until morning. Sadly, in the morning he was found hanged.

When a decision is made to segregate a prisoner, access to some form of diverting activity is important, especially when that prisoner is known to be vulnerable. While legitimate security concerns may restrict provision, in normal circumstances a radio and some form of reading material should be offered to provide some means of occupation during long periods of isolation.

A decision of whether to approve a prisoner as fit for segregation should take into consideration any current suicide and self-harm risks which have been identified, but also their full mental health history, and any other factors that might make segregation particularly difficult for them. PSI 64/2011, Safer Custody, provides a broad but not exhaustive list of risk factors and potential triggers for suicide and self-harm which prison and healthcare staff should take into consideration when reviewing a prisoner's suitability for segregation. These considerations should apply to all prisoners being segregated, whether in designated segregation units or on wings.

## Continued segregation

When a prisoner is approved as fit for segregation at an Initial Segregation Health Screen, this does not dictate that the segregation unit will continue to be an appropriate location for that prisoner. Long periods of segregation have been found to have potentially negative effects on individuals, particularly those who are already vulnerable or have mental health problems. A period of segregation may cause deterioration in a prisoner's health and well-being, compromising their ability to cope with segregated conditions. For this reason, it is particularly important that Segregation Review Boards take place in accordance with the rules outlined in PSO 1700. If a review identifies that a prisoner is no longer able to cope with segregation, steps should be taken immediately to seek alternative arrangements.

PSO 1700 stipulates that the first Segregation Review Board should take place within 72 hours, with subsequent reviews occurring a minimum of every 14 days. An operational manager should chair the review and their attendance is mandatory. A Healthcare Representative or a member of the Mental Health In-Reach Team is also required to attend. Other attendees might include IMB members, the chaplain,

the prisoner's personal officer, and their psychologist. The combination of prison and healthcare staff aims to ensure that all factors relating to a prisoner's health and current circumstances are considered.

While the Segregation Review Board can continue to authorise segregation when they consider it safe and appropriate to do so, if a prisoner is segregated for more than 30 days, a care plan should be drawn up to detail how that prisoner's mental well being is to be supported during the period of segregation. Proactive steps to safeguard their mental health should be considered, which might include increasing the number of visits from a doctor or nurse, increasing observations, encouraging contact with their family, or encouraging exercise and relaxation.

### Case study 3

Mr C claimed to be at threat from other prisoners and asked to be moved from the wing to the segregation unit. He moved to the segregation unit that day. The next day, a Segregation Review Board authorised his continued stay in segregation. Another review took place the following week, where it was decided that there was no threat to him from other prisoners and that he should be moved back to a normal wing. Mr C refused to move from the segregation unit and subsequently remained there for over three months.

During his time in segregation, Mr C's mental health deteriorated. On several occasions staff found him to be tearful and he told them he was struggling to cope. In spite of this, a number of subsequent Segregation Review Boards continued to authorise his segregation. Staff recognised that Mr C's mental health was deteriorating, but there is little evidence to suggest that a structured plan was put together to better support his mental health and combat the detrimental effects of his segregation.

Mr C continued to refuse to move back to a standard wing, believing himself to be at risk there. An attempt was made to move him to another establishment but this was unsuccessful. A decision was then made to move him to the Healthcare Unit for a period of reprieve from segregation. Due to his perceived threat to other prisoners however, he was locked in his cell in the healthcare unit, which effectively resulted in a continuation of segregation conditions.

Mr C stayed in the healthcare unit for over two weeks, before hanging himself in his cell. During this time, he told staff a number of times that he was feeling low, was hearing voices, and had thoughts of suicide.

The purpose of a Segregation Review Board is to determine whether segregation remains a safe option for the prisoner. When that is no longer the case, efforts need to be made to reintegrate that prisoner into standard prison accommodation or a more suitable location. In the case of Mr C, reintegration was difficult as he was refusing to return to a standard wing. Despite this, three months was an excessive amount of time for him to be segregated. Greater efforts should have been made to relocate him, for example through gradual reintegration. Steps should also have been taken to help counter the negative effects that segregation was having on his mental health. When it is necessary for a prisoner to be segregated for a period of more than 30 days, a care plan to safeguard their mental well being should be put in place.

### ACCT and exceptional circumstances

Assessment, Care in Custody and Teamwork (ACCT) is the care planning system that the Prison Service uses to support prisoners at risk of suicide or self-harm. Prisoners who are managed under ACCT procedures are particularly vulnerable, and locating them in segregation units should be avoided wherever possible. PSI 64/2011 and PSO 1700 both make this clear. PSI 63/2011 states:

"Prisoners on open ACCT plans must only be located or retained in Segregation Units only in exceptional circumstances. The reasons must be clearly documented in the ACCT Plan and include other options that were considered but discounted."

Some vulnerable prisoners may also be very challenging, particularly if they have complex mental health needs. This can leave prison staff with some very difficult decisions about where prisoners managed under ACCT procedures should be held, in order to minimise the risk of harm to themselves – and others. As a result, there will sometimes be exceptional circumstances to justify holding prisoners at risk of suicide or self-harm in segregation units. However, this

should only happen when all other options have been considered and exhausted.

Our investigations have found that, too often, prisoners identified as at risk of suicide and self-harm and being managed under ACCT procedures were held in segregation units without sufficient evidence that staff had considered other options or identified exceptional circumstances to justify their segregation. Her Majesty's Chief Inspector of Prisons identified the same issue in each of his last three annual reports, noting that too many people at risk of suicide or self-harm were held under segregation conditions<sup>2</sup>.

### Case study 4

When Mr D arrived at the prison, staff assessed him as fit for normal location and cell occupancy. Two days after his arrival however, he requested vulnerable prisoner status. He claimed to be under threat from other prisoners, due to his size (he was five foot tall and weighed six stones), and because other prisoners knew about his background. Staff agreed to locate Mr D in the segregation unit while they considered his suitability for vulnerable prisoner status. A week later, they did then move him to the vulnerable prisoners unit, where he remained until an incident in which he threatened to jump from an upper landing. He was subsequently moved back to the segregation unit.

While he was in the segregation unit, staff opened ACCT procedures twice for Mr D. The first time was shortly after he arrived at the prison, when he said that he was having serious thoughts of self-harm. The second time was after he threatened to jump from the upper landing on the vulnerable prisoners unit and staff moved him back to the segregation unit. On both occasions, staff filled in a form with details of the exceptional circumstances which justified keeping Mr D in segregation while subject to ACCT procedures. Both times, the reason given was that no other location was suitable. No details were given about which other locations had been considered, for example the healthcare unit, and why they were unsuitable. Two days after he was moved to the segregation unit for the second time, Mr D was found hanged in his cell.

Mr D's situation was not an easy one. He was in the segregation unit for his own protection, having asked not to be located on the main residential wing due to feeling threatened there. There was no evidence, however, that other locations had been considered and discounted, as PSI 64/2011 requires.

The investigation into Mr D's death also found that a number of other prisoners held in the segregation unit at that prison were subject to ACCT procedures. Staff appeared to complete exceptional circumstances forms as a matter of routine, rather than in truly exceptional situations.

This is not an isolated case and locating prisoners who have been assessed as at risk of suicide or self-harm in segregation units is apparent across the estate. Twenty-eight prisoners took their own lives while being held in segregation units between January 2007 and March 2014; nine of them were subject to ACCT procedures at the time of death. In several of these cases, no exceptional reasons to justify holding the prisoner in segregation were recorded.

Where there are exceptional reasons to justify holding prisoners who are managed under ACCT procedures in segregation units, there are some additional requirements that need to be met by prisons. As well as the initial health screen for all prisoners moved to a segregation unit, PSO 1700 makes it clear that prisoners subject to ACCT procedures should have a mental health assessment within the first 24 hours of their segregation. An ACCT review should also be held within 24 hours. Mental health safeguards, for example observations and dialogue, should be put in place, and consideration given to the possibility of moving the prisoners to a safer cell or monitoring by CCTV. The PSO makes it clear that prisoners on ACCTs should remain in segregation only as long as the exceptional circumstances continue to apply.

A number of our investigations have found that some or all of these necessary safeguards had not been applied. In one such investigation, Mr E, a diagnosed schizophrenic, had been moved into a segregation cell for his own protection, despite having a serious mental health condition and being subject to ACCT procedures. Mr E remained in segregation for 12 days before killing himself. During this period he did not have a mental health assessment and no exceptional circumstances were identified for his location in the segregation unit.

The authorisation forms for his continued stay in the segregation unit contained inaccurate information and no one at the segregation reviews questioned the appropriateness of his location or why he had been kept there for so long, although evidence of his declining mental state should have been apparent.

Segregating a prisoner when they are already identified as at risk of suicide and self-harm often heightens their vulnerability. If there is no alternative, it is essential that staff follow all the specific procedures designed to ensure the prisoner's safety while in segregation, in addition to those that apply to all prisoners being managed under ACCT procedures. Not only were procedures specific to segregation not followed in Mr E's case, but there were also a number of general failures in ACCT arrangements. These included staff being poorly trained, ACCT reviews not being multi-disciplinary, and achievable goals not being set as part of his care and management plan. Ensuring ACCT procedures are correctly followed is essential for all at risk prisoners, but is especially important for prisoners whose vulnerability may be increased by segregation<sup>3</sup>.

## Endnotes

<sup>1</sup> A more comprehensive discussion of the dangers of basing judgements on demeanour and giving insufficient weight to known risk factors can be found in the PPO publication: '[Learning from PPO Investigations: Risk factors in self-inflicted deaths in prisons](#)' (2014).

<sup>2</sup> HM Chief Inspector of Prisons for England and Wales, Annual Reports 2011-12, 2012-13 and 2013-14, all found on their [website](#).

<sup>3</sup> More information on general ACCT requirements can be found in PPO publication: '[Learning from PPO investigations: Self-inflicted deaths of prisoners on ACCT](#)' (2014).

## Lessons to be learned

**Lesson 1 – Special accommodation and protective clothing should only be used if absolutely necessary and after all other options have been exhausted.** If they are used, an enhanced case review should be held straight away, staff should engage actively with the prisoner and observe them at least five times an hour, and plans should be made to return the prisoner to standard accommodation and normal clothing as soon as possible.

**Lesson 2 – Staff responsible for the care of prisoners in segregation units should fully understand and follow the mandatory procedures for safeguarding segregated prisoners set out in PSO 1700, Segregation, and PSI 64/2011, Safer Custody.** Staff should be aware of their personal responsibilities for protecting prisoners, particularly those identified as at risk of suicide and self-harm.

**Lesson 3 – Segregated prisoners should be provided with the means to occupy themselves, at minimum reading material and a radio.**

**Lesson 4 – During an Initial Segregation Health Screen and ensuing Segregation Review Boards, staff should base decisions**

**about fitness for segregation on the prisoner's full mental health history and other relevant factors that could potentially compromise their ability to cope, not on current demeanour alone.**

**Lesson 5 – Lengthy periods of segregation are to be avoided.** When unavoidable, Segregation Review Boards should be held regularly to assess how well the prisoner is coping, to plan for their relocation to more appropriate accommodation, and to develop a careplan to help prevent deterioration in mental health.

**Lesson 6 – Exceptional circumstances to justify the segregation of a prisoner subject to ACCT procedures should actually be exceptional.** All other options should have been exhausted and the reasons for this clearly documented.

**Lesson 7 – When there are exceptional reasons to justify a prisoner at risk of suicide and self-harm being held in segregation, the additional required safeguards in PSO 1700 should be followed, including holding a mental health assessment and an ACCT review within 24 hours.**

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The Prisons and Probation Ombudsman investigates complaints from prisoners, young people in secure training centres, those on probation and those held in immigration removal centres. The Ombudsman also investigates deaths that occur in prison, secure training centres, immigration detention or among the residents of probation approved premises. These bulletins aim to encourage a greater focus on learning lessons from collective analysis of our investigations, in order to contribute to improvements in the services we investigate, potentially helping to prevent avoidable deaths and encouraging the resolution of issues that might otherwise lead to future complaints.

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