Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Haydar Jefferies, a prisoner at HMP Coldingley, on 5 March 2023

A report by the Prisons and Probation Ombudsman

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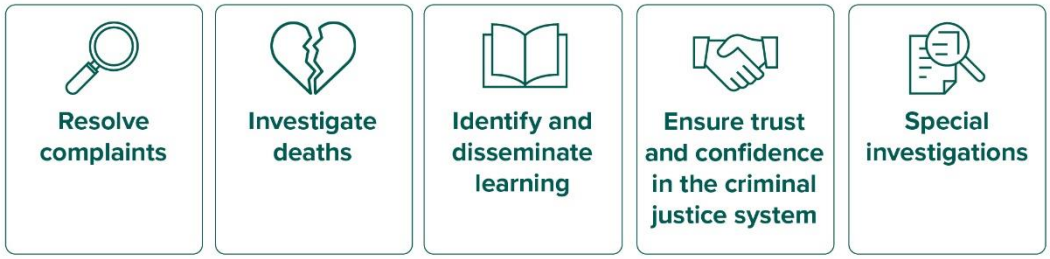
OUR VISION

To deliver high quality and timely independent investigations and work closely with partners to achieve tangible benefits for the safety and confidence of those in custody and under community supervision.

WHAT WE DO



WHAT WE VALUE

The Prisons and Probation Ombudsman aims to make a significant contribution to safer, fairer custody and community supervision. One of the most important ways in which we work towards that aim is by carrying out independent investigations into deaths, due to any cause, of prisoners, young people in detention, residents of approved premises and detainees in immigration centres.

If my office is to best assist HM Prison and Probation Service in ensuring the standard of care received by those within service remit is appropriate, our recommendations should be focused, evidenced and viable. This is especially the case if there is evidence of systemic failure.

Mr Haydar Jefferies died on 5 March 2023 after being found hanged in his cell at HMP Coldingley on 1 March. He was 50 years old. I offer my condolences to Mr Jefferies' family and friends.

Mr Jefferies had received an Imprisonment for Public Protection (IPP) sentence in 2006. He had subsequently been released from prison in 2013 and recalled in 2022. Mr Jefferies had only been at Coldingley for two months before he took his life in the segregation unit, where he had spent 18 days.

Mr Jefferies was found hanging the day before his parole hearing. This seems extremely unlikely to be a coincidence. I recently issued a learning lessons bulletin outlining my concerns about the high number of self-inflicted deaths among IPP prisoners.

The clinical reviewer found that the care provided to Mr Jefferies was equivalent to that he could have expected to receive in the community. I make two recommendations related to missed opportunities to share and communicate important information between prison and healthcare staff to assess and manage Mr Jefferies' risk and mental health.

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

Adrian Usher
Prisons and Probation Ombudsman **September 2024**

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Summary

Events

1. In 2006, Mr Haydar Jefferies was sentenced to an Indeterminate Sentence for the Public Protection (IPP). He was released from prison in 2013. On 1 January 2022, Mr Jefferies licence was revoked due to new charges. On 3 January, he was recalled and taken to HMP Bullingdon. In May, Mr Jefferies' solicitor told him that the charges had been dropped. Due to circumstances beyond Mr Jefferies control, his parole hearing was delayed and rescheduled for 2 March 2023.

2. Mr Jefferies transferred to HMP Coldingley on 28 December 2022. Staff noted that he had a history of substance misuse, attempted suicide and self-harm, and depression, although he had not been monitored by suicide and self-harm procedures, known as ACCT, for over five months.

3. On 12 February 2023, Mr Jefferies moved to the segregation unit because he feared for his own safety. It was agreed that he would remain in the segregation unit until his parole hearing. Staff had no concerns about him and there was no evidence that he was under threat.

4. In the afternoon of 28 February, Mr Jefferies expressed paranoid thoughts and believed others wanted to kill him. Two hours later, he stripped naked and was on the floor barking like a dog. Staff started ACCT procedures. He was due to have a mental health assessment the next day. Staff told Mr Jefferies to stop his bizarre behaviour and to put his clothes back on, which he did. For the remainder of the evening, staff did not witness Mr Jefferies engaging in further bizarre behaviours such as to cause them any additional concern.

5. Just before 2.40am on 1 March, an officer checked and saw Mr Jefferies slumped over his toilet unresponsive. He radioed to ask for help from his colleagues before going into the cell. When staff went into the cell, they saw Mr Jefferies had tied a thin ligature around his neck. Staff removed the ligature from Mr Jefferies' neck and tried to resuscitate him. Ambulance paramedics were already on site and arrived quickly to assist. They found a pulse and, at 4.10am, took Mr Jefferies to hospital. Mr Jefferies died on 5 March.

Findings

6. Mr Jefferies had several risk factors for suicide and self-harm. He was an IPP prisoner, he had a history of depression, substance misuse, attempted suicide and self-harm. Prison staff appropriately started ACCT procedures the day before Mr Jefferies was found hanging due to his bizarre behaviour. We concluded that, aside from his clearly deteriorating mental health, there were no clear signs that he was at imminent risk of suicide when he died. However, prison staff did not adequately communicate their concerns about Mr Jefferies' mental health to healthcare staff responsible for checking and assessing him in the CSU.

7. The clinical reviewer concluded that the clinical care that Mr Jefferies received at Coldingley was equivalent to that which he could have expected to receive in the community. She did, however, highlight areas of concern that related to missed

opportunities to share and communicate important information between prison and healthcare staff to assess Mr Jefferies' mental health.

Recommendations

- The Governor and Head of Healthcare should ensure that relevant information about a prisoner's mental health in the CSU is documented and communicated to staff doing the daily healthcare checks. Staff should also record when they ask whether a prisoner has any thoughts of suicide or self-harm.

- The Governor and Head of Healthcare should ensure that staff refer prisoners to the mental health team the same day that they have concerns, using a clear and consistent template, containing sufficient information to triage the referral.

The Investigation Process

8. The PPO was notified of Mr Jefferies' death on 6 March 2023. The investigator issued notices to staff and prisoners at HMP Coldingley informing them of the investigation and asking anyone with relevant information to contact him. No one responded.

9. The investigator visited Coldingley on 14 March 2023. He obtained copies of relevant extracts from Mr Jefferies prison and medical records.

10. NHS England commissioned a clinical reviewer to review Mr Jefferies' clinical care at the prison. The investigator and clinical reviewer conducted joint interviews with nine members of staff and one prisoner.

11. We informed HM Coroner for Surrey of the investigation. He gave us the results of the post-mortem examination. We have sent him a copy of this report.

12. The Ombudsman's family liaison officer contacted Mr Jefferies' next of kin to explain the investigation and to ask if they had any matters they wanted us to consider. They said that Mr Jefferies was in constant fear for his safety from prison staff and prisoners. They believed he had had a mental breakdown in the days leading up to his death and wanted to know the circumstances that led him to take his own life. We have addressed these issues in the report.

13. Mr Jefferies' family received a copy of the initial report. The solicitor representing the family wrote to us and provided some additional information that has been reflected in this report.

14. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS pointed out three factual inaccuracies, and this report has been amended accordingly.

Background Information

HMP Coldingley

15. Coldingley is a category C training and resettlement prison for adult males, holding mostly long-term, including life-sentenced, prisoners. It holds up to 513 prisoners. Central and Northwest London NHS Foundation Trust provides healthcare services at the prison. The healthcare services are commissioned to be on site between 7.30am to 6.30pm in the week and between 8.30am to 5.30pm at the weekend.

HM Inspectorate of Prisons

16. The most recent inspection of HMP Coldingley was in January 2022. Inspectors reported that Coldingley was a well-run and decent prison.

17. Levels of violence at Coldingley were noted to be around average for the category C estate and the prison generally had a calm and friendly atmosphere. The average length of stay in the segregation unit was relatively short. Staff and prisoner relationships in the unit were positive, but the regime was poor and reintegration planning was inadequate.

18. At the time of inspection, four of the seven prisoners in the segregation unit were there for their own protection because they felt under threat from prisoners on residential wings. Staff told inspectors that they would try and relocate such prisoners to E wing before considering transferring them to another establishment, but none had a formal plan for their care or the best route for their reintegration.

Independent Monitoring Board

19. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report, for the year to July 2022, the IMB reported that there were still too many prisoners feeling at threat of or suffering violence.

Previous deaths at HMP Coldingley

20. Mr Jefferies was the second prisoner to die at Coldingley since January 2020. The previous death was from natural causes.

Segregation units

21. Segregation units are used to keep prisoners apart from other prisoners. This can be because they feel vulnerable or under threat from other prisoners or if they behave in a way that prison staff think would put people in danger or cause problems for the rest of the prison. They also hold prisoners serving punishments of cellular confinement after disciplinary hearings.

22. The unit at Coldingley is known as the Care and Separation Unit (CSU) and comprises 11 cells. Only four of the cells are wired for television and a kettle.

Assessment, Care in Custody and Teamwork (ACCT)

23. Assessment, Care in Custody and Teamwork (ACCT) is the Prison Service care-planning system used to support prisoners at risk of suicide or self-harm. The purpose of ACCT is to try to determine the level of risk, how to reduce the risk and how best to monitor and supervise the prisoner. After an initial assessment of the prisoner's main concerns, levels of supervision and interactions are set according to the perceived risk of harm. Checks should be irregular to prevent the prisoner anticipating when they will occur. There should be regular multidisciplinary review meetings involving the prisoner.

24. As part of the process, a care plan (a plan of care, support and intervention) is put in place. The ACCT plan should not be closed until all the actions of the care plan have been completed. All decisions made as part of the ACCT process and any relevant observations about the prisoner should be written in the ACCT booklet, which accompanies the prisoner as they move around the prison. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011.Dsafds

Imprisonment for Public Protection (IPP)

25. IPP sentences are indeterminate, which means that when the minimum tariff has expired, individuals are required to demonstrate to the Parole Board that their risk has reduced enough to be managed in the community. IPP sentences were introduced in 2005 and abolished in 2012, but the abolition did not apply retrospectively to those who had already received the sentence.

26. In September 2023, the PPO published a learning lessons bulletin on the self-inflicted deaths of IPP prisoners. This was due to an increase in self-inflicted deaths among IPP prisoners in 2022. We concluded that more needed to be done by HMPPS to ensure that the high levels of deaths did not continue. We noted that an IPP sentence should be considered as a potential risk factor for suicide and self-harm. IPP prisoners can often struggle with their uncertain status leading to feelings of hopelessness and frustration. We found that this can cause a lack of engagement with the parole process and sentence planning and create a lack of trust in the system.

Key Events

27. In 2006, Mr Haydar Jefferies was sentenced to an Indeterminate Sentence for Public Protection (IPP). He was required to serve a minimum of two years in prison, for offences of wounding and other acts of endangering life. He was released from custody, on licence, in August 2013.

HMP Bullingdon, 1 January 2022- 28 December 2022

28. On 1 January 2022, Mr Jefferies' licence was revoked following new charges. On 3 January, he was recalled to custody and taken to HMP Bullingdon.

29. On arrival at Bullingdon, Mr Jefferies said he felt low because it was the first anniversary of his husband's death the next day. Although he denied having any thoughts of suicide or self-harm, staff started suicide and self-harm procedures, known as ACCT, to support him. Mr Jefferies said he had the support of his family. Staff referred Mr Jefferies to the chaplaincy for bereavement counselling.

30. A nurse completed Mr Jefferies' reception health screen. She noted his history of attempted suicide (overdose) and self-harm, substance misuse and that he had depression and anxiety, for which he was prescribed mirtazapine (an antidepressant). The nurse referred him to the GP and the mental health team. Mr Jefferies declined to be referred to the substance misuse service. He was subsequently prescribed antidepressant medication.

31. Staff stopped ACCT monitoring on 12 January when he was no longer considered a risk to himself. On 14 January, Mr Jefferies told his key worker that he had no drug or alcohol issues and wanted to focus on his time in prison to improve himself. He obtained a prison job and staff commented that he always demonstrated positive behaviour, followed the regime and worked hard.

32. On 30 March, following a telephone consultation with the GP, Mr Jefferies stopped taking his antidepressant medication. He told the GP that he had already, over the previous weeks and of his own accord, reduced the daily dose of his antidepressant medication and felt that he no longer needed to take them.

33. By April, Mr Jefferies had become a representative for the violence reduction team and staff described him as "an excellent example of how to conduct yourself in the face of adversity".

34. At the beginning of May, Mr Jefferies told his key worker that he was frustrated as his solicitor had told him that the police had dropped the charges against him, and he was unsure of when he would be released from prison. His key worker noted, however, that Mr Jefferies remained positive and kept himself busy.

35. On 11 May, staff started ACCT procedures after Mr Jefferies made a ligature and attempted suicide. Mr Jefferies was frustrated that he had not been released from prison yet. On 18 May, staff stopped ACCT monitoring. Mr Jefferies mood had improved, and he said he no longer had any thoughts to harm himself. He had spoken to his probation officer who had updated him on his current situation and

who was also in the process of setting up a parole hearing. Mr Jefferies said his family continued to support him.

36. On 28 September, Mr Jefferies referred himself to the substance misuse team. He said that he had been "*stitched up"* by his probation officer and believed that he needed to complete relapse prevention work. Subsequently, Mr Jefferies was seen regularly by the substance misuse team until November, when he discharged himself from their services as he stated that he no longer needed their support.

37. On 13 October, Mr Jefferies' scheduled parole hearing was postponed due to the Parole Board chair being unwell. It was noted that the hearing should be relisted at the earliest possible opportunity, but Mr Jefferies' legal representative had no availability until March 2023. Mr Jefferies' hearing was scheduled for 2 March 2023.

38. In November, a nurse from the mental health team saw Mr Jefferies after wing staff reported that his mood was low and that he had voiced paranoid thoughts that he could not trust anyone. Mr Jefferies told the nurse that he had been frustrated because his parole hearing had been delayed but he felt much better now and was coping. He denied having any thoughts of suicide or self-harm. The nurse's assessment noted that Mr Jefferies mood was settled, and she had no concerns about his mental health.

HMP Coldingley, 28 December 2022 onwards

39. On 28 December, Mr Jefferies transferred to HMP Coldingley. A nurse completed an initial health screen and noted Mr Jefferies' history of depression, substance misuse and self-harm. Mr Jefferies told the nurse that he had no current thoughts of suicide or self-harm and no concerns about his transfer to Coldingley. He declined the offer of support from the substance misuse team.

40. On 29 December, a nurse from the mental health team saw Mr Jefferies. She noted that he was not taking any medication and his mood was positive. Mr Jefferies told the nurse that his husband had died two years ago and that he had tried to kill himself when this had happened. However, he said he had no current thoughts of suicide or self-harm. She discussed support for Mr Jefferies as the anniversary for his husband's death was approaching. Mr Jefferies said he was okay and had the support of his family.

41. On 17 January 2023, Mr Jefferies moved to D Wing. An officer said Mr Jefferies was well behaved, positive and never raised any concerns. On 24 January, Mr Jefferies' application to be located on E Wing (the enhanced/drug free wing) was successful. Mr Jefferies was placed on the waiting list pending a space becoming available. Over the next two weeks staff noted Mr Jefferies positive behaviour.

42. On 10 February, a Senior Probation Officer met Mr Jefferies to discuss the recent proposal from the Justice Select Committee to re-sentence those prisoners that were subject to an IPP sentence. She informed Mr Jefferies that the Government had rejected the recommendations and provided him with a letter to support him and explain this. She reminded Mr Jefferies of the support available to him. Mr Jefferies said that he was feeling okay and had expected this outcome. He said that his parole hearing was soon.

43. On 12 February at 10.24am, Mr Jefferies telephoned his mother from his in-cell prison phone. (Prison staff were not monitoring Mr Jefferies calls so would have been unaware of the content of them.) He told her that he feared for his safety and asked her to contact the prison to tell them that he needed protecting. He said that "they" had been talking about him on the wing landing and he believed that prison staff had disclosed details about his offence to other prisoners. He said that prisoners were waiting outside of his cell for him to come out so that they could cut him with cans.

44. At 10.36am, Mr Jefferies phoned his mother again. She had spoken to the prison and relayed his concerns. At 10.50am, Mr Jeffries phoned his brother and repeated his concerns. He said that he had barricaded himself in his cell and that "they" believed he was a sex offender. His brother stated that this was a false accusation and said he would contact the prison. Mr Jefferies said he feared for his life and wanted to be moved to Care and Separation Unit (CSU - segregation unit).

45. Wing staff noted that they had had no concerns about Mr Jefferies, prior to his family contacting the prison, and had not observed anything untoward happening around his cell or on the wing landing, including on that day.

46. A Supervising Officer (SO) from the Safer Custody Team and a Custodial Manager (CM) spoke to Mr Jefferies. He had blocked his cell door but agreed to leave his cell and spoke to staff in the wing office. Mr Jefferies said that he was worried about his safety. He believed that people were talking about him and thought he was a sex offender. He said his parole hearing was soon and he wanted to remain safe until then. Staff agreed to move Mr Jefferies to the CSU for his own safety.

Care and separation Unit (CSU), 12 February onwards

47. Around 11.30am, Mr Jefferies arrived in the CSU. A nurse assessed him and completed a segregation algorithm. This noted that Mr Jefferies was suitable, from a healthcare perspective, to remain in the CSU. Mr Jefferies had no thoughts of suicide or self-harm. He told the nurse that he wanted to stay in the CSU until he was transferred or released.

48. A manager signed CSU paperwork to authorise Mr Jefferies' stay in the CSU. Segregation unit regimes are restricted, and prisoners are permitted to leave their cells only for specific activities such as to have a shower and exercise in the open air. As part of the segregation regime, all prisoners are seen daily by the duty governor and healthcare staff. They are also seen three times a week by a GP and a nurse from the mental health team. During these rounds, cell doors are opened so healthcare staff can observe and interact with the prisoner. The IMB and a member of the chaplaincy team also visit prisoners. Prisoners still have access to the prison phone.

49. Soon after he arrived in the CSU, Mr Jefferies phoned his mother. Part of their conversation was in English, the other part in their native language. Mr Jefferies told his mother that he was now in the CSU. He said that for the last six weeks, he had been terrified that he would be hurt because other prisoners believed that he was a sex offender. He wanted to stay in the CSU until his parole hearing in two weeks' time. Here, he was no longer worried and, although he did not have access to a television, he was able to read books, had use of the phone and was allowed 30

minutes of exercise daily. He said he felt much better and safer. He told his mother that she should cancel her visits to see him as he did not want contact with other prisoners on the way to the visit's hall. He also phoned his brother and updated him on his move to the CSU.

50. At a routine CSU visit on the morning of 13 February, Mr Jefferies was seen by a prison GP and a nurse. They noted no concerns about him.

51. At 9.00am on 14 February, a senior manager chaired a review board with the nurse to consider Mr Jefferies' ongoing segregation. They discussed the reason that Mr Jefferies was in the CSU and offered him a move to E Wing, which was not attached to any of the main residential wings. Mr Jefferies refused this as he believed that he would be under threat on any of the prison wings and wanted to remain in the CSU until his parole hearing on 2 March. He said his mood was low, but he did not want to be prescribed any medication. He had no thoughts to harm himself. The nurse suggested yoga workout sheets to help to support Mr Jefferies and improve his mood. Mr Jefferies refused this. The review board authorised Mr Jefferies' continued stay in the CSU until his parole hearing.

52. In the morning of 15 February, healthcare and prison staff making routine visits to Mr Jefferies raised no concerns. Around midday, Mr Jefferies' mother contacted the prison because Mr Jefferies had told her that he was being threatened in the CSU. Staff spoke to Mr Jefferies and reassured him that he was safe. That afternoon, two IMB members visited Mr Jefferies. They spoke at length to Mr Jefferies about his IPP status and the recent Government decision, that he had already been informed of. Mr Jefferies said he was not surprised at the Government's decision. Regarding his own situation, Mr Jefferies said that his initial parole hearing had been delayed by five months. He said that he felt he had done everything to turn his life around but had "lost hope" and felt that his probation officer had not helped.

53. During daily routine welfare checks between 16 and 25 February, healthcare, prison, IMB and chaplaincy staff had no concerns about Mr Jefferies.

54. On 17 February, Mr Jefferies had a video-link meeting with his Community Offender Manager (COM). This meeting had been delayed due to Mr Jefferies previous COM leaving the service. The COM noted that Mr Jefferies had completed extensive work around violence, substance misuse and domestic abuse when he was previously in prison. Since his recall, he had demonstrated good behaviour, completed courses and been employed. The COM noted that the current charges that led to Mr Jefferies' recall to prison had been dropped. He intended to recommend to the Parole Board that Mr Jefferies could be released from prison or moved to an open prison or an Approved Premises.

55. On 18 February at 11.50pm, an officer noted that Mr Jefferies had called staff to his cell and said that he was in fear for his safety from "everyone". Mr Jefferies made references to staff coming into his cell or opening his cell door. The officer reassured Mr Jefferies that no one would open his cell throughout the night and that he was safe in the CSU.

56. On 20 February, Mr Jefferies was again offered a move to E Wing but refused. An officer described Mr Jefferies as a model prisoner while he had been in the CSU. He was aware that Mr Jefferies was nervous about his upcoming parole hearing

and was observed regularly in his cell checking that his parole paperwork was in order.

57. In the evening of 24 February, Mr Jefferies family called the prison concerned about his welfare. Staff told them that Mr Jefferies was fine, and they had no concerns.

58. An officer told us that around this time, Mr Jefferies had started to become intermittently paranoid and believed that staff were conspiring with other prisoners, who they intended to let out of their cells, to harm him. Mr Jefferies said that he believed staff intended to sexually abuse him. The officer said he reassured Mr Jefferies that he was safe on the unit. He told us that Mr Jefferies' paranoia would last only for a short period and then he would revert to being his normal quiet self. There were also two prisoners on the unit that had been shouting abuse directed at Mr Jefferies, that related to a sexual offence. The officer again spoke to Mr Jefferies and reassured him that he was safe and reminded him that he would not have any physical contact with other prisoners in the CSU. He offered to move Mr Jefferies to a different cell and one that also had a television. Mr Jefferies declined. The officer spoke to the two noisy prisoners about their behaviour and reassured them that any information they had heard about Mr Jefferies was mistaken, to try and stop their poor behaviour. The two prisoners were subsequently transferred out of the CSU within two days.

59. On 25 February, Mr Jefferies phoned his brother. Part of their conversation was in English, the other part in their native language. His brother said that since Mr Jefferies had been at Coldingley, he had claimed daily that he would be stabbed, and that other people were coming to get him. Mr Jefferies appeared fixated that others were trying to hurt him. Mr Jefferies' brother told him that he was in a safe place and that he should stop putting pressure on their mother to help him, which prompted her to then contact the prison. He said Mr Jefferies' paranoia was affecting him and he needed to manage it.

60. On 26 February around 9.50am, a nurse saw Mr Jefferies. She had no concerns about him. However, there is no evidence that she was aware that he was sometimes paranoid that others were going to harm him. Later, while conducting a routine check, the Head of Security noted that while speaking to Mr Jefferies, his conversations were very repetitive. Concerned about this, he planned to refer him to the mental health team. He did so on 28 February.

61. On the morning of 27 February, during the routine CSU visit, a prison GP and two nurses saw Mr Jefferies. They had no concerns about him. Shortly afterwards, Mr Jefferies phoned his mother and told her not to worry about him. They spoke about his parole hearing.

Events on Tuesday 28 February

62. At 8.30am on 28 February, a nurse and a member of the chaplaincy team visited Mr Jefferies and had no concerns. At 9.54am, a SO noted in the wing observation book that Mr Jefferies had told staff that he had made his peace and was ready for them to kill him. Mr Jefferies denied having any thoughts of suicide or self-harm. Due to his unusual behaviour, she referred him to the mental health team by email.

63. Staff entries made in the segregation observation log for the remainder of the morning raised no concerns about Mr Jefferies. He was sat on his bed most of the time and around midday had his lunch.

64. Mr Jefferies phoned his mother twice in the afternoon. In his first call at 1.50pm, he said that he was being moved back to a main residential wing and therefore would not be able to attend his parole hearing. (This was not the case, there was no plan to move Mr Jefferies). He said "everybody" was saying that he was a sex offender, and prisoners were waiting outside to "cut him up". He told his mother that her life was also under threat. In his second phone call at 2.03pm, Mr Jefferies said that he would not get his parole if they moved him. His mother tried to calm him down and said she that she would contact the prison. Mr Jefferies promised to phone his mother back later.

65. At 2.50pm, a SO chaired a segregation review board. Two officer, a mental health nurse and a member of the IMB were present. The panel noted that Mr Jefferies was displaying some bizarre behaviour. The nurse told us that before the review meeting, staff had told her that Mr Jefferies' had displayed some unusual behaviour and referred him to the mental health team. She also received the referral, although there was no detail contained within this about why he had been referred to the team. During the review, she noted that Mr Jefferies appeared paranoid and was fixated on being kept safe until his parole review on Thursday. Mr Jefferies believed others, including staff, wanted to kill him. He made spiritual references about his life and "having an awakening after he had attempted suicide" in 2018. He said he would not leave his cell. Staff said that Mr Jefferies told them he had no thoughts of suicide or self-harm although this is not recorded. The nurse arranged to carry out a mental health assessment the next day. She told us that she was not overly concerned about Mr Jefferies from a mental health perspective and completed a segregation algorithm which documented that he could cope with segregation. An officer told us that Mr Jefferies appeared in a better mood by the end of the review.

66. At 4.03pm, Mr Jefferies phoned his mother. He told her that he was okay and said that "they" were not moving him now and so he would still be able to attend his parole hearing. He said his mother should not worry about him, his parole hearing would be good and that he would call her on Friday.

67. Around 4.15pm, two officers checked Mr Jefferies after hearing strange noises coming from his cell. Mr Jefferies was naked, on his hands and knees, barking like a dog. He also flushed his head down the toilet. Other prisoners on the unit could be heard heckling Mr Jefferies and mimicking the sounds that he was making. One officer told Mr Jefferies to stop what he was doing. Mr Jefferies did so. The officer went to the wing office to inform his manager. On his return, Mr Jefferies had resumed barking and continued to act in a strange manner. He asked Mr Jefferies to stop and stand up. Mr Jefferies did, then thanked the officer and asked if he could put his clothes back on. He said that "she" had told him to behave in the way that he had. As there were only male officers working in the unit that day, the officer was confused who Mr Jefferies was referring to.

68. Concerned about Mr Jefferies' welfare and mental health, the officer started ACCT procedures. A SO attended the CSU and put in place the ACCT immediate action plan. It was noted that the CSU was the most appropriate location for Mr Jefferies at that time and he would be checked twice an hour. Mr Jefferies was reminded of the

support of the Listeners (prisoners who are trained by the Samaritans to offer confidential, emotional support to other prisoners) and Samaritan services. He also had writing material in his cell for distraction purposes. The SO was aware that Mr Jefferies was also due to be assessed by the mental health team the following day.

69. Staff later observed Mr Jefferies sat on his bed. He asked staff for his vape pen, which was being charged in the office, which they gave to him. For the remainder of the evening, the officer completed ACCT observation checks. He noted that Mr Jefferies seemed "fine", had calmed down and appeared "back to his old self".

70. Officer A started work in the CSU around 8.30pm as the night duty officer. He carried out ACCT observations throughout the evening and raised no concerns about Mr Jefferies.

Events on Wednesday 1 March

71. In the early hours of 1 March, Officer A continued to complete ACCT checks for Mr Jefferies, noting that he appeared to be asleep. When he checked Mr Jefferies at 2.00am, he had no concerns about him.

72. At 2.34am**,** while conducting an ACCT check, Officer A looked through Mr Jefferies' observation panel and saw him slumped in the toilet area. He called his name and banged on the door. Mr Jefferies did not respond. He radioed Officer B, the deputy night orderly manager, for assistance. There is no CCTV coverage in the CSU and staff responding did not turn on their body worn cameras.

73. Officer B immediately attended the CSU and looked through Mr Jefferies' observation panel. She saw Mr Jefferies slumped at the side of the toilet, his head tilted towards the toilet bowl, as if he was in a position to vomit. Mr Jefferies still failed to respond, although staff believed they saw his hand twitch. Officer B thought something might be wrong and, as a precaution, radioed a CM. She told him to stop the ambulance paramedics (who had attended the prison due to another emergency) from leaving the prison and to escort them to the CSU. She told Officer C to attend the CSU, as she intended to enter Mr Jefferies' cell. Due to the position Mr Jefferies was in, his location in the CSU and it being night state she wanted three officers present before they unlocked his cell. Officer C arrived within minutes.

74. Officer B unlocked and went into Mr Jefferies' cell followed by Officers A and C. As they approached Mr Jefferies, Officer A saw a ligature tied around his neck. It was a thin, dark blue piece of fabric that was tied around the taps on the sink above the toilet. Officer B immediately radioed a medical emergency code blue (used when a prisoner is unconscious or having breathing difficulties). The control room recorded that this occurred at 2.40am. The ambulance crew in the prison radioed the Ambulance Control Centre to inform them of a new incident within the prison.

75. Officers B and C moved Mr Jefferies away from the toilet area while Officer A cut the ligature from around his neck. Officer B could not find any signs of life so started cardiopulmonary resuscitation (CPR). Officer A had retrieved the defibrillator from the office. Officer C set it up and it instructed that chest compressions should be continued. Officers B and C alternated chest compressions until the paramedics, that were on site, arrived. (Healthcare staff are not on duty overnight.)

76. At 2.41am, the paramedics arrived at Mr Jefferies' cell. On their instruction, staff moved Mr Jefferies to the corridor and the paramedics administered emergency care. The paramedics requested further medical assistance. Officer B radioed the control room and requested a further ambulance, which was requested at 2.49am.

77. The second ambulance arrived at 2.55am and paramedics established a pulse. At 4.15am, the ambulance transferred Mr Jefferies to hospital, where he was taken to the intensive care unit and placed in an induced coma. On Sunday 5 March at 3.11pm, Mr Jefferies died.

Contact with Mr Jefferies' family

78. After Mr Jefferies was taken to hospital on 1 March, the Head of Safety phoned Mr Jefferies' brother and mother, as his next of kin, to inform them that Mr Jefferies was in hospital. The prison appointed a family liaison officer. At around 9.30am, she met Mr Jefferies' family at the hospital and offered ongoing support. After Mr Jefferies' death, Coldingley contributed to his funeral costs in line with national instructions.

Support for prisoners and staff

79. The prison posted notices informing other prisoners of Mr Jefferies' death and offering support. Staff reviewed all prisoners assessed as at risk of suicide or self-harm in case they had been adversely affected by his death.

80. After Mr Jefferies' death, staff involved in the incident were given the opportunity to discuss any issues arising and the staff care team also offered support.

Post-mortem report

81. The post-mortem examination found that Mr Jefferies cause of death was hypoxic brain injury (caused by a lack of oxygen) and pneumonia caused by suspension.

Findings

Identifying Mr Jefferies' risk of suicide and self-harm

82. Prison Service Instruction (PSI) 64/2011, *Safer Custody*, lists risk factors and potential triggers for suicide and self-harm. It says all staff should be alert to the increased risk of self-harm or suicide posed by prisoners with these risk factors and should act appropriately to address any concerns. Any prisoner identified as at risk of suicide and self-harm must be managed under ACCT procedures. PSI 64/2011 also states that any information that becomes available which may affect a prisoner's risk of harm to self must be recorded and shared, to inform proper decision making.

83. When Mr Jefferies arrived at Coldingley in December 2022, he had a number of risk factors: he was an IPP recalled prisoner, he had a history of attempted suicide and self-harm, depression and substance misuse. He had last been monitored under ACCT procedures (for one week) in May 2022, and since then, no concerns had been raised about him.

84. During his time in the CSU, Mr Jefferies initially did not cause any concern to staff. However, he became increasingly paranoid in the days leading up to his parole hearing and it seems unlikely to be coincidental that his mental health declined at this time.

85. On 28 February, at the segregation review, Mr Jefferies was paranoid and said that he had "made peace" with knowing staff wanted to kill him. Staff told us that Mr Jefferies denied having thoughts to harm himself although this was not reflected in either his prison or medical records. The mental health nurse who saw him was not overly concerned by his presentation and booked him in for a mental health assessment with herself the next day. Later that day, when Mr Jefferies displayed increasingly bizarre behaviour, prison staff appropriately started ACCT procedures. Mr Jefferies was subject to two observations per hour which we consider was sufficient in the circumstances. He had not harmed himself or said anything to indicate that was his intention. Later that evening, his behaviour returned to normal, and staff raised no concerns about him.

86. Mr Jefferies was found hanging early next morning, the day before his parole hearing. IPP prisoners can struggle with their uncertain status leading to feelings of hopelessness and frustration. This can cause a lack of engagement with the parole process and sentence planning and create a lack of trust in the system. However, Mr Jefferies had not recently voiced concerns about his parole hearing to staff, only about being kept safe until his parole hearing. We conclude that staff could not reasonably have foreseen that Mr Jefferies was at an imminent risk of suicide in the days leading to his death.

87. However, there is no evidence that prison staff shared the concerns they had about Mr Jefferies' mental health in any detail with healthcare staff carrying out the daily CSU rounds. There was no information about the mental health referrals in Mr Jefferies' medical record. This would have provided useful additional information and was a further missed opportunity to provide a more detailed audit trail of the conversations and holistic assessment of Mr Jefferies' mental health concerns. We

also note that staff conducting the daily checks and segregation review did not routinely document when they had asked him whether he had any thoughts of suicide or self-harm.

88. We make the following recommendation:

The Governor and Head of Healthcare should ensure that relevant information about a prisoner's mental health in the CSU is documented and communicated to staff doing the daily healthcare checks and segregation reviews. Staff should also record when they ask whether a prisoner has any thoughts of suicide or self-harm.

Care and Separation Unit - Segregation

89. Mr Jefferies appeared to have a genuine fear for his safety not just on D Wing, but all residential wings. While we found no substantive evidence to support that he was at risk from others, we accept the decision to relocate him to the CSU was a reasonable decision in the circumstances. Certainly, much of Mr Jefferies' time spent in segregation was uneventful and staff had no concerns about him during the daily welfare checks.

90. We were told by CSU staff that during Mr Jefferies' stay in the CSU, there were two loud and vocal prisoners. The atmosphere these prisoners created may well have impacted on Mr Jefferies' mental well-being and contributed to him feeling less safe. The small size of the CSU meant that any significant sound travelled throughout. Thus, other than staff instructing prisoners to be quiet, which was apparently done, or relocating them, which is difficult because of the reason the prisoners are located in the CSU, there is little than can be done. However, the two main prisoners referred to spent only a short time in the CSU before they were relocated.

Clinical care

91. The clinical reviewer noted that the care Mr Jefferies received was of a reasonable standard and equivalent to that which he would have received in the community. However, she found that there were missed opportunities to share and communicate important information between prison and healthcare staff to manage Mr Jefferies' risk. The Head of Healthcare will wish to review the recommendations made by the clinical reviewer in this area.

Mental Healthcare

92. A prison manager was concerned about Mr Jefferies' mental health on 26 February but did not refer him to the mental health team until two days later. We were told that the referral was not triaged with any urgency because it lacked any detailed information about Mr Jefferies' mental state or reason for the referral. It simply requested that a member of the mental health team review him. Had the referral been received on 26 February, and contained relevant information, the mental health team would likely have reviewed Mr Jefferies the next day, 27 February. We agree with the clinical reviewer that this was a missed opportunity for staff to have provided the mental health team with detailed information about Mr Jefferies' changing mental state in a timely manner. We make the following recommendation:

The Governor and Head of Healthcare should ensure that staff refer prisoners to the mental health team the same day that they have concerns, using a clear and consistent template, containing sufficient information to triage the referral.

93. That said, we noted that when Mr Jefferies was seen as part of the routine CSU healthcare round on 27 February, healthcare staff had no concerns about his mental health and so took no further action. This decision appeared reasonable given Mr Jefferies' reported presentation.

Head of Healthcare to note

CSU healthcare documentation

94. Healthcare staff complete a template on prisoners' medical records as part of the CSU healthcare rounds. In Mr Jefferies' case, staff consistently recorded that they had no concerns about him and that he was medically fit to remain in the CSU. From interviews, we ascertained that there is an option to add free text to the template to provide more detailed information about the consultations. Staff told us that they would not add additional details unless they had concerns. No additional details were recorded about Mr Jefferies in the template, including whether he was asked if he had any thoughts of suicide or self-harm. The Head of Healthcare may wish to consider whether the free text box could be made better use of.

Risk formulation

95. The clinical reviewer notes that a risk formulation should have been completed for Mr Jefferies during his time at Coldingley. A risk formulation is developed to identify holistic factors that may increase a person's risk of suicide and self-harm. It can then be used as a monitoring and assessment tool to determine a level of risk in response to significant incidents and events in a person's life. This is in line with the NICE guideline for 'self-harm: assessment, management and preventing recurrence' (2022). Had a risk formulation approach been used during Mr Jefferies' CSU reviews, earlier indicators of his risk could have been identified. Furthermore, this could then have been used when Mr Jefferies was seen daily by healthcare staff to record decisions around any future interventions.

96. The clinical reviewer notes that risk formulations should be used by healthcare staff working in the CSU and for IPP prisoners. The Head of Healthcare will want to consider the use of risk formulations.

Governor to note

Body worn video cameras (BWVC)

97. Staff responded to the emergency response at Mr Jefferies' cell swifty. However, despite it being a mandatory requirement, staff did not switch on their body worn video cameras to record the incident. When used effectively a BWVC allows first person audio and visual images to be captured to provide a clear and irrefutable

record of events. One member of staff told us that she forgot to switch her camera on. The Governor may wish to consider this.

Inquest

98. An inquest was concluded on 29 November 2024, that the cause of Mr Jefferies' death was from hypoxic brain injury and pneumonia, as a result of tying a ligature around his neck. It was not possible to determine his intention.

99. The coroner concluded that the following are facts, on the balance of probabilities, were found to have happened and made a material contribution to Mr Jefferies' death: Between the 18 February 2023 and 1 March 2023, Mr Jefferies was suffering from psychosis as referenced by the expert psychiatrist. The fact that Mr Jefferies was an IPP prisoner and that his parole hearing was delayed more than minimally contributed to the development of this psychosis due to the psychological stress. In February 2023, during Mr Jefferies' detainment at HMP Coldingley, there was a serious failure by the custodial staff to record risk relevant information in regard to his presentation. Specifically, concerns raised by his family through numerous telephone calls and concerning comments made by Mr Jefferies to custodial staff. There was an additional failure to ensure that risk relevant information was shared with prison officers and clinical staff. Between the 18 and 27 February 2023, there was a serious failure to refer Mr Jefferies to the Mental Health team. This was despite evidence showing acknowledgement and intent to make a mental health referral on more than one occasion. By 5.30pm on 28 of February 2023, Mr Jefferies was floridly psychotic as evidenced by the expert psychiatrist. The proper response would have been to ensure his immediate safety by putting him on constant supervision and taken him to an external place of safety due to Coldingley's unsuitable provision of safer cells. That none of this was done represents a serious failure by HMP Coldingley custodial staff. There was a failure to undertake a substantive mental health assessment on the 28 February 2023 following the morning referral from custodial staff and the subsequent CSU review. A mental health review was booked in for the following day' which was inadequate.

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