Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Craig Anderson, a prisoner at Isle of Man Prison, on 25 November 2022

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.

My office does not have any jurisdiction in the Isle of Man but was invited by the CEO of the Department of Home Affairs to conduct this investigation. PPO investigations are undertaken to assist prisons in ensuring the standard of care received by those within remit is appropriate. Our recommendations should be focused, evidenced and viable. This is especially the case if there is evidence of systemic failure.

Mr Craig Anderson was found dead in his cell at Isle of Man Prison on 25 November 2022, the day after he was sentenced. He had suffocated himself by placing a plastic bag over his head. He was 28 years old. I offer my condolences to Mr Anderson's family and friends. A man died in the same way in March 2020, and there has been another similar death since.

We found that staff at Isle of Man Prison had not been trained in how to effectively use suicide and self-harm prevention measures, known as Folder 5. A recent inspection by HM Inspectorate of Prisons identified poor understanding of risks and how to manage them, and our investigation found similar issues.

The clinical reviewer found that mental health services at Isle of Man Prison were inadequate, unsafe, and not equivalent to what is available in the wider community.

When Mr Anderson was discovered, he had been dead for some time. We have identified a number of factors that should be addressed to improve the management and response during a medical emergency.

Our investigation identified other issues fundamental to the care of prisoners. The Department of Home Affairs and Department of Health and Social Care need to support the Governor and Manx Care to improve staffing levels, governance, oversight, and the management of risk. Clear protocols should be developed and guidance to support staff in undertaking their duties to improve safety.

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 **January 2024**

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Summary

Events

1. On 26 July 2022, Mr Craig Anderson was remanded to Isle of Man Prison, charged with wounding, handling stolen goods and breach of a suspended supervision order. On 24 November, Mr Anderson appeared in court and was sentenced to five years imprisonment. He had been to prison before.

2. Mr Anderson had a long history of substance misuse and mental health issues. He had a history of self-harm and around a month before he was remanded, Mr Anderson spent four days in an inpatient mental health unit, following a suicide attempt by hanging.

3. Mr Anderson was supported by the prison's suicide and self-harm prevention measures (known as Folder 5) on three separate occasions during his remand. The last time was between 16 and 18 November, after staff identified he was anxious and stressed about his impending sentencing hearing.

4. On 24 November, Mr Anderson appeared in court. During the hearing he became distressed and later punched the cell door injuring his hand. When he returned to the prison, staff were proactive in providing support, but nobody considered re-opening the Folder 5. Staff increased observations over the lunch period, but no other special monitoring was in place over night.

5. On 25 November at 7.33am, during the early morning routine check, an officer found Mr Anderson unresponsive on the floor of his cell, with a plastic bag over his head. The officer radioed for assistance and prison and healthcare staff responded. Resuscitation attempts were unsuccessful, and paramedics declared Mr Anderson's death at 7.55am.

Findings

6. We found that Isle of Man Prison had not made sufficient changes or responded to the learning from the death of a prisoner in March 2020. There are many similarities between that death and Mr Anderson's. We found that the learning from the internal prison investigation and subsequent Coroner's inquest did not lead to sufficient change in how the prison manages prisoners' risk of suicide or self-harm.

7. We found, as did HMIP, the management of prisoners at risk of suicide or self-harm was inadequate. Too much emphasis was placed on staff/prisoner relationships and prior knowledge of the person. The decision to start Folder 5 procedures in the lead up to Mr Anderson's sentencing date was appropriate, but there were weaknesses in the management of the process. Staff closed Folder 5 procedures prematurely on 18 November and did not consider that his sentencing date had been postponed until 24 November. After his sentence, staff missed several opportunities to reopen the Folder 5. They placed too great an emphasis on his assurances that he did not have any thoughts of suicide or self-harm when assessing his risk.

8. We found that prison, court and healthcare staff at Isle of Man Prison were not certain what information should be included on the Person Escort Record (PER). Mr Anderson's last PER for his sentencing appearance did not include crucial information about his history or risk.

9. When Mr Anderson returned to prison after sentencing, staff were proactive in providing support. Although staff showed a high degree of concern for him, nobody considered re-opening the Folder 5. We found that there was no formal process or expectation that all prisoners were seen after a court appearance to reassess their risk of suicide or self-harm.

10. The clinical reviewer found that the mental health provision at Isle of Man was inadequate, unsafe and the care Mr Anderson received was not equivalent to that which he could have expected to receive in the community. Despite Mr Anderson's significant mental health history, previous suicide attempts, significant self-harm and numerous requests to see the mental health team, he was never referred and assessed. We found there was confusion and a lack of understanding about the referral process.

11. We identified unsafe practices regarding the issuing of medication, a lack of clinical governance and quality oversight dedicated to prison healthcare.

12. Isle of Man Prison does not have a specific emergency response policy. When Mr Anderson was discovered, staff responded quickly but an ambulance was not immediately called.

13. Staff attempted to resuscitate Mr Anderson when he was clearly dead. Isle of Man Prison and Manx Care did not have an updated policy guiding staff on when resuscitation was not appropriate.

14. Mr Anderson's body was not placed back into his cell after he was declared dead and he was instead left on the prison landing for several hours.

15. Mr Andersons family were informed of his death by the police and not told in person by prison staff as they should have been.

16. Some staff felt they had not been supported adequately by the prison following Mr Anderson's death.

17. Given the learning identified in this investigation, we consider that the Department of Home Affairs should immediately commission an investigation into all non-natural deaths at the prison. This will ensure a timely and objective investigation is completed to identify any learning, providing clear recommendations on any necessary change.

Recommendations

- The Governor, Manx Care and the Regional Manager for Bidvest Noonan should ensure staff understand the purpose of and their responsibilities when completing a PER and introduce a robust quality assurance process to monitor accurate and appropriate information sharing.

- The Governor and Manx Care should establish a process to ensure that prisoners returning from a court appearance (in person or by videolink) are assessed for their risk of suicide and self-harm.

- The Department of Health and Social Care and Manx Care should review the current provision of mental health services at Isle of Man Prison and provide a dedicated mental health service, which is sufficiently resourced to meet the needs of the population.

- Manx Care should undertake a systemic population health needs assessment across Isle of Man Prison to determine the prevalence of mental health conditions and need.

- The Department of Health and Social Care should ensure the practice of transcribing and unsafe medication practices at Isle of Man Prison have stopped.

- Manx Care should ensure there is a dedicated lead pharmacy provision at Isle of Man Prison and there is a prescriber available every day, even if that is for remote prescribing.

- Manx Care should implement electronic medication administration records.

- Manx Care should ensure that patients who come in with complex and high-risk medication (as per the RCGP guidance) have a medication review when they arrive at the prison.

- Manx Care should have a dedicated clinical governance lead responsible for prison healthcare at Isle of Man Prison to ensure practice is compliant and underpinned by national guidance, legislation and evidence-based practice.

- The Governor should introduce a clear protocol to staff for effectively communicating a medical emergency.

- The Governor and Manx Care should ensure that there is clear joint guidance and training for all staff, about the circumstances in which resuscitation is inappropriate in accordance with European Resuscitation Council Guidelines.

- The Governor should consider establishing a protocol with the Isle of Man Constabulary to ensure that following a death in custody the deceased's body is moved back into their cell for dignity, if there is no suspicion of a crime.

- The Governor should ensure that the prison complies with its own policy for contacting the family of a deceased prisoner and that they have adequately trained family liaison officers.

- The Governor and Manx Care should ensure that all relevant staff, irrespective of status, position, or experience, are able to attend a debrief following a death in custody and that they receive appropriate aftercare support.

- The Department of Home Affairs should consider immediately commissioning an independent investigation in the event of any future non-natural deaths at Isle of Man Prison.

The Investigation Process

18. The Isle of Man Department of Home Affairs asked the PPO to conduct an independent investigation into the circumstances surrounding the deaths of two prisoners, Mr Anderson's death in November 2022 and another man in February 2023, who had died in similar circumstances. There had been a third similar death in March 2020, but this was not investigated as the inquest had already concluded (the Coroner provided details of the inquest findings). The PPO were formally commissioned to investigate on 17 April 2023.

19. The investigator issued notices to staff and prisoners at Isle of Man Prison informing them of the investigation and asking anyone with relevant information to contact her. No one responded.

20. The investigator visited Isle of Man Prison on 2 May 2023. She obtained copies of relevant extracts from Mr Anderson's prison and medical records. She visited the wing where he lived, reception, healthcare and met with senior managers.

21. The PPO commissioned an independent clinical reviewer to review Mr Anderson's clinical care at the prison. The investigator and clinical reviewer interviewed 22 members of staff and two prisoners in June 2023. They interviewed the Governor and General Manager for Integrated Mental Health Services on 6 July.

22. The investigator and clinical reviewer met with the prison Governor and separately with Manx Care in July, to provide feedback on the investigation and share the emerging findings.

23. We informed The High Bailiff, Her Worship Coroner for Isle of Man of the investigation. The Coroner gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.

24. The investigator contacted Mr Anderson's mother to explain the investigation and to ask if she had any matters she wanted us to consider. Mr Anderson's mother asked the following:

    - Did Mr Anderson have a full mental health assessment while at the prison?
    - What support was provided after an incident of self-harm in September 2022?
    - What happened after Mr Anderson appeared in court on 24 November 2022; what information was relayed to the prison and what support was provided?
    - What action was taken after Mr Anderson's friend contacted the prison on the evening of 24 November, to share her concerns about his welfare?
    - Do prison staff have any mental health training?
    - How was a letter sent from Mr Anderson's partner given to him when it appears that it did not go through the correct internal post process?
    - Why did nobody from the prison contact Mr Anderson's mother and why did the prison not send a condolence letter?

25. Mr Anderson's mother received a copy of the initial report. She did not highlight any factual inaccuracies.

26. Isle of Man Prison received a copy of the report. They identified some factual inaccuracies, and the report has been amended.

27. Manx Care also received a copy of the report. They identified a number of factual inaccuracies within the PPO and Clinical Review reports. We have made some amendments to the reports as a result. Other points raised were not factually inaccurate and our findings were based on the information provided to us from documentation and interviews. Manx Care did not provide an action plan for the recommendations specific to healthcare at Isle of Man Prison but provided a copy of their Offender Healthcare Improvement Plan.

28. We note that the Prison Healthcare Team has been placed in 'special measures' by the Executive Director of Nursing. This is an internal governance mechanism designed to ensure any incident or issue that is identified as extremely challenging and / or high risk is afforded a level of attention, resource, and leadership in order to facilitate positive change. He commenced special measures meetings on 15 December 2023, and these will continue on a weekly basis until such time Manx Care can be assured that adequate progress has been made against Manx Care's Offender Healthcare Improvement Plan.

Background Information

Isle of Man Prison

29. Isle of Man Prison is in the Jurby parish of the Isle of Man. The prison is operated by the Isle of Man Prison and Probation Service (part of the Department of Home Affairs) and is the only functioning prison on the island, holding up to 138 prisoners. All prisoners at Isle of Man Prison are located in single cells equipped with a toilet and washing facilities. The design of these cells means there no ligature points. There are two wings that accommodate remand and convicted prisoners, as well as wings s for female prisoners, and vulnerable prisoners. There is also a segregation unit.

30. Manx Care (equivalent to the NHS in England) have provided healthcare at the prison since April 2021. Prior to that, services were provided by the Department of Health and Social Care (Isle of Man). Healthcare is provided between 7.30am and 5.30pm Monday and Friday and until 8.30pm Tuesday, Wednesday, and Thursday; and at weekends between 8.30am and 5.30pm. There is no inpatient facility. A GP attends twice a week and a psychiatrist once a week.

HM Inspectorate of Prisons (HMIP)

31. The most recent inspection of Isle of Man Prison was in March 2023. Inspectors reported that the quality of staff/prisoner relationships was a strength. Prisoners were treated with respect and lived in decent conditions. However, governance and oversight of many critically important areas of accountability were weak.

32. Inspectors found the management of prisoners at risk of suicide and self-harm was inadequate. Interventions or responses were often disproportionate, risk averse and too often lacked sufficient focus on care for individuals or their well-being. There was poor understanding of risks and how to manage them, including those associated with the management of prisoners in their early days and those at risk of suicide or self-harm (similar findings were found in the previous HMIP inspection in 2011). Inspectors found the monthly safer custody meetings were unstructured.

33. After a suicide in March 2020, the prison formulated an action plan, but inspectors considered some of the actions to be unnecessarily risk averse. Prisoners with a history of self-harm were monitored irrespective of risk. Folder 5s (suicide and self-harm prevention measures) focused on monitoring rather than promotion of wellbeing and did not address why prisoners felt like self-harming. Some lacked care plans and multi-disciplinary input and case management was inconsistent. Observations were recorded on the prisoners record rather than the Folder 5 and there was no system to monitor these prisoners when they left the wing or travelled outside of the prison, for example to hospital or court.

34. Inspectors found 98% of prisoners had a named Custody Support Officer (CSO) who met with them regularly. Most prisoners said their CSO took an interest in their wellbeing. There was good access to Samaritans, but there was no Listeners Scheme (prisoners trained by Samaritans to support their peers).

35. The Care Quality Commission (CQC) carried out an inspection with HMIP. Clinical governance of health services in some areas was weak. They identified substantial staff shortages in 2022, and gaps in management, nursing and other professions had impaired delivery of healthcare services by Manx Care. The professional oversight and management of medicines and pharmacy services was inadequate.

36. Inspectors noted that there had been recent organisational restructuring at the prison, funding cuts and the retirement of experienced leaders resulting in a leaner senior management team. 40% of officers had less than two years' experience. These changes had been unsettling and almost three-quarters of staff said morale was low. Inspectors said that senior officers were not visible on the wings, but that the Governor was committed to change.

Independent Monitoring Board

37. 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 March 2022, the IMB expressed their concern that Isle of Man Prison was the only facility on the island for those prisoners with significant mental health issues, which was neither safe nor suitable. They reported that prison staff worked tirelessly to monitor and care for prisoners with mental health needs but were not trained to do so. They described the situation as 'an accident waiting to happen'. The IMB acknowledged progress had been made with mental health pathways, although they were not yet in place, and urged the Minister and Government Departments to support and fund this provision within the prison.

38. The IMB noted that attendance at the monthly safer custody meeting was lower than desired and attributed this to low staffing levels. They found overnight concerns monitoring had increased, possibly due to staff being more aware and observant and noted this to be a quick and effective safety net to flag individuals' risk which is used as an early intervention prior to starting Folder 5 procedures.

Previous deaths at Isle of Man Prison

39. Mr Anderson was the second prisoner to die at Isle of Man Prison since March 2020. The previous death was self-inflicted and there has been one self-inflicted death since. All three deaths had similarities, not least the method of suicide. We have identified issues with the management of suicide and self-harm prevention measures, mental health provision, early days in custody and the emergency response.

Folder 5 – suicide and self-harm prevention measures

40. Folder 5 is the Isle of Man Prison's system to support prisoners at risk of suicide or self-harm. The purpose of a Folder 5 is to try to determine the level of risk, how to reduce the risk and how best to monitor and support the prisoner. Guidance on Folder 5 procedures is set out in the Self-harm and Suicide Prevention Policy and Procedures dated 5 May 2022.

41. 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 every 48 hours As part of the process, a caremap (a plan of care, support, and intervention) is completed. The Folder 5 should not be closed until all the supportive actions have been completed and the risk is assessed to have reduced. Observations are recorded separately on the prisoner's electronic prison record.

Incentives and Earned Privileges Scheme (IEP)

42. Isle of Man Prison has an incentives and earned privileges (IEP) scheme which aims to encourage and reward responsible behaviour, encourage sentenced prisoners to engage in activities designed to reduce the risk of re-offending and to help create a disciplined and safer environment for prisoners and staff. Under the scheme, prisoners can earn additional privileges such as extra visits, more time out of cell and the ability to earn more money in prison jobs. There are three levels, basic, standard, and enhanced.

Assessment, Care in Custody and Teamwork

43. Assessment, Care in Custody and Teamwork (ACCT) is the care planning system HM Prison Service uses to support prisoners at risk of suicide or self-harm. The purpose of the ACCT is to try to determine the level of risk posed, the steps that staff might take to reduce this and the extent to which staff need to monitor and supervise the prisoner. Checks should be made at irregular intervals to prevent the prisoner anticipating when they will occur.

44. Part of the ACCT process involves assessing immediate needs and drawing up support actions to identify the prisoner's most urgent issues and how they will be met. Staff should hold regular multidisciplinary reviews and should not close the ACCT plan until all support actions are completed. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011 on safer custody.

Key Events

Background

45. On 26 July 2022, Mr Craig Anderson appeared in court charged with wounding, handling stolen goods and breach of a suspended sentence supervision order. He was remanded in custody and taken to Isle of Man Prison. Mr Anderson had been to prison before.

46. Mr Anderson had a long history of substance misuse and drug induced psychosis. He was also diagnosed with a range of mental health conditions including depression, anxiety, and emotionally unstable personality disorder. Mr Anderson also had a history of self-harm and attempted suicide. In June 2022, he was admitted to Manannan Court, after he had attempted to hang himself. (Manannan Court is not a designated secure mental health unit but is an acute admission unit. The building is designed in accordance with the specification for acute inpatient mental health facilities.) He was discharged four days later back into the community.

47. Mr Anderson was prescribed antipsychotic medication (quetiapine), an antidepressant (diazepam), anti-anxiety medication (pregabalin) and an asthma inhaler (salbutamol). In September 2022, after he had been remanded, Mr Anderson was diagnosed with hepatitis C (an infectious disease affecting the liver, often acquired through intravenous drug use).

Arrival at Isle of Man Prison

48. When Mr Anderson arrived at Isle of Man Prison, prison staff started Folder 5 procedures due to his history of self-harm. Mr Anderson was observed every half hour in the first 24 hours.

49. Healthcare staff assessed that Mr Anderson was not suitable to have his medications in his possession, except for his inhaler, and needed to collect them each day from the medications hatch. Mr Anderson's medication for the first three days were administered without a valid prescription because there was not a dedicated prison prescriber available. (A GP remotely prescribed medications on 29 July.)

50. On 27 July, Mr Anderson's Folder 5 assessment was completed, and a review held shortly afterwards. Mr Anderson told staff that he was impulsive when he was upset or angry. He said that he felt low and worried about Social Services involvement with his children but had no current thoughts of suicide or self-harm. Four actions were identified on his caremap (a support plan to reduce risk): for his medication to be fully issued; complete induction; add names and numbers to phone list; and to be seen by the mental health team. Observations were reduced to hourly.

51. The next day, an officer was assigned as Mr Anderson's Custody Support Officer (CSOs are a named point of contact to provide support to prisoners and help solve any issues they may have). She noted in Mr Anderson's prison record that she knew him well from previous sentences, and that he did not raise any specific issues.

52. Between 29 July and 6 August there were four Folder 5 reviews. During these reviews Mr Anderson continued to be concerned about his children and difficulties with his ex-partner. He told staff that he was impulsive and if he were to self-harm, it was likely to be a quick decision, but he had no current thoughts of suicide or self-harm. During these reviews, Mr Anderson said that he wanted to engage with the mental health team and the drug and alcohol team (DAT).

53. On 9 August, Mr Anderson appeared in court via videolink. Later, he attended his Folder 5 review and told staff that he wanted to progress while in prison. The Folder 5 was closed, without any mention of his earlier court appearance. A post-closure review was scheduled for 16 August. Although he had completed his induction, his medication had been sorted and telephone numbers had been added to his PIN phone, he had still not been assessed by the mental health team. The caremap was not updated at any of these subsequent reviews.

54. Over the next few days, Mr Anderson was noted to be settled and raised no concerns. He regularly attended the gym and received very positive reports from wing staff.

55. On 16 August, a post-closure review was completed. Mr Anderson was noted to be in a better place mentally and was happy the Folder 5 was closed. He had still not been assessed by the mental health team.

56. On 23 August, the CSO spoke with Mr Anderson following contact from Social Services regarding his children. She noted that Mr Anderson appeared to be managing the situation and his court case well. She recorded that Mr Anderson's behaviour on the wing was good, that he was working as a wing cleaner and continued to attend the gym. Over the next few weeks Mr Anderson received excellent reports regarding his standard of work. He spoke at length to staff about his concerns regarding his court case and children, although no specific issues were noted.

57. On 12 September, Mr Anderson appeared in court and was found guilty. Staff recorded that he was very upset and would not speak to them. Mr Anderson also received documentation from Social Services which upset him. A Senior Officer (SO) in the Safer Custody Team spoke to Mr Anderson, and he became calmer. She agreed to credit his account so he could use the telephone. Mr Anderson said that he did not want to be placed on increased observations as he found it irritating but agreed that she could check on him during her evening duty.

58. During the evening Mr Anderson pressed his emergency cell bell but did not answer when the SO used the intercom to speak to him. She went to his cell with another officer and when she opened the door found Mr Anderson had self-harmed by cutting his cheek, neck, and ankle. All sharp objects were removed from his cell and Folder 5 procedures were started. Observations were set at every 15 minutes overnight and half hourly during the day until he could be fully assessed. The Folder 5 healthcare assessment was never completed.

59. At around 8.50pm, the SO and a colleague escorted Mr Anderson to outside hospital for his wounds to be assessed. Mr Anderson said he regretted his actions, that it was impulsive because he was disappointed about the news he received from Social Services regarding his children. They waited at the hospital for three hours. At around 11.50pm, Mr Anderson started to become agitated that he had not been examined as the A&E department appeared quiet. The SO was

told that it was unlikely he would be seen in the next hour and despite trying to persuade Mr Anderson to remain at the hospital, he decided he wanted to return to the prison. When they arrived back at the prison around 12.50am, his wounds were cleaned, and the SO applied steri-strips and a clean dressing to his neck wound.

60. On 13 September, Mr Anderson was seen by the prison doctor and later escorted to outside hospital to have his wounds assessed and treated. He was observed every half hour on his return to the prison.

61. On 14 September, the SO completed the Folder 5 assessment. She noted that Mr Anderson was frustrated that he had been found guilty and was also upset at receiving paperwork from Social Services regarding his children. Mr Anderson told her that he was stressed and regretted his self-harm but that he could be impulsive and self-harmed to manage his frustration. He said he was not suicidal. After the assessment she chaired the first Folder 5 review (this should have been completed within 24 hours of the Folder 5 being opened). Observations were reduced to hourly. Mr Anderson was noted to be frustrated at being observed so frequently. Two issues were identified for the caremap: for mental health to address Mr Anderson's issues; and for Mr Anderson to inform staff if he received any news from Social Services.

62. The next day, Mr Anderson smashed his stereo in frustration and observations were increased overnight to every half hour.

63. On 16 September, Mr Anderson received more bad news from Social Services. Staff allowed him to remain unlocked. Mr Anderson's in-cell phone was not working (there was an issue across the prison) and he was offered the use of the wing office phone, which he accepted. The SO spent time with Mr Anderson and a request was made by an officer for another prisoner to sit with him over lunch. The officer recorded in Mr Anderson's prison record that this request was denied by the Deputy Governor because of security issues. (The Deputy Governor said it was the Governor that made this decision, but the Governor did not recall this). Mr Anderson accepted the decision. During a Folder 5 review it was recorded that Mr Anderson was concerned about his mental health and the referral was being chased by a nurse (who was employed as a bank nurse before taking up her role as Lead Nurse on 8 November).

64. On 17 September, another Folder 5 review took place. Mr Anderson's mood had improved, he had spoken to his child on the telephone, and he had been exercising in the gym with his friend. Observations were reduced to hourly during the day and every two hours during the night. Over the next few days, Mr Anderson appeared settled and compliant on the wing, associating with his friends. No concerns were recorded.

65. On 20 September, Mr Anderson appeared in court. At 10.07am, after he had returned to the prison, a GP at Isle of Man Prison saw Mr Anderson and recorded that he was 'down for MH [mental health] review following self-harm last week, in court, doing much better'. We were unable to establish why Mr Anderson was seen by a GP and not the mental health team. There is no evidence a full assessment of his mental health was completed.

66. Mr Anderson was initially annoyed that his lunch had not been saved, but he quickly settled and was provided with an alternative lunch. He received a letter

from Social Services and was upset so asked to speak to the SO. Mr Anderson asked if he could have peer support (support from another prisoner) during the evening but was told this was not possible. The reason this was declined is not recorded. Mr Anderson gave his Social Services documentation to the SO, saying that he realised keeping the papers in his cell could be a trigger. His cell was searched for any objects that he could use to harm himself; we do not know if this included removing plastic bags. Folder 5 observations were increased to every half hour. Although Mr Anderson said he was unhappy at the increased observations, he accepted this was to ensure his safety and was not a punishment.

67. Mr Anderson's Folder 5 was reviewed on 21 and 23 September. He was noted to be mentally in a better place and coping better with his situation, although he remained concerned about his children and the impact of his court appearance and sentence. Mr Anderson had still not had a mental health assessment.

68. On 28 September, a nurse met with Mr Anderson to inform him tests showed he may have hepatitis C. She recorded that Mr Anderson had taken the news 'okay' but wanted to return to his cell. She explained that Mr Anderson needed to have more tests to confirm the diagnosis, but that treatment was available. Later, Mr Anderson asked to speak to healthcare as he had some questions having read the leaflets given to him earlier on his condition. She went to his cell to provide further advice and information. She asked staff to observe Mr Anderson more frequently overnight. No concerns were noted.

69. On 29 September, the SO chaired the Folder 5 review attended by a nurse and Mr Anderson. The review noted that Mr Anderson had been more settled and while still processing the issues with Social Services, appeared to be managing well. It was agreed to close the Folder 5 and a post-closure review was scheduled for 6 October. The caremap was not updated and there is no evidence that the action for the mental health team to assess Mr Anderson had been completed.

70. During the post closure period, Mr Anderson had one difficult morning when he appeared down after a telephone call to his ex-partner about their children, but he spoke openly to staff. He continued to work to a high standard, attend the gym, associate with his peers and received positive reports. Mr Anderson applied to become an enhanced prisoner, but this was declined until there was a longer period of sustained positive behaviour.

71. On 6 October, a nurse informed Mr Anderson that his hepatitis tests were positive. She noted he was disappointed but accepted the diagnosis and was told that an appointment had been made for him to speak to a specialist. (This appointment took place on 10 October).

72. Later, a SO completed Mr Anderson's Folder 5 post-closure review. He noted that Mr Anderson appeared settled and was managing his issues well and continued to receive support from prison and healthcare staff. Over the next few weeks, Mr Anderson worked to a good standard and was settled on the wing.

73. On 14 October, Mr Anderson appeared in court, and he was told that he would be sentenced on 18 November. When he returned from court, a nurse spoke to Mr Anderson. He spoke about his anxieties around sentencing and the impact on his children and told her that he felt less anxious having shared his feelings. She

requested he was offered peer support over the lunch period but was told this was not possible. The reasons for her request being declined are not recorded.

74. Mr Anderson's deputy CSO also went to see Mr Anderson to check on him after his court appearance. Mr Anderson told him that he was expecting to receive around four years imprisonment and that he knew what triggered him so spoke to staff or sat with another prisoner to manage his emotions. The CSO noted that Mr Anderson had made real progress during his time on remand and if his behaviour continued, he would likely receive his enhanced status.

75. On 26 October, the DAT Keyworker (a Criminal Justice Specialist), met with Mr Anderson. She recorded he had completed work in respect of his drug misuse, and he recognised the link to his mental health. Mr Anderson was able to identify strategies that he could put in place to manage or avoid problems. Mr Anderson told her that his mental health was not being addressed and that he wanted help to manage his anger and emotions, and it was not just about medication. She told him that she would arrange Dialectal Behaviour Therapy to support Mr Anderson's drug recovery work (DBT is used to develop skills to cope with stress and to regulate emotions). This did not start before Mr Anderson died.

76. On 28 October, the CSO met with Mr Anderson. She recorded that his behaviour and engagement were good and that she had no concerns. She noted that Mr Anderson had secured a job with the gardening team and that he intended to reapply for his enhanced status, which she supported. Mr Anderson applied for his enhanced status after their meeting. On the application he wrote that he had been asking to speak to the mental health team since he arrived at the prison and, had he met with them, may have been able to manage his difficult emotions better and achieved his enhanced status sooner.

77. On 30 October, Mr Anderson dropped two bags of rubbish from the upper landing to the one below, which he refused to clean up. There are no other details recorded.

78. On 31 October, Mr Anderson met with his advocate (legal representative). The advocate told prison staff that they should be vigilant, as Mr Anderson would be in court the following week and that 'his behaviour and mood may be all over the place'.

79. On 2 November, a SO told Mr Anderson that he had not been successful in his application for enhanced status due to his behaviour a few days earlier. The SO recorded in Mr Anderson's prison record that he responded by saying 'I might as well go back to behaving the way I used to which includes cutting myself'. Later, Mr Anderson asked to speak to the SO. He apologised for how he reacted to the news about his enhanced status. Mr Anderson said he did not want his hard work on improving his behaviour to go to waste and said that boredom played a part. Mr Anderson also disclosed that his impending court hearing and dealing with his children's custody case was playing on his mind.

80. On 3 November, the deputy CSO recorded in Mr Anderson's prison record that he had pressed his cell bell and asked staff to remove his razor. Mr Anderson said he had received documents from Social Services regarding his children and recognised he may be triggered and wanted to keep himself safe. The CSO put Mr Anderson on overnight concerns (additional monitoring throughout the night before assessing if the prisoner requires ongoing support). There is no evidence

staff considered starting Folder 5 procedures. No concerns were recorded overnight, and Mr Anderson appeared to sleep well.

81. Over the next week, Mr Anderson attended the gym and his job in the gardens, receiving positive reports. On 11 November, the CSO made an entry in his prison record that his behaviour had been good, and, if it continued, he would be able to apply for his enhanced status. Mr Anderson told her that there was some confusion about his sentencing date, but that he was managing.

82. On 15 November, during lunch, Mr Anderson asked to speak to two SOs about how he was feeling. He spoke about his history of self-harm, that he had recently been 'crying out for help with his mental health' and that he did not always manage situations well. Mr Anderson told them that his job with the gardens team had a positive effect on his mental health. One SO recorded that Mr Anderson explained that he was expecting to receive a parole sentence (over four years) and that he had seen a nurse earlier and was hoping to work with healthcare to break the cycle of the previous few years.

83. During the evening Mr Anderson pressed his emergency cell bell. The CSO responded and found him with his head in his hands, upset that he had written a letter which he said there was no point in sending it as he had missed the post. Mr Anderson said he was 'sound' and just wanted to be left alone. She asked him if he felt like self-harming. Mr Anderson said he did not, but that he had nothing in his cell which he could hurt himself with. She spoke to a SO, and Mr Anderson was placed on overnight concerns. No concerns were recorded, and Mr Anderson appeared to sleep well.

16 November

84. On 16 November, Mr Anderson appeared very agitated. An officer recorded that he was unsettled due to his impending sentencing hearing and that he would not engage with staff. The officer recorded that Mr Anderson asked to speak to a SO about a transfer out of the prison and said 'yous either keep me here and I'll murder someone or get me shipped, the choice is on you'. Mr Anderson said he was going to start causing trouble and fighting. The officer noted this was a concerning shift in attitude and told Mr Anderson that the SO would see him later that morning. Mr Anderson went to the library and was more settled when he returned to the wing.

85. The SO spoke with Mr Anderson for over an hour. She recorded that Mr Anderson accepted that he could be surly and difficult at times when he was struggling but had also shown that, at times, he was able to manage his emotions. Mr Anderson said he had been rude to an officer and wanted to apologise.

86. Mr Anderson spoke of his personal issues, including his children and impending sentence and that he thought a transfer may be beneficial. The SO explained that a transfer to a prison elsewhere in the UK was very unlikely. Mr Anderson also spoke about his frustration at being locked in his cell more now he was part of the gardens team than when he was a wing cleaner (this information was passed to senior management for awareness about time out of cell). Mr Anderson said that he enjoyed attending the gym and working in the garden as it felt less like prison but was concerned that he would be removed from the gardens team once he was sentenced.

87. The SO started Folder 5 procedures at 1.00pm, due to Mr Anderson's impending sentence on 18 November and how this was affecting his mood. In the entry on Mr Anderson's prison record she noted that once he had been sentenced the period of 'limbo' would end. The SO completed the immediate action plan which included that Mr Anderson should continue working, but as he was assessed as low risk, peer support was not necessary. Observations were set to every four hours. The SO completed the Folder 5 assessment and noted Mr Anderson was having trouble sleeping, was low in mood, thinking negatively and upset that he only spoke to his children once a month. The SO recorded that Mr Anderson was focussed on the future and wanted an opportunity to rehabilitate himself.

88. The SO identified four actions for Mr Anderson's caremap: to stay active through work and education (in cell education packs were requested); keep safe and not to self-harm; progress on rehabilitation (apply for enhanced status when appropriate); and apologise to the officer (Mr Anderson apologised a short time after the Folder 5 was opened). As the day progressed Mr Anderson appeared calmer and slept throughout the night.

89. On 17 November, Mr Anderson attended the gym, spoke with staff, and had lunch with his friends on the wing. No issues were recorded. The escort contractor for court contacted the prison to inform them that Mr Anderson's sentencing date had been moved from 18 to 24 November. He was told to contact his advocate for advice. Mr Anderson had a visit with a friend in the afternoon. No further issues were recorded, and he was described as settled on the wing and in a good mood.

90. On 18 November at 3.00pm, a nurse completed a Folder 5 healthcare assessment. He wrote that Mr Anderson was 'in a good place' and despite some concerns 'happy he is not at risk'. A SO chaired the Folder 5 review, attended by a nurse and Mr Anderson. (The SO incorrectly noted on the Folder 5 review that another nurse attended). The SO recorded that Mr Anderson did not think he needed to be on a Folder 5 and mentally felt 'fine' but that a transfer would benefit his rehabilitation. The review recorded that all actions had been completed, although three remained outstanding. The only action completed was that Mr Anderson had apologised to an officer for being rude. There was no record that the rescheduled sentencing date on 24 November was considered, despite this being the reason for initiating supportive measures. The Folder 5 was closed, and a post-closure review was scheduled for 25 November.

91. Mr Anderson continued to be monitored during the post-closure period. His mood was described as 'up and down'. On 20 November, the CSO met with him, and she recorded that his impending sentencing date was playing on his mind and that he did not know what to expect but would accept his sentence. Mr Anderson said he enjoyed working in the gardens, but also attended the gym and helped with cleaning on the wing to keep himself occupied.

92. On 21 and 22 November, Mr Anderson was reported to be in a settled mood and had worked well.

93. On 23 November at 10.17am, a nurse noted in Mr Anderson's record that he had a telephone consultation with a hepatitis C specialist nurse. The nurse noted that Mr Anderson needed further blood tests and the specialist nurse indicated that treatment in Liverpool would be considered, to start as soon as possible. Mr Anderson understood and had no questions.

94. At 3.10pm, an officer made an entry in Mr Anderson's prison record and described him as 'very highly strung'. When he asked if he was concerned about sentencing the next day, Mr Anderson responded by saying he 'wasn't arsed'. The officer tried to encourage him to open up about his feelings, but Mr Anderson said he was 'just thinking about everything', before changing the subject and speaking about some CDs that he wanted. The officer made another entry a few hours later, where he described Mr Anderson as more relaxed and that he was socialising with other men on the wing.

95. The person escort record (PER - a document that accompanies all prisoners when they move between police stations, courts and prisons which sets out the risks they pose) was completed by a SO ahead of Mr Anderson's court appearance the next day. There was no information on this form regarding Mr Anderson's history of self-harm or that he was in Folder 5 post-closure. The lead nurse completed the medical section of the form. There was no information noted about Mr Anderson's mental health and she recorded that there were no known risks.

24 November

96. On 24 November, around 6.30am, Mr Anderson was woken to attend court, and he requested a shower. Before he left for court Mr Anderson asked to speak to a SO, and she went to see him. He said that he was concerned about how he would manage if he was not sentenced, as he wanted to know his situation. Mr Anderson said that he was hoping that a longer sentence than he had served before would give him the opportunity to break the cycle of offending and work with DAT. Mr Anderson gave her his razor, saying that if he was not sentenced, he wanted to safeguard himself. Mr Anderson asked if she could arrange for him to have peer support when he returned from court.

97. At 8.00am, Mr Anderson was searched and taken to court by Bidvest Noonan staff. When he arrived, a senior custody officer met with Mr Anderson before he appeared in court. She described him as chatty and that he appeared his 'normal self' (it is not clear exactly how well she knew him). Mr Anderson appeared in court and was sentenced to a total of five years imprisonment. During the hearing it was reported that he had an outburst in court, but there is no specific information recorded on the PER.

98. When he returned to the court cells he punched the door several times, injuring his knuckle. The senior custody officer saw Mr Anderson was crying and he told her that he was upset at the prospect of phoning his children to explain his sentence. She said that he appeared to calm down and that punching the door seemed to be an act of frustration. At 11.10am, she documented on the PER that she cleaned the wound on Mr Anderson's hand, applied a plaster and advised him to put a cold dressing on his hand when he returned to prison. At around 12.00pm, Mr Anderson arrived back at the prison from court.

99. A SO had been made aware that Mr Anderson had punched the door at court and went to see him as he arrived back in reception. She told him that she had arranged peer support and Mr Anderson said he had calmed down. He told her he had been sentenced to longer than he had expected but was okay. They walked back to the wing together and she told Mr Anderson she was placing him on observations over the lunch period. No concerns were recorded.

100. At around 1.45pm, a nurse and an officer went to see Mr Anderson. He told them he was frustrated and upset at the length of his sentence but had no other thoughts of self-harm. They did not consider that his risk of suicide or self-harm had increased. The nurse examined Mr Anderson's hand and, although it was swollen, he could move his fingers. He declined pain relief. Mr Anderson asked for his medication early as he wanted to settle for the evening. He took this in front of staff, except his antipsychotic medication which he took with him to take later.

101. A SO saw him after he met with healthcare and noted that he appeared settled and was in a good mood. Mr Anderson had been given some CDs from his property, but the wrong disc was in one and he asked her to sort this out. She agreed but explained that it may not be until the following day, which Mr Anderson accepted. He told her that he wanted to have a resettlement meeting and wanted to focus on setting his sentence targets.

102. Later that afternoon, the CSO went to see Mr Anderson. He told her that he was fine with his sentence but would struggle not seeing his children regularly over the next few years. They discussed how his behaviour would determine if he reached his enhanced status as he would have extra visits and family days. Mr Anderson said that he wanted to have a custody plan in place as soon as possible to make the best of his sentence.

103. Around 5.00pm, CCTV shows Mr Anderson associated with his peers on the wing. He had a bandage on his left hand. Mr Anderson spoke to an officer for a short time, who then locked him in his cell at 5.16pm.

104. At around 6.25pm, the prison received a call from one of Mr Anderson's friends who said she was concerned having received an email from him the previous week. She said that he had cut himself but had not yet been seen by the mental health team or psychiatrist. A SO spoke to Mr Anderson's friend, who said she had just spoken to him on the phone and that he appeared in a good mood, but she was concerned that in a few days' time he may be affected when the length of his sentence 'sinks in'. The SO reassured her that staff had spoken to him at length when he returned from court and that Mr Anderson would be seen by the mental health team. The SO said that Mr Anderson's friend did not share any immediate concerns and he did not consider reopening the Folder 5 or placing him on overnight concerns because he knew that Mr Anderson got frustrated with being observed frequently.

105. At 9.06pm, an officer responded when Mr Anderson pressed his emergency cell bell. He asked the officer why the telephone was no longer working, and the officer explained that the phone system was down across the prison. Mr Anderson appeared to accept this, and no concerns were noted. Because Mr Anderson was not on any additional monitoring, he was not checked again throughout the night.

106. The prisoner who lived in the cell next door to Mr Anderson said that they spoke during the evening and Mr Anderson had said he was not bothered about his sentence. He said that the conversation was no different to any other night and there was no obvious sign that Mr Anderson was in crisis. He said when he woke during the night he could hear Mr Anderson's television but thought he had possibly taken a sleeping tablet and just fallen asleep without switching it off.

107. Between 15 November and 24 November, Mr Anderson made 138 calls to his family and friends; not all calls were answered. The investigator listened to the calls in the week before he died. At times Mr Anderson was jovial, but at others sounded down. He told his family and friends that he was struggling with his mental health and had waited over four months to be seen by the mental health team and was only referred to the psychiatrist after he had self-harmed.

108. On 24 November, Mr Anderson made 26 calls, again not all were answered. He spoke to six different friends, his mother and partner. He said that he had been sentenced and that the information on the news made him look bad. Mr Anderson spoke about getting off the island and wanted to rehabilitate himself. The last conversation he had was at 6.19pm with his mother, which lasted for around five minutes. Although at times he sounded a little down, there was nothing in these calls that suggested he was in crisis. Mr Anderson spoke to his ex-partner five times the day he was sentenced. These were not recorded as the prison had incorrectly marked her number as though she was an advocate (despite being listed as his partner). Mr Anderson tried to call her again twice after he spoke to his mother, but they were not answered. (All prisoners' telephone calls, except those that are legally privileged, are recorded, and prison staff listen to a random sample.)

25 November

109. CCTV shows that around 7.31am, an officer started the early morning routine check of all prisoners on the unit. She arrived at Mr Anderson's cell two minutes later. She looked through the observation panel in the door and could not see Mr Anderson in bed. She checked to see if he was using the toilet, put the night light on and saw him on the floor. She said Mr Anderson looked as though he had slumped off his bed with his head was between his legs. She tried to get a response from Mr Anderson by shouting his name and kicking the door. She used her radio to request the operational manager attend the wing and made a further urgent request for healthcare to attend.

110. The officer entered the cell at 7.35am, when she saw her colleagues responding to her urgent request. She did not enter sooner, as there had been recent incidents of prisoners pretending to be dead or trying to jump out at staff to scare them, so she made a dynamic risk assessment not to enter until other colleagues were present for her own safety. When staff entered the cell, they found Mr Anderson with a white plastic bag over his head, tied with headphones. The officer said that when she touched him, Mr Anderson was cold. Staff removed the plastic bag and moved Mr Anderson to the landing where there was more space to start cardio-pulmonary resuscitation (CPR). Two nurses quickly responded, and officers shouted for them to bring the emergency medical equipment. They attached a defibrillator to Mr Anderson which indicated he had no shockable heart rhythm. One nurse was unable to insert an airway, as Mr Anderson's jaw was clamped shut due to rigor mortis.

111. Isle of Man Ambulance Service records show that an ambulance was requested at 7.38am. Paramedics arrived at the scene at 7.49am. Mr Anderson's death was declared at 7.55am.

112. Staff covered Mr Anderson's body with a sheet and placed screens around him to preserve his dignity. A nurse sat holding Mr Anderson's hand until around

9.25am, before returning to her duties. Mr Anderson's body remained in situ on the landing. Police attended the scene at around 9.53am, and Mr Anderson's body was removed at 1.12pm.

113. Mr Anderson did not leave a suicide letter. After his death Mr Anderson's mother provided the investigator with a letter from his ex-partner, the contents of which are likely to have upset Mr Anderson. We do not know when Mr Anderson received this letter or if it had any impact on his decision to take his own life.

Contact with Mr Anderson's family

114. Isle of Man Constabulary broke the news of Mr Anderson's death to his family. The police told prison managers that the family did not want anything to do with them and so they did not attempt to make any further contact. The family did not receive a condolence letter and there was no offer of assistance towards funeral costs. Mr Anderson's funeral was held on 21 December 2022.

Support for prisoners and staff

115. After Mr Anderson's death, there was not a collective debrief for all staff involved in the emergency response as there should have been. Senior managers did speak to people individually, but not everyone felt supported. The staff care team and prison psychologists also offered support.

116. The prison posted notices informing other prisoners of Mr Anderson's death and offering support. Staff reviewed all prisoners assessed as being at risk of suicide or self-harm in case they had been adversely affected by Mr Anderson's death. The prison does not have a Listeners Scheme (prisoners trained by Samaritans to support other prisoners), but Samaritans attended the prison and offered support. A memorial service was held on 22 December 2022.

Post-mortem report

117. The post-mortem report concluded that Mr Anderson's death was due to plastic bag suffocation and ligature compression of the neck. Toxicology results showed only his prescribed medication and did not find any illicit substances.

Findings

Management of Mr Anderson's risk of suicide and self-harm

118. Isle of Man Prison's suicide and self-harm prevention measures are known as Folder 5. This process is set out in the prison's Self-harm and Suicide Prevention Policy and Procedures dated 5 May 2022. This process is, in part, reflective of the ACCT procedures adopted in England and Wales. The documentation is similar to a previous version of ACCT plans, but the recording of daily observations and contacts are made separate to the document in the prisoners' electronic record.

119. In their recent inspection of Isle of Man Prison, HMIP found that the management of prisoners at risk of suicide and self-harm was inadequate. We also found the approach to the prevention and management of suicide and self-harm relied heavily upon good staff/prisoner relationships, and previous knowledge of the individual, rather than there being an evidenced based, objective assessment of the risks and triggers. Staff had not been sufficiently trained and the process for supporting prisoners at increased risk relied on monitoring rather than addressing the needs of the prisoner to reduce that risk. This was evident in how Mr Anderson was managed in the week leading up to and on his return from court, when he was sentenced.

Folder 5 procedures

120. Prison staff started Folder 5 measures on three separate occasions during Mr Anderson's most recent time in custody (26 July to 9 August, due to history of self-harm;12 to 29 September, after he made significant cuts to himself and 16 to 18 November, when he became stressed about his upcoming sentencing hearing).

121. There was some good practice. Staff spent time with Mr Anderson to understand his issues and frustrations, they were proactive in providing support and showed compassion and understanding. There were frequent and detailed entries on his prison record. However, we found too much emphasis was placed on staff's previous knowledge of Mr Anderson, rather than assessing and understanding other factors that impacted on his risk. Staff did not consider asking Mr Anderson if he wanted his family involved in the Folder 5 process as an additional source of support.

Folder 5 - 16 to 18 November

122. Mr Anderson had received excellent reports for his work and engagement on the wing and he was hoping to gain his enhanced status. Yet in the week or so before he was due for sentencing (originally scheduled for 18 November), he struggled controlling his emotions. Mr Anderson had previously spoken freely about his impulsiveness and how this sometimes led him to self-harm. The decision to start Folder 5 procedures was appropriate to provide him with additional support leading up to his court appearance. However, when his sentence date was rescheduled to 24 November, the upcoming court date was not considered as an ongoing trigger. Nor, it seems, was his ongoing anxiety

about Social Services' involvement with his children, or the possibility that his recent diagnosis of hepatitis C might also cause him to worry.

123. The decision to close the Folder 5 on 18 November was poorly judged, and apparently based on Mr Anderson's statement that he had no thoughts of suicide or self-harm, rather than an objective consideration of the ongoing stressors in his life.

124. Isle of Man Prison did not have an effective staff suicide and self-harm awareness training programme. Staff who completed and managed Mr Anderson's Folder 5s had not been trained to complete the Folder 5 assessment and nobody had been trained as case manager. Most staff had either never had any specific Folder 5 training, or not received recent refresher training or ever, except for observing a colleague. The policy requirement that reviews were held every 48 hours, regardless of risk and need, meant that it was difficult to ensure consistency in who chaired or attended the reviews.

125. Caremaps, used to record the specific issues that led to the opening of a Folder 5 and what actions would be completed to reduce the risk, were ineffective and not reviewed. A good caremap identifies specific, realistic, achievable actions which are linked to and should address the prisoner's individual risks. One of the actions on Mr Anderson's caremap was that he should 'keep himself safe and not self-harm', with little further detail of how that would be achieved. Several risk factors were unresolved, including ongoing mental health problems that had not been assessed, despite having been flagged as an issue when he first arrived at the prison. A full mental health assessment would have assisted staff to make a more informed decision about Mr Anderson's risk. (The provision of mental health support is covered in more detail in a separate section.) Drawing up an effective caremap requires training, and in the circumstances, we are not surprised that staff struggled with this aspect of Mr Anderson's Folder 5.

126. Isle of Man Prison had been reviewing the Folder 5 process for some time and had intended introducing a bespoke Custody Care Plan. However, during the PPO investigation, the Head of Isle of Man Prison and Probation Services and prison Governor decided the prison would adopt the newest version of the ACCT process used in England and Wales, which was already well established. The implementation of ACCT is set out in a comprehensive Prison Service Instruction (PSI) 64/2011 *Management of prisoners at risk of harm to self, to others and from others (Safer Custody)*.

127. On 10 July, HMPPS Safety Team visited Isle of Man Prison for four days to deliver ACCT training. During this training week, 79% of prison officers were trained and 100% of healthcare, education, and Bidvest Noonan staff. In addition, seven staff were trained as ACCT assessors and five as case coordinators. Four staff have also been identified to complete the train the trainer course for ACCT assessors, to ensure ACCT training can be delivered to those not able to attend the initial training, or new starters. Any officer promoted to SO will be trained as a case co-ordinator.

128. The decision to implement ACCT is a positive step forward. The ACCT process will replace the Folder 5 from 1 October 2023. Given that Isle of Man Prison has already made the decision to adopt the latest version of ACCT and introduced a

comprehensive training strategy, we do not make a separate recommendation. HMIP are due to return to Isle of Man Prison in April 2024, and will review how the new system has been implemented.

Court appearance

129. Before he left for court on 24 November, Mr Anderson had asked for peer support to be arranged for him on his return and handed over his razor. This should have alerted staff to him feeling anxious and concerned for his safety.

130. Mr Anderson travelled to court with a PER form that was inaccurate and did not have any detail about his mental health, previous incidents of suicide attempts and self-harm or the fact he was in Folder 5 post-closure. We found that all staff responsible for completing the PER were unsure what information should be recorded. This meant that Bidvest Noonan escort contractors, and court staff, were unaware of his risks. Mr Anderson was distressed in the courtroom dock, but no specific details were recorded on the PER. When he was taken to the cell after sentencing, he punched the door injuring his hand, yet nobody at the court considered starting a Folder 5. The Regional Manager for Bidvest Noonan said that it had been rare for court staff to initiate a Folder 5, but in more recent times they had started the Folder 5 process very regularly. He said awareness of the process had been poor and staff had not been provided with sufficient training on when or how to complete them, despite several requests to the prison.

131. In March 2020, a prisoner took his own life the day after he had been remanded into custody. The inquest found that vital information about his risk of suicide and self-harm noted on the PER had not been considered when he arrived at Isle of Man Prison. In response, the prison changed their process and emailed the PER to all managers to ensure information was considered when assessing risk. Although this change meant staff had the PER, there was no process to audit the quality and accuracy of information or if staff understood how to assess the risks.

132. We found that despite the changes made after the previous death, crucial information was missing from Mr Anderson's PER which indicates that current processes are not sufficient. We make the following recommendations:

    The Governor, Manx Care and the Regional Manager for Bidvest Noonan should ensure staff understand the purpose of and their responsibilities when completing a PER and introduce a robust quality assurance process to monitor accurate and appropriate information sharing.

Return to the prison after sentencing

133. When Mr Anderson returned from court, staff were proactive in checking on his welfare and offering support, including safer custody, the healthcare manager and his CSO. Observations were put in place over the lunch period, but staff appear to have been overly accepting of Mr Anderson's assurances that he did not have any thoughts of suicide or self-harm and they did not consider re-opening the Folder 5.

134. Although a prisoner's presentation can reveal something of their level of risk, it is, at best, only a reflection of their state of mind at the time that staff assess their

risk (and it may not even be that) and should be considered as one piece of evidence. It is critical that all risk factors are considered to ensure that a prisoner's level of risk is judged holistically. While we cannot know if continued monitoring on Folder 5 in the days before sentencing or re-opening the Folder 5 on the day of sentencing would have prevented Mr Anderson from taking his life, it would have provided an additional level of monitoring and support.

135. Isle of Man Prison has no separate policy or guidance for Early Days in Custody. In England and Wales PSI 07/2015, *Early days in custody*, states that there must be arrangements in place to assess prisoners whose status or demeanour may have changed after a court appearance whether in person or via video link. Further, Prison Service Order (PSO) 3050, *Continuity of healthcare for prisoners*, says that events such as attending court or sentencing at court, are factors that might have a significant impact on the health of a prisoner. When prisoners pass through reception on their return from court, prisons are required to have protocols in place for screening them to identify any potential suicide and self-harm issues. Prison and healthcare staff at Isle of Man Prison said there was no routine assessment of prisoners following an appearance in court. We consider that Isle of Man Prison would benefit from adopting a similar approach to that in English and Welsh prisons and make the following recommendation:

The Governor and Manx Care should establish a process to ensure that prisoners returning from a court appearance (in person or by videolink) are assessed for their risk of suicide and self-harm.

Availability of plastic bags

136. In response to the death of a prisoner in March 2020, the prison removed plastic bags from reception and the induction unit. Following Mr Anderson's death, they stopped using plastic bags to deliver prisoners' canteen. Since the death of another prisoner in February 2023, all plastic bags used on the wings have been removed, except for those used in the bins situated on the wing landing which were swapped on a one for one basis. We do not know why all three men had used this method, but it was suggested by most people interviewed, including other prisoners, that this was the chosen method simply because it had been effective previously. Not including the deaths at Isle of Man Prison, between January 2020 and October 2023, the PPO has been notified of and began investigations into 297 self-inflicted deaths in the prison estate in England and Wales. Six of these (or 2%) were classified as suffocation using a plastic bag.

137. The ongoing availability and use of plastic bags at the prison was questioned by the bereaved families. The cells in Isle of Man Prison had few, if any, ligature points and we know that if a person is intent on taking their own life they will find a way. We consider that a blanket approach to the management of suicide and self-harm risk is not helpful and should be based on individual circumstances and factors. If a prisoner is identified as at risk of suicide or self-harm then the removal of plastic bags should be considered as part of the management plan.

Clinical care

138. While there cannot be a direct comparison, the objective of the clinical review is to establish if Mr Anderson received equivalent care to that he would have expected to receive in the community. To provide a meaningful conclusion on equivalence of care, the clinical reviewer focused on whether there was equivalence of access to healthcare within the prison compared to the Isle of Man community (given Manx Care provide both services) and compared with healthcare provision delivered within prisons in England and Wales.

139. The clinical reviewer produced two reports. An overview of healthcare services provided by Manx Care, and one specifically reviewing Mr Anderson's care. These reports should be read in conjunction with the findings in this report. The clinical reviewer has made a number of recommendations which we have not included in our report but should be actioned by the Department of Health and Social Care and Manx Care.

Mental health

140. We found that the mental health services provided within Isle of Man Prison were inadequate, unsafe, and not equivalent to what is available in the wider community and in other comparable prisons in England and Wales. Issues identified following the inquest into the previous death in March 2020, had not been sufficiently addressed.

141. Mr Anderson had been known to mental health services since he was 11 years old. Throughout his time at Isle of Man Prison, he asked to be referred to the mental health team and was told that he had been. The referral process at the time of this investigation was by way of an electronic form, completed by healthcare staff, and emailed directly to the Integrated Mental Health Service (IMHS). However, we found no evidence that Mr Anderson had been referred, despite medical records suggesting he had. It is understood that Mr Anderson was 'open' to the mental health team already when he arrived at the prison (so no referral was necessary), but no one alerted them that Mr Anderson was in custody or asked them to see him during his time there. Healthcare staff, prison staff and prisoners told us that accessing mental health services within the prison was difficult and waiting lists excessive. However, the General Manager of the Integrated Mental Health Service said that referrals from the prison were low and that there were no waiting lists.

142. The General Manager confirmed that the IMHS did not receive a referral for Mr Anderson. We were unable to establish why a referral was not made or why his mental health was never fully assessed. During the investigation, healthcare staff told us that prisoners can either be under the care of the mental health team or DAT, but not both. The General Manager confirmed that, if it was clinically appropriate, a prisoner can be under the care of both services. A forensic psychologist works at the prison, but we were told they only work with sentenced prisoners. Referrals/allocations open to the IMHS should be checked on RiO (the electronic mental health record) on reception, but this check was not carried out for when Mr Anderson arrived at Isle of Man Prison.

143. The clinical reviewer concluded that the confusion over Mr Anderson's referral to the mental health team reflected poor understanding of the process, poor communication between services and poor integrated working. We make the following recommendations:

The Department of Health and Social Care and Manx Care should review the current provision of mental health services at Isle of Man Prison and provide a dedicated mental health service, which is sufficiently resourced to meet the needs of the population.

Manx Care should undertake a systemic population health needs assessment across Isle of Man Prison to determine the prevalence of mental health conditions and need.

Medication

144. Mr Anderson had been prescribed psychotropic medication for his mental health before entering prison. However, when he arrived at Isle of Man Prison the clinical reviewer found that the reasons for this medication were not fully ascertained or understood. He was never seen for a face-to-face review of his medication while in prison.

145. Between 26 and 29 July, Mr Anderson was given his medication without a prescription, via a transcribed medication record (copying of previously prescribed medications) created by prison nurses. We were told that nurses felt they had to transcribe in the prisoners' best interests, so they did not go without their medication. This is not lawful prescribing and against the Nursing and Midwifery Council prescribing code (NMC - professional standards of practice). We found no evidence the medications prescribed to Mr Anderson had any adverse impact on him. However, the governance around medication, in particular medications that are deemed a high risk in prison settings, was poor. Manx Care do not use The Royal College of General Practitioners (RCGP) 2019 guidance for 'safer prescribing in prisons'. There should have been better governance around prescribing highly sedative medication in response to Mr Anderson's increasing risk of suicide and self-harm. Further, he had his quetiapine medication in his possession, which posed a potential risk of overdose, a method he had previously used. We make the following recommendations:

The Department of Health and Social Care should ensure the practice of transcribing and unsafe medication practices at Isle of Man Prison have stopped.

Manx Care should ensure there is a dedicated lead pharmacy provision at Isle of Man Prison and there is a prescriber available every day, even if that is for remote prescribing.

Manx Care should implement electronic medication administration records.

Manx Care should ensure that patients who come in with complex and high-risk medication (as per the RCGP guidance) have a medication review when they arrive at the prison.

Physical health

146. The clinical reviewer concluded the physical healthcare Mr Anderson received was good. He had an annual asthma review, which was stable, in line with NICE guidelines (National Institute for Health and Care Excellence). Mr Anderson was diagnosed with hepatitis C while at Isle of Man Prison. Staff provided him with support and information and the management of his condition was in line with NICE guidelines.

Governance of healthcare services

147. We found healthcare staff morale was low. Staff felt frustrated by the lack of response from senior managers when issues were raised and how long processes took to change. We were provided with the Manx Care governance structure and there appeared to be a lack of clinical governance and quality oversight dedicated to prison healthcare. The approach to making changes around clinical governance and healthcare policy seemed to be largely reactive after an event, rather than it being a proactive approach with a drive for continuous evaluation and improvement. We found there were evident layers of complicated bureaucracy when it came to clinical governance and making changes to the healthcare system. We were not assured that there were clear lines of responsibility within the governance and executive structure.

148. There was evidence of good clinical practice by individual members of healthcare staff who worked on goodwill and dedication. However, we found that the importance of promoting staff wellbeing and resilience was not given the priority it deserves, with an overall lack of support, supervision, and training. Healthcare staff said that there were no regular team meetings and that they did not have clinical supervision. We were told that this issue related to recruitment challenges, staff turnover, sickness, and several senior management changes. Throughout our investigation the healthcare manager was required to help on an operational level due to staffing issues, impacting on her managerial and strategic responsibilities. We found there was not enough resilience within the healthcare system at the prison. We make the following recommendation:

    Manx Care should have a dedicated clinical governance lead responsible for prison healthcare at Isle of Man Prison to ensure practice is compliant and underpinned by national guidance, legislation and evidence-based practice.

Emergency response

Communicating the emergency

149. Isle of Man Prison does not have a clearly understood policy on communicating a medical emergency. (During the consultation process, Manx Care said that a medical emergency response procedure was introduced by prison healthcare in 2014 in conjunction with the then Governor. Changes in prison and healthcare leadership have led to a ‘loss of organisational memory’ which resulted in this procedure not being recalled by staff during the investigation). When Mr Anderson was discovered, an ‘urgent’ message was radioed. Some staff thought this was for a medical emergency, some staff said this was for any significant

incident and other staff did not know what an 'urgent' call signified. Staff did respond quickly, including healthcare staff, but it was only once Mr Anderson had been assessed that an ambulance was requested, a delay of around five minutes. In this instance, the delay did not make any difference to the outcome, as Mr Anderson was already dead.

150. PSI 03/2013, *Medical Emergency Response Codes*, which is used within English, Welsh and Scottish prisons, sets out the actions staff should take in a medical emergency. Two distinct codes are used; code blue if a person is unresponsive or not breathing, and code red if there is significant blood loss or burns. It contains mandatory instructions for Governors to have a protocol on efficiently communicating the nature of a medical emergency, ensuring staff take the relevant equipment to the incident and that there are no delays in calling an ambulance. It says that if a medical emergency code is called over the radio, an ambulance must be called immediately.

151. We found that staff did not have any clear guidance on effectively communicating when there is a potentially life-threatening medical emergency. We recommend the following:

The Governor should introduce a clear protocol to staff for effectively communicating a medical emergency.

Resuscitation

152. In September 2016, Professor Sir Bruce Keogh, National Medical Director at NHS England wrote to Heads of Healthcare for prisons and Immigration Removal Centres in England and Wales introducing new guidance to support staff on when not to perform cardiopulmonary resuscitation. This guidance was designed to address the issue of inappropriate resuscitation following a sudden death in a prison and was taken from the European Resuscitation Council Guidelines 2015 which state, "Resuscitation is inappropriate and should not be provided when there is clear evidence that it will be futile". We were told that the Manx Care Governance Team were not aware of this guidance, despite it being published in 2016.

153. The officer told the investigator that she believed Mr Anderson was already dead when she discovered him. A nurse said she observed that Mr Anderson showed signs of rigor mortis, which occurs some hours after death. When paramedics arrived, they also recorded there were obvious signs of death, and that rigor mortis was present. We understand the commendable wish to attempt and continue resuscitation until death has been formally recognised, but staff should understand that they are not required to carry out CPR in these circumstances. Trying to resuscitate someone who is clearly dead is distressing for staff and undignified for the deceased.

154. Isle of Man Prison does not have a policy or guidance on when it is not appropriate to start CPR. We were told by all those we interviewed that they were required to commence CPR until a doctor or paramedic declared death, which was reflected in guidance from 2015 which stated that staff should continue CPR 'irrespective of the length of time they (the prisoner) was thought to have been lifeless'. We were unable to establish what informed this guidance and it was

suggested it was based on personal, moral, and ethical views of those involved in writing the policy, although it was ratified by the Policies and Procedures Committee of the Department of Health and Social Care.

155. Manx Care had identified the need for guidance on when it is not appropriate to commence CPR after the previous death, which was again highlighted after Mr Anderson's death. There has been another death since, when staff felt the need to commence CPR when it was not appropriate to do so. During her interview in June 2023, the Care Quality and Safety Coordinator for Manx Care said that new guidance was in the process of being agreed. Given this was three years since the first of the three self-inflicted deaths, seven months after Mr Anderson's death, and there had been a similar incident in February 2023, we do not understand why this guidance was not given greater priority. Had the guidance been published sooner, the trauma staff experienced would have been reduced, and the indignity for the deceased would have been avoided.

156. After Mr Anderson's death there was a review of the prison healthcare department's response to the care needs of Mr Anderson by the Care Quality and Safety Coordinator, which concerningly highlighted that the prolonged CPR given to him was good practice.

157. Manx Care responded to feedback during the PPO investigation about the need to expedite and publish revised guidance. The new guidance was agreed in June 2023, and reflects that in effect in England and Wales. However, it is directed to Manx Care staff only and is not joint guidance for both healthcare and prison staff. We make the following recommendation:

The Governor and Manx Care should ensure that there is clear joint guidance and training for all staff, about the circumstances in which resuscitation is inappropriate in accordance with European Resuscitation Council Guidelines.

Events after Mr Anderson was declared dead

158. The Death in Custody Policy dated 19 April 2018 (subsequently reviewed on 1 December 2022 by the Deputy Governor) states that following a death the body must be moved in accordance with the protocols previously agreed with the police and Coroner. We requested a copy of this protocol, but it was not provided.

159. After paramedics declared that Mr Anderson had died, his body was covered with a sheet and screens placed around him. Prisoners remained behind their doors and food was delivered to them by staff. Mr Anderson's body was left lying on the landing for around five hours before it was collected by a private ambulance. All staff interviewed said that they believed his cell and the area on the landing was a 'crime scene' and they could not move Mr Anderson's body until the police had given their authority. Isle of Man Prison do not have any specific death in custody contingency plans, so were guided by the police who advised them to leave Mr Anderson's body on the landing.

160. The investigator contacted the Acting Detective Chief Inspector for Major and Specialist Investigations and Intelligence Departments from the Isle of Man Constabulary, to ask if there was guidance or policy on returning the deceased to

their cell. She explained that the police would always request that, as far as reasonably possible, a body is left in situ to prevent any further disturbance of forensic evidence (although there was no shared understanding of what specific evidence this referred to) in a suspicious case and to rule out any third-party involvement. She said this was standard practice in any sudden death, but the context of a prison death had not been specifically considered.

161. We consider it was inappropriate and distressing that Mr Anderson was not moved back into his cell. There was no suspicion a crime had been committed. Staff had already entered Mr Anderson's cell when he was discovered and moved him to the landing, so it would not have made any significant difference if his body had been sensitively placed back into the cell. Prison managers reflected that they were very conscious of the time it had taken to remove Mr Anderson's body, which was also the case in the previous death in March 2020 and the subsequent death in February 2023, but had not specifically had any discussion with the Isle of Man Constabulary regarding a protocol following a death in custody. We make the following recommendation:

The Governor should consider establishing a protocol with the Isle of Man Constabulary to ensure that following a death in custody the deceased's body is moved back into their cell for dignity, if there is no suspicion of a crime.

162. Both nurses did not want to leave Mr Anderson, and both stayed with him after he was declared dead. One nurse had to return to her duties, so the other nurse sat with Mr Anderson for around two hours because she did not want to leave him alone where he was. When she did leave him, she also returned to her healthcare duties. This event was hugely distressing for all staff involved in the emergency response. Both nurses showed a high degree of compassion, went beyond what could be reasonably expected and should be commended for their level of care.

Informing Mr Anderson's family

163. The Death in Custody Policy states that it is essential following a death that prison staff work openly with bereaved families, that the prison must inform the next of kin and any other person reasonably expected to be informed and that it was good practice to appoint a dedicated family liaison officer (FLO).

164. Isle of Man Constabulary broke the news of Mr Anderson's death to his family before the prison had an opportunity to do so. The visiting prison chaplain is a trained FLO at Isle of Man Prison and had undertaken his training at HMPPS training centre. Although the Governor said he knew the chaplain was a trained FLO, the Deputy Governor did not. He said he believed the decision for the police to inform Mr Anderson's family was made because there was not a trained FLO at the prison.

165. Because the police told the prison that Mr Anderson's family wanted no further contact from the prison, they did not attempt to do so. Isle of Man Prison did not consider contributing towards the cost of Mr Anderson's funeral (in England and Wales the prison contributes up to £3,000 towards funeral costs) and did not send the family a condolence letter.

166. The Governor explained that the Acting Detective Chief Inspector was against the prison making contact, given the family's feelings, and that the police had appointed a FLO. He said he did not want to antagonise the family by contacting them, against the advice from the police, but accepted that further efforts could have been made and a condolence letter should have been sent.

167. We found that contact with Mr Anderson's family should have been more considered and the prison did not follow its own Death in Custody Policy. Although the chaplain is a trained FLO, the prison must have enough trained prison staff to undertake this vital role. We make the following recommendation:

The Governor should ensure that the prison complies with its own policy for contacting the family of a deceased prisoner and that they have adequately trained family liaison officers.

Staff support

168. Giving staff the opportunity to collectively discuss an incident and reflect on all aspects of how it was managed is fundamental to providing the prison with feedback on any issues that need to be addressed. It also provides those directly involved with an opportunity to process events. This is also stipulated in the prison's Death in Custody Policy.

169. Although staff involved in the emergency response were spoken to individually after Mr Anderson's death by the operational manager, there was not a collective debrief as there should have been. The staff care team and the TRiM manager (trauma risk management for staff) contacted staff and support was offered by a prison psychologist.

170. Many staff involved in the emergency response said that support after Mr Anderson's death could have been better and they did not feel sufficiently supported. Both nurses had to return to medication duties, despite senior Manx Care staff being in the prison. Neither Isle of Man Prison nor Manx Care have specific death in custody contingency plans, which meant they were being reactive on the day in a situation that was not common. While we accept that the prison does not have many deaths, there should have been a proactive response after the previous death in March 2020 and contingencies reviewed and agreed so senior staff understood the expectations. We make the following recommendation:

The Governor and Manx Care should ensure that all relevant staff, irrespective of status, position, or experience, are able to attend a debrief following a death in custody and that they receive appropriate aftercare support.

Isle of Man Prison response to deaths in custody

171. There was no independent investigation into the circumstances surrounding the death in March 2020. We understand that the prison conducted an internal investigation and they responded to the findings at the conclusion of the inquest. Changes were made to practice and processes at Isle of Man Prison; plastic bags were removed from reception and the induction wing, anyone with a history

of suicide or self-harm was placed on a Folder 5 when they arrived at the prison and PER forms were sent to all managers. However, we found that these changes did not result in improved management of those at risk of suicide or self-harm.

172. The PPO was commissioned to complete an investigation into the two most recent deaths, following the HMIP Inspection that took place between 27 February and 10 March 2023 (a prisoner died in similar circumstances in February 2023). There are many similarities in all three self-inflicted deaths. Although some of the learning in this report had already been identified by the prison and Manx Care, the healthcare providers, this has not resulted in the change we would have expected to see. We therefore recommend:

The Department of Home Affairs should consider immediately commissioning an independent investigation in the event of any future non-natural deaths at Isle of Man Prison.

Governor to Note

Safer Custody Meeting

173. Isle of Man Prison holds a monthly Safer Custody Meeting (SCM). The Self-harm and Suicide Prevention Policy and Procedures document, dated 5 May 2022, sets out who is required to attend, including the Deputy Governor, who is chair, the Safer Custody Principal Officer and Healthcare Manager. The objectives of the meeting include the monitoring, delivery and quality of the Folder 5 procedures. We found, as did HMIP, that governance and oversight of this critically important area was poor.

174. The investigator requested copies of SCM minutes between June 2022 and June 2023. There were no minutes for July or December 2022. The Deputy Governor said that the meetings may have been rescheduled for staff to attend and that they were not cancelled but 'postponed… so one meeting is counted as two, effectively'. Of the ten meetings that did take place between these dates, the healthcare manager only attended three meetings (10 January, 9 February, and 20 June 2023). The current manager only took up post a few weeks before Mr Anderson's death and there was no agreed protocol for someone else from Manx Care to attend. The Principal Officer from Safer Custody also attended just three meetings (8 September, 9 February and 20 June 2023). There was no specific mention in these meetings of Mr Anderson's death.

175. While we understand that there is a daily briefing and staff exchange information about those prisoners where there are concerns, the SCM should be a priority for the prison. We found that the information recorded lacked meaning. The meetings were only monthly, and attendance was inconsistent.

176. During the investigation we raised our concerns with the Governor. Since 24 June 2023, the prison has now introduced a weekly Review of Complex Cases (RoCC) meeting, the aim and objective of which is set out in the new Complex Case Strategy. All staff have been informed and advised how to make a referral. Attendance by the senior leadership team is mandatory, as well as representatives from across the prison. The RoCC aims to ensure that risk

information is accurately recorded, and relevant information is shared with all prison and probation staff, as well as external agencies to ensure the safety and well-being of prisoners. Given the prison has already taken action to address this issue, we do not make a separate recommendation.

Prison record

177. Isle of Man Prison uses PIMS (Prisoner Information Management System) an electronic record where all contacts and events are recorded. We found that entries in Mr Anderson's record were frequent and detailed. However, each time a prisoner comes into custody, a new record is created for them. This means that information recorded on earlier sentences is not so easily accessible, resulting in potentially key information about risk being overlooked. The Governor will wish to consider this.

Listeners Scheme

178. Isle of Man Prison does not have a Listeners scheme. (Listeners are prisoners who have been specially trained by Samaritans to provide support to their peers.) The first Listener scheme was introduced in an English prison in 1991 and Listener schemes operate in almost every prison in the UK. The Deputy Governor said the prison would be keen to introduce Listeners at Isle of Man Prison, but Samaritans on the island were reluctant to deliver training. While we understand the population is very small and many prisoners would not be serving sufficiently long sentences to justify training, this should be further explored.

Body Worn Video Cameras

179. Body Worn Video Cameras (BWVC) are not currently used in Isle of Man Prison. BWVC's are an important source of evidence for investigations and wider learning for prisons following an incident. HMPPS staff are required to wear BWVCs, and the relevant policy requires prison staff to activate them during any reportable incident, including medical emergencies. The Department of Home Affairs will wish to consider this.

Healthcare to Note

Medical records

180. We found the clinical records system at Isle of Man Prison (and across the island) was disjointed, cumbersome and not fit for purpose. The prison, hospital, mental health team, and GP surgeries all have separate recording systems that do not link up. This means that information either has to be duplicated across systems, or more concerningly, significant information about care and clinical need is not shared. We were told that various reviews of the medical record system had taken place and that the introduction of one system to record all clinical contacts was being considered, but that this had been ongoing for 'years'. The Department of Health and Social Care and the Department of Home Affairs should expedite their considerations.

Inquest

181. The inquest into Mr Anderson's death concluded on 25 April 2024. Mr Anderson's death was suicide, as a result of plastic bad suffocation and ligature compression of neck, while the balance of his mind was disturbed.

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