Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Christopher Corkill, a prisoner at Isle of Man Prison, on 24 February 2023

A report by the Prisons and Probation Ombudsman

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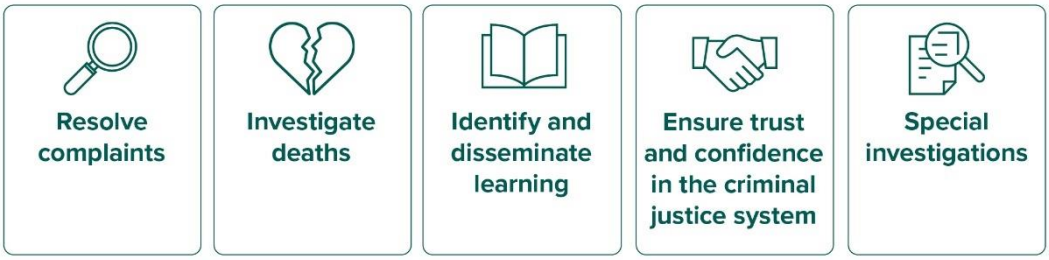
OUR VISION

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

WHAT WE DO



WHAT WE VALUE

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

My office does not have any jurisdiction in the Isle of Man but was invited by the CEO of the Department of Home Affairs, Mr Dan Davies, 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 Christopher Corkill was found dead in his cell at Isle of Man Prison on 24 February 2023. He had suffocated himself by placing a plastic bag over his head. He was 46 years old. I offer my condolences to Mr Corkill's family and friends. This is the third self-inflicted death at the prison since March 2020.

Mr Corkill had a history of self-harm and was supported by suicide and self-harm prevention measures, known as Folder 5, when he first arrived at Isle of Man Prison in July 2022. However, we found no evidence that staff could have reasonably identified that his risk of suicide had increased before he died.

The clinical reviewer found the overall care provided to Mr Corkill by Manx Care was not equivalent to that which he could have expected to receive in the community.

Mental health services within Isle of Man Prison were found to be inadequate, unsafe, and not equivalent to what is available in the wider community. Despite Mr Corkill's history of mental health issues, and recent self-harm before he entered prison, he was never referred for a mental health assessment. This was a significant failing. Mr Corkill also had a number of chronic physical health issues. There were no care plans, and he was not adequately monitored.

When Mr Corkill was discovered, he had been dead for some time. We have identified a number of factors that should be addressed to improve the 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 management of risk and the need to develop clear protocols 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**

Contents

Summary

Events

1. On 23 July 2022, Mr Christopher Corkill was remanded to Isle of Man Prison, charged with drug offences. On 29 July, he appeared in court and was sentenced to 34 months and 20 days imprisonment. Mr Corkill had been to prison before.

2. Mr Corkill had a long history of substance misuse and mental health issues. He had been diagnosed with schizophrenia, drug induced psychosis and had a history of self-harm and attempted suicide. In the month before he was remanded, Mr Corkill had made significant cuts and burns to his arms. He also had some chronic physical health issues, including heart failure.

3. Mr Corkill was supported by the prison's suicide and self-harm prevention measures (known as Folder 5) on one occasion, when he first arrived at Isle of Man Prison. There was nothing obvious in his demeanour in the weeks before he died to suggest his risk of suicide had increased.

4. At 7.52am on 25 February, an officer unlocked Mr Corkill's cell for him to collect his medication. The officer looked into the cell, saw Mr Corkill lying on his bed and moved on. The officer returned to the cell four minutes later and discovered Mr Corkill lying unresponsive on his bed, with a plastic bag over his head. The officer radioed for assistance and prison and healthcare staff responded. Paramedics declared Mr Corkill's death at 8.09am.

Findings

5. Mr Corkill's was the third self-inflicted death at Isle of Man Prison since March 2020, and we found that the prison had not made sufficient changes or responded to the learning from the previous deaths.

6. We found, as did HM Chief Inspector of Prisons, the management of prisoners at risk of suicide and self-harm was inadequate. Too much emphasis was placed on staff/prisoner relationships and prior knowledge of the person. Mr Corkill was subject to Folder 5 procedures when he first arrived, the management of which was poor; there was no assessment, no medical report and no caremap.

7. The clinical reviewer found that the mental health provision at Isle of Man was inadequate, unsafe and the care Mr Corkill received was not equivalent to that which he could have expected to receive in the community. Despite Mr Corkill's significant mental health history, previous self-harm, and 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.

8. Mr Corkill did not receive equivalent care for his physical health issues. Despite his chronic conditions, there were no care plans and no formalised process to assess and review him.

9. We identified unsafe practices regarding the issuing of medication, a lack of clinical governance and quality oversight dedicated to prison healthcare and an insufficient response to Mr Corkill's death from Manx Care.

10. The immediate response when Mr Corkill was found unresponsive was inefficient, largely because the prison has no specific emergency response policy. Similarly, the lack of clear guidance for staff led them to attempt to resuscitate Mr Corkill despite clear signs of death.

11. We found that it was inappropriate that Mr Corkill's body was not placed back into his cell after he was declared dead.

12. We also have concerns about how Mr Corkill's family were informed of his death and staff support following it.

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.

- Manx Care should ensure there is a long-term conditions monitoring register and clinic.

- 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 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 implement electronic medication administration records.

- 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 Serious Incident Review Group of Manx Care should always complete an investigation following a death in custody.

- 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 for all staff, and check their understanding, 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 families of deceased prisoner and that they have adequately trained family liaison officers.

- The Governor should ensure in the event of a death in custody, prisoners' in-cell telephones should be disconnected immediately to avoid families being notified before the prison have an opportunity to break the news.

- 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

13. 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 Corkill's death in February 2023 and another man in November 2022, 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.

14. 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.

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

16. The PPO commissioned a clinical reviewer to review Mr Corkill's clinical care at the prison. The investigator and clinical reviewer interviewed 18 members of staff and two prisoners in June 2023. They interviewed the prison Governor and General Manager for Integrated Mental Health Services on 6 July.

17. The investigator and clinical reviewer met with the Governor and separately with Manx Care in July, to provide feedback on the investigation and share the emerging findings so they could act before the publication of the PPO report.

18. 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.

19. The investigator contacted Mr Corkill's brother and partner to explain the investigation and to ask if they had any matters they wanted us to consider.

Mr Corkill's brother asked:

- Why are plastic bags still available when a previous review into a death said they should all be removed?
- What was known about Mr Corkill's history of suicide attempts?
- Are prisoners checked as they should be while subject to enhanced monitoring as part of the suicide prevention measures?
- Why was Mr Corkill discovered by another prisoner and not a member of staff?
- Why did Mr Corkill's partner find out about his death two hours before the prison made contact?
- Why did the prison not make any direct contact and why was communication from the prison, police and Department of Home Affairs poor?
- Did Mr Corkill leave a suicide note?

Mr Corkill's partner asked:

- Why were plastic bags available, given there had been previous deaths at the prison by this method?
- Why was she informed of Mr Corkill's death via a message from another prisoner?
- Why there was no other contact from the prison and no condolence letter.

20. Mr Corkill's brother and partner received a copy of the initial report. They did not highlight any factual inaccuracies.

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

22. 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.

23. 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

24. 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 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 for female prisoners, and vulnerable prisoners. There is also a care and separation unit (segregation).

25. Manx Care (equivalent to the NHS in England) have provided healthcare at the prison since April 2021. Prior to that date 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; 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)

26. 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.

27. 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.

28. After a suicide in March 2020, and another similar death in November 2022, 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 the 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.

29. Inspectors found 98% of prisoners had a named Custody Support Officer 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).

30. 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.

31. Inspectors noted that there had been recent organisational restructuring, 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 the Governor was committed to change.

Independent Monitoring Board

32. 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 has 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.

33. 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 HMP Isle of Man

34. Mr Corkill was the third prisoner to die at Isle of Man Prison since March 2020. The previous deaths were both self-inflicted and 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

35. Folder 5 is 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.

36. 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 prisoners' electronic prison record.

Assessment, Care in Custody and Teamwork

37. 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.

38. 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

39. On 23 July 2022, Mr Christopher Corkill (known as Peanut) appeared in court charged with drug offences and he was taken to Isle of Man Prison. Mr Corkill had been to prison before. On 29 July, Mr Corkill was sentenced to a total of 34 months and an additional 20 days for breaching a previous licence.

40. In the month before he was imprisoned, Mr Corkill was under the care of the Mental Health Crisis Response Team. He was described as extremely paranoid, hearing voices and had visual hallucinations. He also self-harmed by cutting and burning his arms. Mr Corkill was due to have an operation to have an implantable defibrillator fitted (due to heart failure) but the procedure was deferred as his arms were infected.

41. Mr Corkill had a long history of substance misuse. He was diagnosed with schizophrenia, drug induced psychosis and had a history of self-harming and suicide attempts. Mr Corkill also had a number of physical health conditions including heart failure, angina, chronic obstructive pulmonary disease (COPD), high blood pressure and eczema. Mr Corkill was prescribed medications to manage his physical health issues. In addition, he was prescribed medication for anxiety (diazepam), an antidepressant (mirtazapine), medication that controls neuropathic pain that also treats anxiety (pregabalin) and an antipsychotic (risperidone).

Arrival at Isle of Man Prison

42. When he first arrived at the prison, Mr Corkill was managed under the prison's suicide and self-harm procedures, known as Folder 5, as his 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) outlined his recent self-harm. Mr Corkill was insistent that he had never attempted suicide and had no thoughts of doing so. Mr Corkill was initially observed every half an hour, which was reduced to hourly the next day.

43. During his initial healthscreen, Mr Corkill's medical history was noted and that he was under the care of the Drug and Alcohol Team (DAT). Mr Corkill was allowed to have his GTN spray in possession (to treat angina and chest pain), but he had to collect all other medications daily. Mr Corkill's blood pressure was high. He was examined the next day and an electrocardiogram (ECG – a test to check the heart's rhythm) was completed. Although his blood pressure remained high, we found no evidence that staff reviewed the ECG results or planned to continue monitoring him. Between 23 – 26 July, Mr Corkill was given his medication without a prescription, via a transcribed medication record (when staff copy previous prescriptions) created by nurses at the prison.

44. Prison staff had no concerns about Mr Corkill when he arrived. He appeared settled on the wing, mixed well with other prisoners, and raised no issues, other than a request for a more comfortable mattress. Folder 5 observations were reduced to three a day. The Folder 5 assessment and caremap were never completed.

45. On 26 July, Mr Corkill appeared in court and pleaded guilty to all offences. No bail application was made, and he returned to Isle of Man Prison. Although there is an

entry in Mr Corkill's prison record that he left the prison, there is nothing in the record to detail what happened at court or that anyone checked on Mr Corkill's wellbeing or if his court appearance and guilty status had impacted upon his risk of suicide or self-harm.

46. On 28 July, an officer was assigned as Mr Corkill's Custody Support Officer (CSO - a named point of contact to provide support to prisoners and help solve any issues they may have). Mr Corkill said his only concern was about his partner being made homeless as the tenancy for their property was in his name. The officer contacted the resettlement team to provide advice and support to Mr Corkill. He met with Mr Corkill regularly. He facilitated contact with the resettlement team to help him sort issues regarding his housing and finances. Mr Corkill worked in the prison laundry before he asked for a wing-based job, as he found the laundry work too strenuous.

47. On 29 July, Mr Corkill appeared in court and was sentenced. He told staff that he was expecting double the sentence he received and was pleased with the outcome. Later, at a Folder 5 review, Mr Corkill told staff that he did not require support through the Folder 5 process, and they agreed to close it. A post-closure review was scheduled for 5 July. This is an error and should have read 5 August. A post closure review was never completed.

48. On 12 August, Mr Corkill submitted a complaint that he had not been seen by a doctor, despite being at the prison for a month, and felt weak and dizzy. He also said he had not been seen by the mental health team and felt at an 'all time low' and wanted to be treated fairly 'as he would if he was in the community'.

49. On 20 August, Mr Corkill had an ECG and an entry in his medical record noted that it was handed to a consultant psychiatrist specialising in substance misuse working with DAT. The ECG results are not documented in his medical record nor if a GP reviewed them. On 22 August, Mr Corkill complained of chest pain and was placed on the GP waiting list. The same day, a GP at Isle of Man Prison noted that there was nothing recorded in Mr Corkill's medical record that he was experiencing chest pains, no acute concerns and that he was waiting for a cardiology appointment. Mr Corkill was to be monitored, but there is no evidence he was. On 24 August, a nurse recorded that Mr Corkill required an ECG and that his cardiology follow up appointment needed to be chased, but there is no evidence either was done.

50. On 7 September, Mr Corkill met with a DAT keyworker. He said that he felt much better than he had in the community and his mood was stable. Mr Corkill said his physical health had also improved but said that he had not seen a GP since his arrival in prison.

51. On 18 September, Mr Corkill had his clinical observations taken, which were all within normal parameters. He told the nurse he had not seen a GP since his arrival, and he was placed on the GP waiting list. On 20 September, he was examined by a GP at Isle of Man Prison, who noted all his clinical observations were within normal range and that his chest was clear, but that it was over a year since he had been seen by cardiologist.

52. The same day, Mr Corkill met with his DAT keyworker. They discussed his substance misuse, harm reduction and relapse prevention. They agreed to meet in a month.

53. On 22 September, Mr Corkill was placed on report for being in possession of prescription medication and for having excessive vapes which belonged to another

prisoner; staff were concerned he was trading on the wing. On 26 September, he was found guilty of breaching the prison rules and given a total of 14 days cellular confinement, loss of television, loss of association and 50% stoppage of earnings as a punishment. He spent his cellular confinement in the prison's Care and Separation Unit (CSU). There is no evidence he was seen by healthcare staff while segregated, other than to dispense his medication.

54. On 6 October, Mr Corkill asked for nicotine lozenges, but was told he would not get these until Monday. (There was a supply issue. An order was made on 5 October with an estimated delivery date of 10 October. Healthcare staff only supply lozenges to prisoners signed up to a smoking cessation programme). He was unhappy and made threats to harm himself by swallowing batteries. Mr Corkill was briefly moved to a camera cell while his cell was made safe, including having his radio removed. He later said that he would never harm himself and was just frustrated that he was not given the nicotine lozenges. No other issues were recorded, and Mr Corkill moved back to B Wing on 9 October. He was told that he had been sacked from his laundry job. Over the next few weeks Mr Corkill complied with the wing regime and was employed as a cleaner.

55. On 26 October, Mr Corkill met with his DAT keyworker. He explained he had been segregated for having too many e-cigarettes. They agreed to meet in two weeks.

56. On 12 November, the CSO met with Mr Corkill for a CSO contact. He noted that Mr Corkill was quiet and difficult to engage in conversation, but said he was pleased to be working on the wing as a cleaner. They met again several times over the next month and no issues were recorded.

57. On 23 November, Mr Corkill was seen by healthcare staff as prison staff reported he had been vomiting blood. However, healthcare staff quickly established this was not correct and he had heart burn. Mr Corkill told the nurse that he was very anxious because of his cardiology history. Initially his blood pressure was raised, but a short time later was within normal range. The nurse saw him later that evening and again the next day. Mr Corkill was given Gaviscon to relieve his heart burn and he told the nurse that he felt better.

58. On 18 December, Mr Corkill was seen by a psychiatrist from the DAT, and he said that he was happy on his prescribed medication and no changes were made.

59. On 24 December, following a cell search, Mr Corkill was placed on report as he was found with a tampered vape and a milk carton that had been repurposed as a 'bong' to smoke drugs. The adjudication was adjourned until after Christmas.

60. On 5 January, Mr Corkill failed a mandatory drug test which showed that he had used opiates, cannabis, and gabapentin. He was placed on report, but these charges were later dismissed as staff did not complete the documents in the correct time frame.

61. On 6 January Mr Corkill was awarded a total of 21 days cellular confinement, as well as loss of his other privileges, as punishment for having the tampered vape and bong. Mr Corkill spent his cellular confinement in the CSU. Throughout this time, Mr Corkill was described as polite, compliant, and caused no problems. There is no evidence he was seen by healthcare staff while in the CSU, other than for his medications to be dispensed. On 26 January, Mr Corkill returned to B Wing.

62. On 1 February, the CSO visited Mr Corkill for a CSO contact. He was sleeping and did not want to be disturbed. He noted that Mr Corkill slept a lot and was often difficult to engage in conversation. He told Mr Corkill to let him know if he had any issues and said he would visit him again the following week.

63. On 14 February, the CSO completed his monthly CSO report for Mr Corkill. He noted that Mr Corkill slept most of the day which made it hard to have effective sessions with him, that he was quiet and hard to engage in conversation but that he caused staff few problems and was polite. This CSO entry was the last recorded event in Mr Corkill's prison record.

64. Mr Corkill's partner visited him 15 times during this sentence, the last visit was on 5 November. Between 17 February and 21 February, Mr Corkill made five calls to his partner, totalling around 28 minutes. The investigator listened to these calls. Mr Corkill said he was concerned that he had not been able to speak to her in the previous couple of weeks and that his 'mind had been going overtime'. His partner explained that her phone had been broken. Mr Corkill told his partner that he loved her, and he had been panicking, had felt depressed and was worried something was wrong with their relationship.

65. During their last conversations on 21 February, Mr Corkill's partner explained that she had been unable to visit him as she had to work. The phone kept cutting off and Mr Corkill's partner said her phone was 'playing up'. The call ended with Mr Corkill saying he was 'sound.. plodding along'. There is nothing of concern within these telephone calls, although at times the conversation was stilted. Mr Corkill did not attempt to use his phone again. He had £9.28 credit remaining on his account. (All prisoners' telephone calls, except those that are legally privileged, are recorded, and prison staff listen to a random sample.)

66. On 23 February, at around 4.52pm, Mr Corkill's cell was unlocked and, a few minutes later, he left and collected his evening meal. He left his cell again at 5.04pm, spoke to Officer A and returned a minute later. (The officer was on long term sick leave for the duration of the investigation and could not be interviewed). At 5.18pm, an officer locked Mr Corkill in his cell for the night. At 8.26pm, another officer completed a routine check of all prisoners. She recalled Mr Corkill was sitting on his bed and raised his hand to acknowledge her. Because he was not subject to special monitoring Mr Corkill was not checked again during the night.

25 February

67. At 7.14am, Officer A started the early morning routine check. He arrived at Mr Corkill's cell two minutes later, looked through the observation panel, and continued his duties.

68. CCTV shows that at around 7.52am, Officer B went to Mr Corkill's cell to unlock him so he could collect his medication. He looked through the observation panel, saw Mr Corkill lying on his bed and unlocked the door before moving on to the next cell. He said good morning as he usually did and believed he got a response from Mr Corkill, but in interview accepted he must have been mistaken. Other prisoners had been unlocked and were on the landing. He returned to Mr Corkill's cell at 7.56am. He pushed the door open and looked in, he saw Mr Corkill had a clear plastic bag over his head. He used his radio to request assistance and pressed the general

alarm. Other prisoners on the landing looked into Mr Corkill's cell from a few metres away but did not enter.

69. Officer B went back into Mr Corkill's cell. He was lying on his bed with a plastic bag over his head, secured by a dressing gown cord. He shouted Mr Corkill's name and shook his ankle, which he described as ice cold. Staff responded. They removed the plastic bag, moved Mr Corkill to the landing outside his cell where there was more space and started cardiopulmonary resuscitation (CPR). A nurse quickly responded with emergency medical equipment, followed by another nurse. They attached a defibrillator to Mr Corkill which indicated he had no shockable heart rhythm. The second nurse was unable to insert an airway, as Mr Corkill's jaw was clamped shut due to rigor mortis. Other prisoners had been locked away in their cells and their observation panels closed.

70. Isle of Man Ambulance Service records show that an ambulance was requested at 7.56am. Paramedics arrived at the scene at 8.00am. Mr Corkill's death was declared at 8.09am.

71. The second nurse sat with Mr Corkill's body until staff covered him with a sheet and placed screens around him to preserve his dignity. Mr Corkill's body remained on the landing. Police attended the scene at around 8.36am, and Mr Corkill's body was removed at 12.19pm.

72. Mr Corkill did not leave a suicide letter.

Contact with Mr Corkill's family

73. Isle of Man Constabulary broke the news of Mr Corkill's death to his family. The family did not receive a condolence letter and there was no offer of assistance towards funeral costs, which was held on 31 March 2023.

Support for prisoners and staff

74. After Mr Corkill'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.

75. The prison posted notices informing other prisoners of Mr Corkill'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 Corkill'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 5 April 2023.

Post-mortem report

76. The post-mortem report concluded that Mr Corkill'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 Corkill's risk of suicide and self-harm

77. Mr Corkill had a long history of substance misuse, metal health issues, and had previously self-harmed. We found that in the weeks leading up to his death, Mr Corkill gave no indication that he was at imminent risk of suicide or that staff could reasonably have foreseen his actions. Staff and his friends on the wing said that he appeared no different from usual and did not disclose how he was feeling. After his death, his friends discovered that he was having some personal issues.

78. In their recent inspection, HM Inspectorate of Prisons 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 at Isle of Man Prison relied heavily upon good staff/prisoner relationships, and previous knowledge of the individual, rather than there being an evidenced based assessment of the risks and triggers that might increase risk. 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 Corkill was managed when he first arrived at Isle of Man Prison.

Folder 5 procedures

79. Prison staff started Folder 5 measures on 23 July 2022, when Mr Corkill first arrived at Isle of Man Prison, due to his recent history of self-harm. However, there was no Folder 5 assessment, which should have been completed within 24 hours, no medical officer report and no caremap. There were frequent observations recorded and detailed entries in Mr Corkill's prison record during the time he was on a Folder 5, but we found too much emphasis was placed on Mr Corkill's assertion that he had no thoughts of suicide or self-harm, rather than assessing and understanding other objective factors that impacted on his risk and the ongoing stressors in his life. The Folder 5 was closed on 29 July, but the post closure review scheduled for 5 August, was never completed.

80. 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 (if even 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.

81. Isle of Man Prison did not have an effective training programme. Staff who completed and managed Mr Corkill's Folder 5 had not been trained to complete the Folder 5 assessment and nobody had been trained as a case manager. Most staff had either not received refresher training or not recently and some staff had never had any specific Folder 5 training, except for observing a colleague. Reviews were set for every 48 hours, regardless of risk and need so there was no consistency with regards to chairing the review. The caremap which should be 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 was absent and there was no managerial oversight to ensure compliance with the Folder 5 process.

82. 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 Service 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)*.

83. 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 escort staff. In addition, seven staff were trained as ACCT assessors and five as case coordinators. Four staff have also been identified to attend HMPPS Learning and Development Team to complete the train the trainer 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 attend to be trained as a case co-ordinator.

84. 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 procedures and training has already taken place, with the provision for ongoing training, we do not make a separate recommendation. HMIP are due to return to the prison in April 2024 and will provide feedback to Isle of Man Prison on how the new system has been implemented.

Availability of plastic bags

85. In response to the death in March 2020, the prison removed plastic bags from reception and the induction unit. Following the second death, they stopped using plastic bags to deliver prisoners' canteen. Since Mr Corkill's death, 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 a 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 within England and Wales. Six of these (or 2%) were classified as suffocation using a plastic bag.

86. 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

87. While there cannot be a direct comparison, the objective of the clinical review is to establish if Mr Corkill received clinical care equivalent 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 equity 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.

88. The clinical reviewer produced two reports: an overview of healthcare services provided by Manx Care, and one specifically reviewing Mr Corkill'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 repeated in our report but should be actioned by the Department of Health and Social Care and Manx Care.

Mental health

89. We found that the mental health services provided within Isle of Man Prison are currently inadequate, unsafe, and not equivalent to what is available in the wider community and within other comparable prisons in England and Wales.

90. Mr Corkill was never referred to the mental health team, which was a significant failing. He had been under the care of the Crisis Response Team in the community prior to his imprisonment and had a long standing severe mental health condition. But, contrary to National Institute of Health and Care Excellence (NICE) guidelines, he did not get access to mental health services during his time in prison. The clinical reviewer therefore concluded that the mental health care Mr Corkill received at Isle of Man Prison was not equivalent to what he would have received in the community.

91. During his time at Isle of Man Prison, Mr Corkill asked to be referred to the mental health team, he even wrote that he wanted to be treated fairly 'as he would if he was in the community'. The current referral process is an electronic form, completed by healthcare staff, which is emailed directly to the Integrated Mental Health Service (IMHS). However, we found no evidence a referral had been made for Mr Corkill. 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.

92. The General Manager confirmed that a referral was never received for Mr Corkill. We were unable to establish why a referral was not made or why his mental health was never fully assessed. During the investigation, we were also told by healthcare staff that a prisoner can either be under the care of the mental health team or DAT, but not both. He confirmed that if it was clinically appropriate, a prisoner can be under the care of both services.

93. There were many missed opportunities to assess and engage Mr Corkill about his mental health. The clinical reviewer concluded that the confusion over Mr Corkill's referral to the mental health team reflected poor understanding of the process, poor

communication between services and poor integrated working. We therefore 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.

Physical health

94. The clinical reviewer concluded that the physical health care Mr Corkill received at Isle of Man Prison was not equivalent to what he would have received in the community.

95. Mr Corkill had a number of significant health issues, and he was especially anxious about his heart condition. These were not monitored in line with NICE guidelines and there were no care plans in place. Mr Corkill submitted a complaint around three weeks after he arrived, asking to see a GP as he had chest pains. However, the GP concluded, without examining Mr Corkill, that he did not need to be seen. We find it difficult to understand why he was not physically examined given the seriousness of his underlying health conditions. While Mr Corkill was monitored on an ad-hoc basis, this was not formalised as part of a care plan We make the following recommendation:

Manx Care should ensure there is a long-term conditions monitoring register and clinic.

Medication

96. 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) guidance for ‘safer prescribing in prisons’ dated 2019.

97. Mr Corkill had been prescribed psychotropic medication for his mental health, and medications for his physical health issues, before entering prison. However, when he arrived at Isle of Man Prison the clinical reviewer found that the reasons for these medications were not fully ascertained or understood. He was never seen for a face-to-face review of his medications while in prison. Between 23 July and 26 July, Mr Corkill was given his medication without a prescription, via a transcribed medication record 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).

98. On the morning that Mr Corkill died, a nurse dispensed medication and signed to say it had been given to him when he was already deceased. We were told that because Mr Corkill had so much medication, and always collected it, this was a quicker way of dispensing it. Although the nurse accepted signing for medications

that have not been collected was not the correct protocol, he said it was common practice and, concerningly, did not consider this posed a major risk. We found there was a level of complacency based on familiarity, rather than there being a fundamental approach to safety. This is unsafe clinical practice and against the NMC code for contemporaneous record keeping.

99. During the investigation we raised our concerns with Manx Care and were assured these practices had now stopped. Despite these reassurances and to ensure medications are administered correctly we make the following recommendations:

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 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 implement electronic medication administration records.

Governance of healthcare services

100. 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 dedicated 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.

101. 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 leave her duties to help on an operational level due to staffing issues. While this addressed an immediate issue, this took her away from the strategic responsibilities. We found there is not enough resilience within the healthcare system. 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.

Serious incident investigation

102. Manx Care undertakes a 72-hour review following a death in custody. However, not all incidents go on to have a comprehensive serious incident investigation. The decision whether a serious incident investigation is conducted is made by the Serious Incident Review Group of Manx Care.

103. After the death in November 2022, we were told that initially it was not going to be investigated because it was deemed that there were no obvious acts or omissions that contributed to his death. This decision was challenged, and his death was then investigated. However, following Mr Corkill's death the decision was made that an investigation was not required and was not completed. We found this decision difficult to understand given that the previous death was eventually subject to a serious incident investigation.

104. Manx Care's policy for 'incident reporting, investigation and learning' dated 2021, states that a serious incident can be defined as 'an unexpected or avoidable injury which results in serious harm'. A self-inflicted death in prison is without question a serious event, resulting in the ultimate harm to the individual. Without investigating the circumstances surrounding a death, it is difficult to understand how a decision can be reached that there are no acts or omissions relating to the healthcare provided to the prisoner. Our investigation has highlighted significant issues that could and should have been identified sooner. We make the following recommendation:

    The Serious Incident Review Group of Manx Care should always complete an investigation following a death in custody.

Emergency response

Communicating the emergency

105. Isle of Man Prison do not have a policy on communicating a medical emergency. When Mr Corkill was discovered, an 'urgent' message was radioed before Officer B pressed the general alarm. Some staff thought an urgent message was for a medical emergency, other 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. An ambulance was requested with very little delay, because staff recognised the seriousness of the situation, not because there was a clear policy in place.

106. PSI 03/2013, *Medical Emergency Response Codes*, which is used within UK 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 to provide guidance 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.

107. 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

108. 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 Manx Care Governance Team were not aware of this guidance, despite it being published in 2016.

109. Officer B told the investigator that he believed Mr Corkill was already dead when he discovered him. The second nurse said she observed that Mr Corkill 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.

110. Isle of Man Prison do 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.

111. Manx Care had identified the need for guidance on when it is not appropriate to commence CPR after the first of the three self-inflicted deaths in 2020, which was again highlighted after the second death. When Mr Corkill died, staff again thought they needed to commence CPR when it was not appropriate. During interview in June 2023, the Care Quality and Safety Coordinator Manx Care said that new guidance was being drafted which was in the process of being agreed. Given this was three years since the first death and seven months after the second death 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 avoided.

112. Manx Care responded to feedback during the investigation about the need to expedite and publish revised guidance. The new guidance was agreed in June

2023, and which reflects that issued in England and Wales in September 2016. However, it is directed to Manx Care staff 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 for all staff, and check their understanding, about the circumstances in which resuscitation is inappropriate in accordance with European Resuscitation Council Guidelines.

Events after Mr Corkill was declared dead

113. The Death in Custody Policy 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.

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

115. The investigator contacted the Acting Detective Chief Inspector for Major and Specialist Investigations and Intelligence Departments from 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 a body is left in situ as best practice, to prevent any further disturbance of forensic evidence in a suspicious case as far as reasonably possible 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.

116. We found it was inappropriate and distressing that Mr Corkill was not moved back into his cell. There was no suspicion a crime had been committed. Staff had already entered Mr Corkill'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 Corkill's body, which was also an issue in the two previous deaths. Despite this issue being identified, this had not prompted any discussion with the Isle of Man Constabulary regarding establishing an agreed 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.

Informing Mr Corkill's family

117. 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).

118. Isle of Man Constabulary broke the news of Mr Corkill's death to his family before the prison had an opportunity to do so and Mr Corkill's partner found out via a telephone call from another prisoner. Isle of Man Prison did not attempt to make any further contact with Mr Corkill's family or partner. They did not consider contributing towards the cost of his funeral (in England and Wales the prison contributes up to £3,000 towards funeral costs) and did not send the family a condolence letter.

119. The visiting prison chaplain is a qualified FLO at Isle of Man Prison and had undertaken his training at the HMPPS training centre. Although the Governor said he knew the prison chaplain was FLO trained, the Deputy Governor did not. The Deputy Governor said he believed the decision for the police to inform Mr Corkill's family was made because they were unaware there was a trained FLO at the prison. The Governor said he was aware that the FLO knew Mr Corkill's family, and had been in contact with them, and passed messages to them from the prison about collecting his belongings. This contact was established as the FLO knew the family rather than in an official capacity as prison FLO. The Governor accepted that greater efforts could have been made to contact Mr Corkill's family and a condolence letter should have been sent.

120. We found that contact with Mr Corkill's family should have been more considered. Utilising a trained FLO to visit a family in person to break the news, with a senior prison manager, should be an expectation, in line with the prison's own Death in Custody Policy. There needs to be a better understanding by senior managers of the need to ensure families are notified as soon as possible and provided with appropriate support. We make the following recommendation:

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

The Governor should ensure in the event of a death in custody, prisoners' in-cell telephones should be disconnected immediately to avoid families being notified before the prison have an opportunity to break the news.

Staff support

121. 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 Death in Custody Policy.

122. Although staff involved in the emergency response were spoken to individually after Mr Corkill'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.

123. Many staff involved in the emergency response said that support after Mr Corkill's death could have been better, they did not feel sufficiently supported by managers and were expected to return to a normal regime too quickly. The second nurse who had also responded when the previous prisoner died said she was not expected to return to her duties immediately, but her colleague was. We were provided with a copy of the Death in Custody Contingency Plans dated 2019, during the consultation period. These plans are outdated and do not reflect the current expected response following a death in custody. This meant staff 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

124. 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.

125. 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. 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

126. 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 (PO) 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.

127. 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). A prison 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 Corkill's death and no mention of the PPO investigation.

128. 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 often poor from critical areas.

129. During the investigation we raised our concerns with the Governor. Since 24 June, the prison has now introduced a weekly Review of Complex Cases (RoCC) meeting, the implementation of which is set out in the new Complex Case Strategy, and all staff have been informed and advised on 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, but the Governor must ensure the newly introduced RoCC is audited to ensure compliance with the prisons new protocol.

Prison record

130. Isle of Man Prison use the Prisoner Information Management System (PIMS) an electronic record where all contacts and events are recorded. We found that entries in Mr Corkill'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. We would encourage the Governor to consider reviewing the process for creating new prisoner records for those who have previously been in custody.

Listeners Scheme

131. Isle of Man Prison do not have a Listeners scheme. The first Listener scheme was introduced in 1991 and Listeners are in almost every prison in the UK. Listeners are selected prisoners who have been specially trained by Samaritans to provide support to their peers. The visiting chaplain said the prison would be keen to introduce Listeners at Isle of Man Prison, but there was a reluctance from Samaritans on the island 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. The Governor should consider this further.

Body Worn Video Cameras

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

Healthcare to Note

Medical records

133. 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 is either having to be duplicated across systems, or more concerningly significant information about care and clinical need is not shared that is vital to the care of prisoners (and residents on the island).

134. We were told that various reviews of the medical record system had taken place and that consideration of implementing one system to record all clinical contacts was being considered but that this had been ongoing for 'years'. We would urge the Department of Health and Social Care and Department of Home Affairs to urgently review the need for a medical record system that is fit for purpose and support Manx Care in introducing one electronic record keeping system to provide a more cohesive, safer means of sharing patient information.

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