Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Ms Kayleigh Melhuish, a prisoner at HMP Eastwood Park, on 7 July 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 carries out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

Ms Kayleigh Melhuish died in hospital on 7 July 2022, three days after she was found hanging in her cell at HMP Eastwood Park. She was 36 years old. I offer my condolences to her family and friends.

It was Ms Melhuish's first time in prison. When she arrived at Eastwood Park on 15 June 2022, she was highly distressed and had already tried to strangle herself in the prison van. Staff started suicide and self-harm monitoring (known as ACCT).

Over the next three weeks, Ms Melhuish continued to be highly distressed. She banged her head repeatedly against her cell wall, punched herself in the face and made cuts to her arms. She had autism and told staff that she was extremely sensitive to noise and found it very difficult to cope on the noisy prison wing. She also had issues with physical contact.

On 4 July, staff found Ms Melhuish hiding under a table in the association room. She said she was being bullied and refused to return to her cell. Staff used control and restraint techniques to move her. They forced her into a lying position on the floor, handcuffed her and then carried her to her cell and locked her in. Less than an hour later, an officer found Ms Melhuish hanging in her cell. She was taken to hospital but died three days later.

This is a very troubling case. The ACCT procedures were poorly managed. Staff failed to create a care plan for Ms Melhuish and there was little evidence that they had properly explored her risks and issues of concern. While Ms Melhuish received good mental health care and a neurodiversity specialist created a comprehensive communication support plan for her, it appears that not all staff were aware of it or of Ms Melhuish's specific needs.

This was especially so during the events of 4 July. Use of force should be a last resort in any situation, but in the case of Ms Melhuish, everything should have been done to avoid it. Use of force was initiated when continued dialogue should have been used instead. This decision had devastating consequences.

Staff also delayed going into Ms Melhuish's cell when she was not responding to them. They could have discovered her earlier had they reacted more promptly.

The Governor needs to learn the lessons from this investigation and ensure that staff are aware of prisoners' specific care needs and how best to support them. I consider that staff did not do enough to try to keep Ms Melhuish safe.

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

Kimberley Bingham
Acting Prisons and Probation Ombudsman **March 2023**

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Summary

Events

1. Ms Kayleigh Melhuish arrived at HMP Eastwood Park on 15 June 2022. It was her first time in prison. She arrived with a suicide and self-harm warning form as she had tried to strangle herself with a seatbelt in the prison van. Staff started suicide and self-harm monitoring (known as ACCT).
2. Ms Melhuish had autism, post-traumatic stress disorder (PTSD), attention deficit and hyperactivity disorder (ADHD) and a personality disorder. Throughout her time at Eastwood Park, she was highly distressed. She banged her head repeatedly against her cell wall, punched herself in the face and made cuts to her arms. She told staff that she was very sensitive to noise and found it difficult to cope on a noisy prison wing.
3. A neurodiversity specialist met Ms Melhuish on 21 June and created a communication support plan for her. This set out the difficulties Ms Melhuish had with various issues, including noise, smells, food and physical contact, and suggested ways that the people who interacted with her could help her to understand and cope with these issues.
4. At around midnight on 27 June, during an ACCT check, an officer found Ms Melhuish with a ligature around her neck which was tied to the bedframe. She said that she felt unsettled and was frustrated about her medication. On 3 July, she was again found with a ligature.
5. At around 6.30pm on 4 July, staff found Ms Melhuish hiding under a table in the association room. She refused to return to her cell. She said she was being bullied by other prisoners and staff were not listening to her or doing anything to help her. A custodial manager spoke to her and told her that they would try to move her the next day, but Ms Melhuish continued to refuse to return to her cell. The custodial manager asked for more staff to attend. When more staff arrived, Ms Melhuish came out from under the table. Officers restrained her. They forced her into a lying position on the floor, handcuffed her and then carried her to her cell and locked her in.
6. An officer carried out an ACCT check at 7.01pm. He said that Ms Melhuish was sitting on the toilet and looked over but did not say anything. The officer went back again at 7.15pm. He said that Ms Melhuish was still sitting on the toilet and did not say anything.
7. At 7.25pm, a supervising officer went to check on Ms Melhuish. He could not see her or get a response from her so went to the office to ask the officer if he had got a response during his last check. The officer said they should go into her cell. They found Ms Melhuish hanging from a ligature tied to a privacy screen. They cut her down and started CPR, which paramedics continued when they arrived. They took Ms Melhuish to hospital, but she did not recover and died there on 7 July.

Findings

8. The ACCT procedures were poorly managed. Healthcare staff were not always invited to case reviews even though Ms Melhuish was under the care of the mental health team. There was no ACCT care plan and little evidence that staff had properly explored Ms Melhuish's risks and issues of concern, including her options for moving to another wing due to her issues with noise. While the prison's neurodiversity specialist had created a comprehensive communication support plan for Ms Melhuish, it is unclear whether all wing staff were aware of this, particularly the staff involved in the events of 4 July.

9. A HM Prison and Probation Service use of force instructor and expert reviewed the use of force incident on 4 July. He noted that force was initiated when Ms Melhuish posed no risk to staff and that staff should have had continued dialogue with her rather than calling for more staff, which appeared to escalate the situation. Use of force should be a last resort in any situation, and we consider that given Ms Melhuish's issues associated with her autism, it should have been avoided if at all possible. The decision to use force to return Ms Melhuish to her cell had devastating consequences.

10. We consider that there was a delay in going into Ms Melhuish's cell before she was found hanging. We consider that the check carried out at 7.15pm was inadequate and the officer should have gone in or called for staff when Ms Melhuish did not respond. We also consider that the supervising officer should have gone in or called for staff, rather than going to the office and back.

11. We found that Ms Melhuish was unable to use her PIN phone to telephone her next of kin. This should have been resolved sooner, especially as Ms Melhuish was being supported using ACCT and contact with her next of kin was identified as a protective factor.

12. Ms Melhuish told staff on 30 June that she was being bullied by other prisoners. Staff did not investigate these allegations before she died.

13. The clinical reviewer found that the care Ms Melhuish received at Eastwood Park was equivalent to that which she could have expected to receive in the community. She noted that the mental health team saw Ms Melhuish daily and built a good relationship with her, and the communication support plan was an example of good practice. However, she considered that given Ms Melhuish's complex needs and her combination of medication, she should have been prioritised for a face-to-face medication review, which was not carried out until she had been at the prison for over two weeks. She also considered that her sleeping pills were stopped too suddenly.

Recommendations

- The Governor and Head of Healthcare should ensure that staff manage prisoners at risk of suicide or self-harm in line with policy, and in particular, staff should:
    - ensure relevant staff involved in the prisoner's care, including healthcare staff where appropriate, are invited to all case reviews;
    - complete the care plan with meaningful, individualised actions to reduce the prisoner's risk, and update the care plan after each case review;
    - ensure that the prisoner's risks and triggers are properly discussed and explored at case reviews and a record is made of how these issues will be addressed;
    - review the level of observations required after significant events, such as incidents of self-harm, discovery of ligatures and use of force; and
    - refer complex cases to the Safety Intervention Meeting at the earliest opportunity.
- The Governor should ensure that staff are:
    - aware of autism and the range of issues that prisoners with autism may face; and
    - aware of prisoners with a communication support plan in place and refer to it before interacting with the prisoner.
- The Governor should commission an investigation into the actions of staff involved in the use of force incident on 4 July and inform the Ombudsman of the outcome.
- The Governor should ensure that when carrying out an ACCT check, the staff member satisfies themselves that the prisoner is alive and well and if they have any concerns, they enter the cell or summon assistance immediately.
- The Governor should ensure that the PIN phone application process is reviewed to consider how PIN phone access for prisoners subject to ACCT monitoring can be prioritised.
- The Governor should ensure that incidents of violence, bullying or intimidation are taken seriously, investigated, and dealt with in line with local and national policies, and victims are supported and protected.
- The Head of Healthcare should ensure that when new prisoners arrive at Eastwood Park with complex medication and health issues, a prescriber (or equivalent registered professional) has an early face-to-face conversation with the patient about their medication.
- The Head of Healthcare should ensure that medication reconciliations are made in accordance with the community prescriber of that medication and where this is the community mental health team, they must confirm they are prescribing that medication and support this with evidence.

The Investigation Process

14. The investigator issued notices to staff and prisoners at HMP Eastwood Park informing them of the investigation and asking anyone with relevant information to contact her. Two prisoners asked to speak to the investigator.

15. The investigator obtained copies of relevant extracts from Ms Melhuish's prison and medical records.

16. NHS England commissioned an independent clinical reviewer to review Ms Melhuish's clinical care at the prison.

17. The investigator and clinical reviewer interviewed 17 members of staff and two prisoners on 6, 13, 16 and 29 September.

18. We informed HM Coroner for Avon of the investigation. Ms Melhuish's post-mortem report was not available. We have sent the coroner a copy of this report.

19. The Ombudsman's family liaison officer contacted Ms Melhuish's next of kin to explain the investigation and to ask if she had any matters they wanted us to consider. They asked

    - why Ms Melhuish lived on a standard wing;
    - whether Ms Melhuish was subject to ACCT;
    - how often Ms Melhuish should have been checked; and
    - how often staff checked on her.

    These issues have been addressed in the report.

20. We provided the next of kin with a copy of our initial report. Both she and her solicitor raised a number of issues that have been addressed separately.

21. We shared our initial report with HM Prison and Probation Service (HMPPS). They raised two factual inaccuracies, which have been corrected in this report.

Background Information

HMP Eastwood Park

22. HMP Eastwood Park is a closed prison in Gloucestershire which holds up to 442 women. It has ten residential wings. Up to 30 September 2022, healthcare services were provided by Inspire Better Health consisting of Avon and Wiltshire Mental Health Partnership Trust (AWP), which provided mental health services and Hanham Secure Health, which provided 24-hour primary health services. From 1 October 2022, Practice Plus Group took over as the provider of primary health services.

HM Inspectorate of Prisons

23. The most recent inspection of HMP Eastwood Park was in May 2019. Inspectors reported their concern about the prison's oversight of use of force, as there was no regular quality assurance of video footage. This prevented lessons being learned and unacceptable practices being challenged.

24. Inspectors reported that a high number of women were managed by ACCT. They found that the documentation to manage and support prisoners in crisis was poor. They found ACCTs where suicide or self-harm triggers had not been identified or recorded, and caremaps lacked meaningful actions. Also, these actions were not always completed, and some caremaps had been left blank. Inspectors reported that peer support was good, and the Listener scheme was reasonably well developed.

25. Inspectors found that living conditions for prisoners were good, except on residential units 1,2 and 3, which were poor. The cells and corridors had damp patches and peeling paint and a large backlog of repairs. Inspectors recommended the living conditions on these units should be improved.

26. Inspectors reported that the Challenge Support Intervention Plan (CSIP) had recently been implemented, but staff seemed unsure of their role and how to contribute after an initial referral. However, the safer custody team provided good, regular support to victims of bullying and violence.

27. Inspectors reported there had been no self-inflicted deaths since their previous inspection, but recommendations from three PPO reports had only been partially achieved.

28. Avon and Wiltshire Partnership NHS Trust provided a good and responsive mental health service and a crisis team responded promptly to urgent mental health referrals.

Independent Monitoring Board

29. 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 October 2021, the IMB reported that they were concerned about the high level of self-harm among prisoners, particularly those with mental health issues, compounded by the COVID-19 lockdown and regime restrictions.

30. The IMB remained concerned about prisoners with mental health and complex needs, who would be better managed in a healthcare setting, rather than the criminal justice system.

31. Version 6 of ACCT had been implemented in April 2021. Staff shortages impacted on managing wellbeing checks and ACCT assessments.

32. The IMB remained concerned about damp cells and corridors, which had been evident since 2018.

Previous deaths at HMP Eastwood Park

33. Ms Melhuish was the second prisoner to die at Eastwood Park since February 2020. The previous death was from natural causes. There was another self-inflicted death at Eastwood Park two days after Ms Melhuish died. In our investigation into that death, we found that ACCT procedures were also managed poorly.

Assessment, Care in Custody and Teamwork

34. ACCT is the Prison Service care-planning system used to support prisoners at risk of suicide or self-harm. The purpose of ACCT is to try to determine the level of risk, how to reduce the risk and how best to monitor and supervise the prisoner. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011. 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.

35. As part of the process, a care plan (plan of care, support and intervention) is put in place. The ACCT should not be closed until all the actions on the care plan have been completed. All decisions made as part of the ACCT process and any relevant observations about the prisoner should be written in the ACCT booklet, which accompanies the prisoner as they move around the prison.

Key Events

36. Ms Kayleigh Melhuish was remanded in prison custody on 15 June 2022, charged with carrying an offensive weapon, harassment and damage to property. She was sent to HMP Eastwood Park. It was Ms Melhuish's first time in prison.

37. While on the journey from court to Eastwood Park, Ms Melhuish tied a seatbelt around her neck. Escorting staff completed a suicide and self-harm warning form which they passed to reception staff when they arrived at the prison.

38. The reception officer started suicide and self-harm prevention procedures (known as ACCT) and set observations at three an hour, with three meaningful conversations a day. A crisis support worker referred Ms Melhuish for a mental health assessment.

39. Ms Melhuish was distressed and would not engage with the reception process. Staff took her to a cell in the induction unit (also known as Residential Unit 8 or Kinnan Unit) to allow her to settle that night.

40. That evening, a mental health crisis support worker spoke to Ms Melhuish, who said she was struggling with the noise on the unit and that the graffiti on the cell walls triggered her. Ms Melhuish told her she had autism, attention deficit hyperactivity disorder (ADHD), post-traumatic stress disorder (PTSD) and a personality disorder and was under the care of the community mental health team. She arrived at the prison with none of her prescribed medication. The support worker arranged for Ms Melhuish to have some distraction gadgets while she looked into these issues.

41. A prison GP went to see Ms Melhuish in her cell. The GP noted that Ms Melhuish was very distressed about being in prison and was pacing around, banging her head and pulling her hair. Ms Melhuish said that she was prescribed zopiclone (sleeping pills), diazepam (to treat anxiety) and venlafaxine (an antidepressant) in the community. The GP prescribed zopiclone and diazepam for one night only. Healthcare staff requested Ms Melhuish's medical record to check the medications she was prescribed in the community.

42. Later that evening, a nurse telephoned the next of kin to let her know she was at Eastwood Park and to ask if she knew of anything that might help Ms Melhuish with her anxiety. Ms Melhuish's friend advised a vape and music, so the nurse said she would try to get a radio for her cell. The nurse told Ms Melhuish's friend to call anytime if she was concerned about Ms Melhuish. Healthcare staff facilitated a telephone call between Ms Melhuish and her friend the next day.

43. On 16 June, a Supervising Officer (SO) held a first case review with Ms Melhuish. A mental health worker attended. They recorded that Ms Melhuish had a history of self-harm and that she was engaging with the mental health team. They kept observations at three an hour.

44. On 17 June, the crisis support worker obtained Ms Melhuish's records from the community mental health team, which contained a mental health care plan, a risk assessment and a list of prescribed medication. She also spoke to Ms Melhuish's psychologist who had been working with her since March 2022. The psychologist said Ms Melhuish would find it difficult to cope with noise in the prison due to her autism.

45. A nurse tried to carry out Ms Melhuish's reception health screen, but she did not engage. Ms Melhuish gave consent for the nurse to contact her community GP as she wanted her medication.

46. Later that day, the crisis support worker and a nurse met Ms Melhuish. She said she was struggling, felt low in mood and was missing her prescribed medication, in particular, venlafaxine and pregabalin (used to treat anxiety and nerve pain). The crisis support worker spoke to Ms Melhuish a little later and told her that healthcare staff had now received a list of her medication from the community mental health team, and a doctor would write up a prescription for her as soon as possible.

47. A prison GP prescribed the medication on the community mental health team's list (which included venlafaxine, diazepam and mirtazapine (an antidepressant)). The GP later received the community GP's list of medications and noted it was different. The community GP's list did not include mirtazapine and said that diazepam was not prescribed for regular use, so he reduced the diazepam prescription. The community GP's list also included pregabalin, which he prescribed.

48. That night, Ms Melhuish told the crisis support worker that she had not been unlocked to collect her tea and had not been given a breakfast pack. She said she did not eat much as she struggled with hot food and smells. The crisis support worker organised food for her.

49. Ms Melhuish agreed to a health screen on 18 June. She was assessed as fit to move to a standard cell, and to attend work.

50. On 19 June, Ms Melhuish went to the medication hatch to collect her medication. However, she refused to take the mirtazapine, and told the nurse she thought she should take it at night. She said that when she took it in the morning, she slept for most of the day and stayed awake at night. The nurse sent a task to the GP for a medication review. The next day, a nurse asked why Ms Melhuish had been prescribed mirtazapine when this was not on the list of medications from the community GP. She was concerned that Ms Melhuish was already taking venlafaxine, which could react with mirtazapine. Ms Melhuish was not prescribed mirtazapine again.

51. A nurse saw Ms Melhuish on 19 June. Ms Melhuish said she was struggling in prison, did not understand the regime, was not used to having her medication at certain times and had no vapes. She said she had no money on her telephone account and could not ring her friend. The nurse added Ms Melhuish to the peer mentor list, which meant that a prisoner would speak to her daily to help her adjust to prison life.

52. On 21 June, a nurse saw Ms Melhuish after she banged her head against her cell wall which had caused bruising above her right eye. The nurse took her clinical observations, which were normal.

53. A SO held a case review. A nurse attended. Ms Melhuish told them that she was frustrated that her court date had been cancelled. She said that she found change hard to process due to her autism.

54. That afternoon, a neurodevelopment practitioner and the prison's learning disability specialist met Ms Melhuish. The practitioner noted that Ms Melhuish had received a letter that day from her solicitor which said that her court date (scheduled for 23 June) had been postponed and she felt anxious not knowing when it would be. She noted that Ms Melhuish was struggling due to her autism. Changes in her

medication times had affected her and her sensory issues were heightened when she felt overwhelmed. She said she would develop a communication support plan to assist prison and healthcare staff to identify the best way to support Ms Melhuish.

55. A Custodial Manager (CM) held a case review on 22 June. No one from healthcare attended. He recorded that Ms Melhuish had been banging her head and had punched herself in the face due to medication issues. He noted that she had been seen by a nurse and was now more settled.

56. On 23 June, a nurse asked for a GP to review Ms Melhuish's medications, as wing staff had reported that she had been banging her head all night and most of the day. The nurse noted that Ms Melhuish was no longer prescribed zopiclone and that diazepam had been prescribed at half her community dose. A prison GP saw Ms Melhuish on the wing and prescribed an increased dose of diazepam until the planned review date of 28 June. Later that day, at the request of the crisis support worker, the GP prescribed three days' worth of zopiclone.

57. A CM chaired a case review on 23 June. The crisis support worker, a prison chaplain, and Ms Melhuish attended. The CM noted that it was Ms Melhuish's first time in prison and due to autism and ADHD, she struggled with the regime. The CM noted that the mental health team were seeing Ms Melhuish daily and that the prison's learning disability specialist would see Ms Melhuish and create a care plan, which would be shared with wing staff so they could help her cope with prison life. Staff reduced observations to one an hour, with three conversations a day. Staff also gave Ms Melhuish a radio for her cell.

58. That evening, staff called a healthcare assistant to Ms Melhuish's cell after she was sick and asked to see a nurse. The healthcare assistant recorded that Ms Melhuish had bruising to the left side of her face and evidence of some trauma to the right side. Ms Melhuish said she had punched herself in the face in the early hours of the morning. She said she had blurred vision. The healthcare assistant examined her and found that her pupil was not reacting to light (which could indicate a neurological concern). She passed this information to the nurses but there is no evidence they saw Ms Melhuish overnight.

59. Healthcare staff carried out neurological observations on Ms Melhuish the next day. They recorded that she had slightly raised blood pressure, but they had no other concerns.

60. The crisis support worker saw Ms Melhuish on 25 June. Ms Melhuish said she would struggle to cope another two nights without her medication as her mirtazapine had been stopped. (A nurse prescriber subsequently prescribed two nights' worth of zopiclone.) They talked through her communication support plan. The support worker told Ms Melhuish that wing staff would try to follow the plan as best they could, and Ms Melhuish said she understood this. The support worker noted in the unit's observation book that a copy of Ms Melhuish's support plan had been placed in her ACCT folder and a copy had been sent to the Safer Custody Team. She wrote, "Can everyone please read her support plan".

61. That evening, Ms Melhuish told a healthcare assistant that she had blood coming out of her ears. The healthcare assistant recorded that she had passed this onto a nurse. It is unclear whether any action was taken.

62. Later that evening, a CM chaired an ACCT review after Ms Melhuish told them she had made cuts to her left arm because she was frustrated with staff and her circumstances. An officer attended. Ms Melhuish did not attend, and healthcare

staff had not been invited. Staff kept the level of observations and conversations the same.

63. The next morning, a nurse saw Ms Melhuish after she made cuts to her right arm. She refused treatment. That afternoon, the crisis support worker recorded that a supervising officer had told her that they had referred to Ms Melhuish's communication support plan when they told her that she would be moving to a new cell (to a lower spur on the same unit). She was moved that afternoon.

64. That evening, staff held an ACCT review. A SO chaired the review. The crisis support worker attended. Ms Melhuish did not attend. The SO recorded that Ms Melhuish had told mental health staff that her anxiety had increased following the cell move and she had an increased desire to harm herself. Staff increased observations to two an hour.

Move to Residential Unit 3

65. On 27 June, Ms Melhuish was due to be moved from the induction unit to Residential Unit 3 as she had completed the induction process. Ms Melhuish did not understand why she had to move again and became distressed. A SO held an ACCT review and two crisis support workers attended. The SO noted that mental health staff thought that Residential Unit 3 was appropriate as it was smaller than other units. After both crisis support workers explained to Ms Melhuish why she had to move again, she allowed them to escort her to Residential Unit 3. The case review team kept her observations at two an hour.

66. At around midnight, during an ACCT check, an officer found Ms Melhuish with a ligature, made from pieces of a ripped t-shirt, tied around her neck. She had tied it to the bedframe, and it was hanging down into the toilet area. She said that she had done this because she had had to move cells frequently, she felt unsettled and did not know anyone. She was also frustrated about her medication. A CM held an ad hoc ACCT review. She noted that staff had provided good support to Ms Melhuish by sitting and talking things through with her and that she had refused to see healthcare staff. She noted that the mental health team was supporting Ms Melhuish daily and that she had been referred to the learning disabilities specialist. She kept observations at two an hour.

67. On 28 June, a prison GP held a joint review with members of the mental health team. They noted that Ms Melhuish was clearly struggling with being in prison, was not coping on Residential Unit 3 and felt like she was being targeted by other prisoners who were approaching her for vapes, milk and sugar. They noted that she wanted to return to the induction unit where she had made friends. The GP tasked a nurse with raising this at the next Safety Intervention Meeting (SIM, a multidisciplinary safety risk management meeting, chaired by the Senior Management Team) on 30 June (which she did). The GP noted that Ms Melhuish had a communication support plan in place, but that Ms Melhuish was not sure whether staff were referring to it so had given her copy to an officer on the unit. The next day, healthcare staff sent Ms Melhuish another copy of her communication support plan.

68. On 30 June, during an ACCT check, Ms Melhuish told an officer that she was being bullied by a few of the prisoners on the wing, who had also taken her food. The officer told the investigator that she reported this to a SO, who said he was aware of the issues and staff were looking into them.

69. The learning disability specialist and the mental health crisis support worker spoke to Ms Melhuish that afternoon. She told them she had a court date of 14 July. She said she had remained in her cell because the unit was so noisy, and she had only eaten biscuits as she had not been offered any alternative. Ms Melhuish said she was upset that she still had not been able to telephone her friend, due to PIN phone issues. The specialist agreed to contact the kitchen about providing food options and to find out why Ms Melhuish was unable to use the telephone.

70. Ms Melhuish telephoned her friend from the unit office on 2 July. Later that evening, a nurse attended Ms Melhuish's cell as she had been banging her head. The nurse noted no injuries, apart from bruised eyes. A SO held an ad hoc case review, which Ms Melhuish attended. She said she had banged her head because the unit was too loud, and she wanted to return to the induction unit. The SO kept observations at two an hour.

71. On 3 July, staff found Ms Melhuish with a ligature made from clothing. There are differing accounts, but it was either around her neck or she was holding it. A SO held an ad hoc case review. No one else attended but he noted that Ms Melhuish had provided a non-verbal contribution. He noted that she had autism and was struggling to settle anywhere in the prison. She wanted to move back to the induction unit, but this was not possible. The SO noted that mental health staff had said that the best place for Ms Melhuish was on Residential Unit 3 and that it would be discussed again at the SIM. He increased her ACCT observations to three an hour.

Events of 4 July

72. At approximately 7.40am on 4 July, Ms Melhuish cut her arms with a razor blade, which staff removed from her cell. A nurse cleaned and dressed her wounds, and Ms Melhuish handed her a ligature she had made. The nurse noted this in Ms Melhuish's ACCT document and wrote that she would contact the mental health team. A SO held an ad hoc case review at 9.33am. No one else attended but he noted that Ms Melhuish had provided a verbal contribution. She said she was still struggling on the unit, did not like the loud music and wanted to return to the induction unit. The SO noted that he had asked the mental health team to see her. He also noted that they had previously told him that Ms Melhuish would have these issues on any wing. He kept observations at three an hour.

73. A nurse saw Ms Melhuish later that morning. Ms Melhuish repeated that she was finding it hard to cope with the noise on the unit and thought that it had been agreed she could move. The nurse checked this and reported back to Ms Melhuish that she would remain on Residential Unit 3. She said most units had similar noise levels (although the nurse noted that the noise on the unit was exceptionally high at that time) and Ms Melhuish seemed to accept this. Ms Melhuish mentioned again that she had not been able to telephone her friend.

74. Staff checked on Ms Melhuish throughout the day. At 4.15pm, an officer wrote in her ACCT "settled afternoon watching TV". Ms Melhuish collected her medication from the medications hatch on the unit at approximately 6.00pm.

75. At approximately 6.30pm, an officer told a CM that Ms Melhuish was not in her cell and she could not find her. After checking the first floor, they went to the ground floor where they found Ms Melhuish hiding under a table in the association room.

She said she was being bullied by other prisoners on the unit and nobody was listening to her or trying to help her. She refused to go back to her cell.

76. The CM told the investigator that he was dealing with two other incidents at the time, a serious case of self-harm and a prisoner needing a hospital transfer, and so he needed to get Ms Melhuish into a cell. He checked whether there were any other cells available for her to move to, but there were none available on the ground floor of Residential Unit 3, Residential Unit 2 was shut and Residential 1 had a COVID outbreak. Ms Melhuish wanted to go back to the induction unit (Residential Unit 8) but that was not possible as they needed the space for people arriving from court. He told Ms Melhuish that she would have to go back to her cell, but he would try to move her the next day.

77. Ms Melhuish became increasingly distressed and would not stand up. The CM radioed for staff to attend and told them that force may be needed. After several officers had arrived in the association room, Ms Melhuish came out from under the table. He said she looked as if she was going to jump over the pool table, so staff restrained her. Four officers took hold of each arm and leg and one officer held Ms Melhuish's head. They lowered Ms Melhuish to the floor in a lying position and applied handcuffs. Ms Melhuish struggled and tried to kick staff. She complained that she was not even able to make telephone calls. Staff carried Ms Melhuish upstairs to her cell. Staff left Ms Melhuish's cell at 6.49pm. They removed her television and other items for her own safety, including a plastic bag of laundry.

78. A nurse arrived at the association room just after officers started restraining Ms Melhuish and she stayed throughout the rest of the incident. She went to Ms Melhuish's cell after she had been returned there by officers and said that one of her colleagues checked on her by looking through the cell door observation panel. Her colleague said that Ms Melhuish was sitting on the bed and looked sad.

79. Staff involved in the use of force met for a debrief. The nurse told the investigator that she asked whether Ms Melhuish's ACCT observations would be increased but was told she would remain on three an hour.

80. Officer A carried out an ACCT check at 7.01pm. He said Ms Melhuish was sitting in the toilet area behind a privacy screen. He said she looked over at him but did not say anything. He returned to the cell at 7.15pm. He said Ms Melhuish was still sitting in the same position and again did not respond to him.

81. At 7.25pm, a SO went to Ms Melhuish's cell to do a case review. On the case review document, he recorded that before the use of force, a member of staff had heard Ms Melhuish say that she was going to 'string up'. The SO could not see Ms Melhuish or get a response from her, and thought she was hiding behind the toilet's privacy screen. He returned to the wing office and asked Officer A if he had got a response from her during his last check. The officer said he had not, and they agreed that they should go into her cell.

82. The SO and Officer A returned to Ms Melhuish's cell at approximately 7.26pm, with Officer B. Ms Melhuish was still out of sight, so the SO opened the cell door. The SO and Officer B went into the cell and saw Ms Melhuish hanging from the privacy screen by a ligature made from clothing. Officer B used her anti-ligature knife to cut the ligature, while the SO radioed a medical emergency code blue (indicating a prisoner is unresponsive or not breathing). They laid Ms Melhuish onto the cell floor and the SO checked for signs of life. He found none and started cardiopulmonary resuscitation (CPR). The SO continued until healthcare staff arrived.

83. A nurse responded to the code blue call. As she got to Ms Melhuish's cell, staff were moving Ms Melhuish onto the landing, as there was more room. Ms Melhuish was not breathing, and the SO was giving chest compressions. Healthcare staff administered oxygen and applied a defibrillator, but it advised not to shock. Staff continued administering oxygen and chest compressions until paramedics arrived at 7.35pm (they had already arrived at the prison for another medical emergency but were diverted to Ms Melhuish) and took over Ms Melhuish's care. Paramedics left the prison at 8.26pm and took Ms Melhuish to Southmead hospital.

84. Ms Melhuish died in hospital at 2.30pm on 7 July.

Contact with Ms Melhuish's family

85. The prison appointed a prison manager and a custodial manager as family liaison officers. The prison manager telephoned the next of kin and told her Ms Melhuish had been taken to hospital.

86. The prison contributed to the cost of Ms Melhuish's funeral, in line with national instructions.

Support for prisoners and staff

87. After Ms Melhuish was discovered, the CM debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.

88. The prison posted notices informing other prisoners of Ms Melhuish'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 Ms Melhuish's death.

Post-mortem report

89. Ms Melhuish's post-mortem and toxicology reports were not available when this report was issued.

Findings

Assessment of Ms Melhuish's risk of suicide or self-harm

90. Prison Service Instruction (PSI) 64/2011, *Management of prisoners at risk of harm to self, to others and from others (Safer Custody),* sets out the procedures for identifying, managing and supporting prisoners at risk of suicide and self-harm using the ACCT process.

91. Ms Melhuish was supported using ACCT throughout her time at Eastwood Park. However, we found failings in the way the ACCT procedures were managed.

92. PSI 64/2011 says that the ACCT case coordinator should ensure that healthcare staff are always invited to attend, or provide a written contribution to, all case reviews where they are relevant to supporting the prisoner. As Ms Melhuish was supported by the mental health team, we are concerned that no one from that team, or any member of healthcare staff, was invited to the case review held on 25 June, after Ms Melhuish made cuts to her arm, or to the review held on 28 June, after Ms Melhuish had been found with a ligature around her neck. There were also case reviews held on 2 and 3 July which had no healthcare staff in attendance.

93. We note that while Ms Melhuish's friend (whom she referred to as her sister) was listed as a source of support in the ACCT document and Ms Melhuish had agreed for her to be involved in the ACCT process, there is no detail recorded about that discussion or about how Ms Melhuish wanted her friend to be involved. There is no evidence that the ACCT case coordinator tried to engage Ms Melhuish's friend in the ACCT process.

94. Staff failed to develop an ACCT care plan for Ms Melhuish, which should have been done at the first case review and then updated at each subsequent case review. It appears that an entry was made at the ACCT assessment interview, but nothing was added after that. The only trigger recorded was 'loud noise' and the protective factor recorded was 'a quiet environment'. The Risks, Triggers and Protective Factors page was blank, as was the Support Actions page. PSI 64/2011 says that after each case review, the ACCT coordinator should update the Risks, Triggers and Protective Factors form with any new information and complete the Support Actions page with meaningful and individualised actions to reduce or mitigate risk of harm, as agreed by the case review team. This was never done. The care plan is fundamental to keeping the prisoner safe and we are extremely concerned that none of the managers who held case reviews completed it.

95. An issue of particular concern to Ms Melhuish was her location. She struggled with noise and after she was moved to Residential Unit 3, she said it was too noisy and asked if she could move back to the induction wing. A move back to the induction wing was ruled out as the space was needed for prisoners arriving from court and staff said that it would be noisy wherever Ms Melhuish was in the prison, so she stayed where she was. We consider that more could have been done to explore location options with Ms Melhuish and that these discussions should have been recorded in the case review logs to show that staff had considered alternative options with her. We note that the issue of Ms Melhuish's location was raised by a nurse at the SIM on 30 June, but the only action was for a custodial manager to have a conversation with her about it and it is unclear whether that happened.

96. We are concerned that staff did not properly review Ms Melhuish's level of risk after significant events. For example, on 28 June, after staff had found Ms Melhuish with a ligature around her neck, the ACCT case manager kept the level of observations the same. There was also little consideration about how her risks could be reduced, other than a reference to her being seen regularly by the mental health team and being referred to the learning disabilities specialist.

97. On 4 July, while Ms Melhuish was under the table in the association room, a member of staff heard her say she was going to 'string up'. This is mentioned in the subsequent case review document completed by a SO, but there is no mention of increasing her observations. A nurse asked at the use of force debrief whether ACCT observations were going to be increased but was told they would stay the same. We consider that this should have been considered more fully, including whether a period of constant supervision was necessary, given the level of Ms Melhuish's distress and previous self-harm.

98. PSI 64/2011 says that prisoners who are being managed using ACCT procedures should be referred to the SIM if they have particularly challenging needs and their circumstances pose a significant level of risk and/or complexity. Given Ms Melhuish's complex needs and escalating risks, we consider that she should have been referred to the SIM by one of the ACCT case managers. Although a nurse raised Ms Melhuish's possible relocation at the SIM, there is no evidence that her case was referred to the SIM for a full discussion about how best to address her needs and keep her safe given her complex needs. We recommend:

The Governor and Head of Healthcare should ensure that staff manage prisoners at risk of suicide or self-harm in line with policy, and in particular, staff should:

- **ensure relevant staff involved in the prisoner's care, including healthcare staff where appropriate, are invited to all case reviews;**
- **complete the care plan with meaningful, individualised actions to reduce the prisoner's risk, and update the care plan after each case review;**
- **ensure that the prisoner's risks and triggers are properly discussed and explored at case reviews and a record is made of how these issues will be addressed;**
- **review the level of observations required after significant events, such as incidents of self-harm, discovery of ligatures and use of force; and**
- **refer complex cases to the Safety Intervention Meeting at the earliest opportunity.**

Ms Melhuish's specific needs

99. Ms Melhuish was very distressed when she arrived at Eastwood Park. She told staff she had autism, PTSD, ADHD and a personality disorder. It was also her first time in prison. It was clear that she was going to struggle being in prison given her autism and the issues associated with it, particularly her difficulties coping with noise.

100. The prison's neurodiversity practitioner developed a comprehensive communication support plan for Ms Melhuish, which set out her issues and how both she and staff

could manage them to help her cope in the prison environment. This was good practice. However, apart from one occasion when staff mentioned to the crisis support worker that they had used the communication support plan to discuss a cell move with Ms Melhuish, there is little evidence that prison staff were aware of and used the plan when interacting with Ms Melhuish.

101. Ms Melhuish herself commented that staff did not appear to know much about autism and that there were no notices about it on the wing, even though there were notices about lots of other issues. We consider that more could be done to educate staff about autism and how best to interact with autistic prisoners, particularly those, like Ms Melhuish, who find it very difficult to adjust to the prison environment. We recommend:

The Governor should ensure that staff are:

- **aware of autism and the range of issues that prisoners with autism may face; and**
- **aware of prisoners with a communication support plan in place and refer to it before interacting with the prisoner.**

Use of force on 4 July

102. A use of force expert reviewed the CCTV and body-worn video camera footage from the use of force incident on 4 July. He noted that Ms Melhuish appeared to pose no threat to staff when one member of staff was talking to her initially and the threat only appeared to escalate when more staff entered the room (after a CM radioed for staff assistance). The use of force expert noted that when Ms Melhuish came out from under the table, she stood by the window and again appeared to pose no threat to staff. He considered that staff could have continued dialogue with Ms Melhuish as she posed no threat. Instead, they made the decision to use force when Ms Melhuish came out from under the table. The expert also noted that they took the decision to take her to the floor straightaway rather than deal with the situation in the standing position. They also applied handcuffs while she was in the prone position, rather than considering alternative techniques to get control of the situation.

103. Use of force is a distressing situation for any prisoner and should be a last resort. We consider this was especially so for Ms Melhuish who had autism and was particularly sensitive to physical contact as highlighted in her communication support plan. It appears that no one involved in restraining Ms Melhuish was aware of her autism and the trauma the use of force would cause her. We accept that in cases where a prisoner is causing an imminent threat to staff or other prisoners, use of force would be necessary in order to protect others, regardless of the prisoner's own care needs. However, this was not such a case. Ms Melhuish was distressed but she was not violent, and she posed no threat to staff. As the use of force expert concluded, staff should have been able to deescalate the situation and avoided the use of force. This was even more important in the case of Ms Melhuish. The decision to use force on Ms Melhuish had devastating consequences. We recommend:

The Governor should commission an investigation into the actions of staff involved in the use of force incident on 4 July and inform the Ombudsman of the outcome.

Emergency response

104. We consider that there was a delay in staff entering Ms Melhuish's cell on the evening of 4 July. Based on Officer A's account, at 7.01pm, Ms Melhuish was sitting in the toilet area. She looked over at him but did not speak. The officer said that at the 7.15pm check, Ms Melhuish was still sitting in the toilet area and again did not respond.

105. We consider that given Ms Melhuish was in the same position at the 7.15pm check, Officer A should have tried to get a response from her. If he was unable to get a response, he should have gone into her cell to check on her, or summoned staff assistance if he considered it unsafe to go in alone.

106. It was another ten minutes before the SO checked on Ms Melhuish. He said he could not see her and could not get a response. Again, we consider he should have gone into the cell or summoned staff assistance if he considered it unsafe to go in alone. Instead, he went to the office to speak to Officer A and then they both returned to Ms Melhuish's cell and found her hanging. We recommend:

The Governor should ensure that when carrying out an ACCT check, the staff member satisfies themselves that the prisoner is alive and well and if they have any concerns, they enter the cell or summon assistance immediately.

PIN phone

107. Prison records show that two telephone numbers had been approved for Ms Melhuish to use on her PIN phone. One of these numbers was her next of kin. PIN phone records show that Ms Melhuish dialled her next of kin's number nine times between 24 June and 4 July (the last call was at 5.30pm on 4 July). Ms Melhuish dialled an incorrect number on two occasions, but on the other seven occasions, when the number was dialled correctly, it showed that the telephone number was not on the allowed list, so Ms Melhuish was unable to get through. She had £2.50 credit, so should have been able to call. Healthcare staff facilitated two telephone conversations from an office telephone on 16 June, and 2 July, but there is no record of any wing staff trying to solve this problem. This is particularly concerning as her next of kin was established as one of her protective factors.

108. The prison told the investigator that at the time of Ms Melhuish's death, telephone numbers were entered by an administrative PIN phone officer and a number of different departments needed to approve the number, including the public protection department. The public protection department had not approved Ms Melhuish's numbers before she died, although there was no reason for them to do so, as she was not a public protection risk. Eastwood Park have since changed the system so that approval from other departments can be bypassed.

109. While Eastwood Park has taken steps to address this issue, we are still concerned that Ms Melhuish was left without access to her PIN phone numbers, despite being on an ACCT and prison staff being aware that her next of kin was an important protective factor. We consider that PIN phone issues should be prioritised for prisoners being supported using ACCT and recommend:

The Governor should ensure that the PIN phone application process is reviewed to consider how PIN phone access for prisoners subject to ACCT monitoring can be prioritised.

Bullying

110. Eastwood Park's Violence Reduction Policy says that all allegations of bullying should be referred using the CSIP (Challenge, Support and Intervention Plan) process and staff should complete an intelligence report.

111. Ms Melhuish told an officer during an ACCT check on 30 June, that she was being bullied, (although she did not disclose the names of the alleged bullies). This was reported to an SO on the unit, but no action appears to have been taken, and there were no investigations into these allegations. Ms Melhuish also completed a general application form the same day asking for replacement vapes, which had been taken from her. She wrote that she had been bullied on the unit, and other prisoners had taken her food and vapes. At no time did staff raise a CSIP referral, complete an intelligence report or investigate Ms Melhuish's complaint before she died. This was still an issue for Ms Melhuish on 4 July, just before use of force was applied, when she told staff that nobody listened to her and complained, among other things, that she was being bullied.

112. After Ms Melhuish's death, staff recorded intelligence from prisoners that Ms Melhuish had been bullied by some prisoners on Residential Unit 3. These prisoners were identified and CSIPs raised for these alleged perpetrators.

113. Despite Eastwood Park's Violence, Safety and CSIP strategies, there is no evidence that staff investigated Ms Melhuish's bullying concerns before she died. We recommend:

The Governor should ensure that incidents of violence, bullying or intimidation are taken seriously, investigated, and dealt with in line with local and national policies, and victims are supported and protected.

Clinical care

114. The clinical reviewer concluded that the care Ms Melhuish received at Eastwood Park was equivalent to that which she could have expected to receive in the community. She noted that the mental health crisis team visited Ms Melhuish regularly and built up a good relationship with her. They understood her needs well and did what they could to help her adjust to prison life.

115. The clinical reviewer found that the communication support plan created for Ms Melhuish was an example of good practice. It was compassionate, person-centred and detailed Ms Melhuish's needs from her own perspective.

116. However, the clinical reviewer considered that more could have been done to understand Ms Melhuish's medication needs when she first arrived at Eastwood Park. A medication review was done on 28 June, but this was almost two weeks after she had arrived. Ms Melhuish had complex mental health needs, high risks and a high number of sedating and complex medications. The clinical reviewer considered that she should have been prioritised for a face-to-face consultation with a prescriber when she arrived.

117. The clinical reviewer also considered that Ms Melhuish's prescriptions of zopiclone and diazepam were stopped too suddenly, without any discussion with Ms Melhuish. Her community records showed that she had been prescribed both medications long-term and at a higher dose than given to her in prison. We recommend:

The Head of Healthcare should ensure that when new prisoners arrive at Eastwood Park with complex medication and health issues, a prescriber (or equivalent registered professional) has an early face-to-face conversation with the patient about their medication.

The Head of Healthcare should ensure that medication reconciliations are made in accordance with the community prescriber of that medication and where this is the community mental health team, they must confirm they are prescribing that medication and support this with evidence.

Inquest

118. The inquest, held from 23 September to 17 October 2024, concluded that Ms Melhuish died from suspension by a ligature contributed to by neglect.

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