Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Simon Faherty, a prisoner at HMP Elmley, on 20 November 2023

A report by the Prisons and Probation Ombudsman

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OUR VISION

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

WHAT WE DO

WHAT WE VALUE

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

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

Mr Simon Faherty was found hanged on his cell at HMP Elmley on 20 November 2023. He was 20 years old. I offer my condolences to Mr Faherty's family and friends.

Mr Faherty took his life a little over 48 hours after arriving at Elmley, on what was his first time in prison. He had some risk factors for suicide and self-harm, not all of which were recognised by staff. It is particularly concerning that Reception staff told us that they did not see Mr Faherty's Person Escort Record and that they did not expect to. Without sight of such an important document, it is hard to understand how they could ever properly consider the risk of a newly arrived prisoner.

Within around three hours of arrival, Mr Faherty had a fight with another prisoner. No one recognised that this might increase his risk, and there was limited follow-up engagement from staff who did little to demonstrate concern for his welfare in the aftermath. Mr Faherty did not receive the standard prison induction, which is especially important for a young man who had not previously been to prison and who arrived over the weekend.

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 **October 2024**

Contents

Summary

Events

1. On 16 November 2023, Mr Simon Faherty was arrested and held in police custody. On 17 November he was charged with possession of Class B drugs, criminal damage, affray, and possession of an offensive weapon.

2. On Saturday 18 November, Mr Faherty appeared at Medway Magistrates' Court where he was remanded in custody and transferred to HMP Elmley. He was 20 years old, and it was his first time in prison. Mr Faherty's Person Escort Record (PER) detailed that he was being assessed for bipolar disorder (a mental health condition that affects mood). It stated there was no known risk of suicide or self-harm however, Mr Faherty should be checked at least every 30 minutes.

3. On his arrival at Elmley, staff did not see the PER. Mr Faherty was unable to make a telephone call on his first night as his phone had no battery left and there were no chargers available to allow him to access his contact numbers. Following his reception health screen, the clinical lead for primary care referred Mr Faherty to the mental health team.

4. Both prison staff and healthcare staff assessed that no factors were present to indicate that Mr Faherty had an increased risk of suicide and self-harm, and they did not start suicide and self-harm prevention procedures (known as ACCT).

5. At around 5.00pm, Mr Faherty and his cellmate (who knew each other in the community) were found fighting in their cell. They were both charged with an offence against prison discipline. Mr Faherty was moved to a single occupancy cell.

6. On 19 November, Mr Faherty attended an induction appointment with the Chaplain and prison staff issued adjudication paperwork to him relating to the fight. There is no record of any other member of staff having any interaction with Mr Faherty.

7. On 20 November, Mr Faherty did not receive his scheduled prison induction. At 10.50am, he attended his adjudication hearing and accepted responsibility for initiating the fight.

8. At around 7.22pm, Mr Faherty sounded his cell bell alarm, and subsequently spoke to an officer for around 18 minutes. Mr Faherty told the officer that he missed his mother and grandmother, and she gave advice about how she could assist him to make a phone call.

9. At 8.22pm, prison staff found Mr Faherty hanging in his cell during a routine check. They sounded the general alarm and began cardiopulmonary resuscitation but did not immediately radio a medical emergency code blue. When the Ambulance Service was contacted, no one told them, or healthcare staff who arrived on the scene, that they were attending a hanging.

10. Around 8.47pm, paramedics attended and continued with chest compressions. At 9.22pm, they confirmed that Mr Faherty had died.

Findings

Assessment of risk of suicide and self-harm

11. There were some missed opportunities to identify Mr Faherty as at risk of suicide and self-harm. Some staff recognised that he had some risk factors (such as his age and first time in prison), whereas others told us that they did not think Mr Faherty had any risk factors at all. No one recognised that having a fight within a very short time of arrival in prison might increase Mr Faherty's risk. There was a lack of meaningful engagement with Mr Faherty in his 48 hours at Elmley, and he did not receive a prison induction in line with expectations.

Emergency response

12. Staff sounded a general alarm rather than calling a medical emergency when they discovered Mr Faherty hanging. Communication between wing staff, healthcare staff and paramedics was very poor.

Recommendations

- The Governor and Head of Healthcare should review the training for Reception and Induction staff to ensure they:
    - understand how to identify prisoners at risk of suicide and self-harm, and
    - know how to provide appropriate support to those with risk factors and emerging triggers, including by starting ACCT procedures when required.
- The Governor should review the reception process to understand why staff did not see Mr Faherty's PER and ensure that reception staff understand how to use this information within the first night screening.
- The Governor should ensure that all newly arrived prisoners receive an 'Induction to Custody presentation' in line with the expectations of PSI 07/2015 and that the local induction process is reviewed to ensure support is available for prisoners that arrive over the weekend.
- The Governor and Head of Healthcare should conduct a review of the emergency response to identify learning in relation to the errors and omissions identified and, facilitate training to rectify these issues.

The Investigation Process

13. HMPPS notified us of Mr Faherty's death on 21 November 2023.

14. The investigator issued notices to staff and prisoners at HMP Elmley informing them of the investigation and asking anyone with relevant information to contact her. No one responded. Ms Peters obtained copies of relevant extracts from Mr Faherty's prison records.

15. NHS England commissioned a clinical reviewer to review Mr Faherty's clinical care at the prison.

16. The investigator visited HMP Elmley in December 2023, with her colleague, and, in January 2024 with the clinical reviewer.

17. The investigator, her colleague and the clinical reviewer interviewed 16 staff members in December 2023, January 2024 and February 2024, either in person at Elmley or via Microsoft Teams.

18. We informed HM Coroner for Kent and Medway 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 Ombudsman's office contacted Mr Faherty's mother to explain the investigation and to ask if she had any matters she wanted us to consider. Mr Faherty's mother did not raise any specific questions.

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

21. Mr Faherty's family received a copy of the draft report. They did not make any comments.

Background Information

HMP Elmley

22. HMP Elmley holds remand and sentenced prisoners in six houseblocks, with a mixture of single and double cells. Oxleas NHS Foundation Trust provides healthcare services.

23. The Mental Health In-reach Team (MHIRT) provides a non-crisis pathway of support. The MHIRT are available Monday to Friday to process referrals, triage and conduct mental health assessments. The Head of Mental Health at Elmley reported that on average they receive 30 referrals a day. The crisis pathway includes an in-patient unit at Elmley, which is managed by Oxleas nurses.

HM Inspectorate of Prisons

24. The most recent inspection of HMP Elmley was in February and March 2022. Inspectors reported that there had been four self-inflicted deaths since the last inspection and that some new prisoners missed important aspects of induction. The prison had begun implementing PPO recommendations, but implementation was not monitored over time to ensure on-going compliance. Reported self-harm was lower than in most comparable prisons but had increased since the last inspection. Prisoners supported through ACCT case management were generally positive about the care they received, although there were some weaknesses in the process itself.

25. In February 2023, HMIP published an Independent Review of Progress. The report said that Elmley faced substantial staff shortages, but leaders were focused on how to make improvements with the resources they had and were delivering more than many prisons with a similar or better staffing position. HMIP referenced the improvement in quality of induction and the positive “imaginative work” being undertaken with young adults to reduce violence in one of the wings in Elmley. Inspectors highlighted the effective changes made to the induction programme which resulted in prisoners being better prepared for assessments.

Independent Monitoring Board

26. 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 2022, the IMB agreed with HMIP’s inspection report that not enough was being done to understand and address the underlying causes of self-harm. However, they highlighted that there was now a custodial manager (CM) with the overall responsibility for quality assuring ACCT case management.

27. The IMB also reported that Elmley was developing a Young Adult (YA) strategy which includes a rigorous cross fit programme delivered by gym staff, which was available to all young adults.

Previous deaths at HMP Elmley

28. There have been 18 deaths at Elmley since 20 November 2020, including Mr Faherty. Of these, four were self-inflicted. There are no significant similarities between Mr Faherty's death and the circumstances of the other self-inflicted deaths.

29. To the end of April 2024, there has been one further death at Elmley, which was due to natural causes.

Person Escort Records (PERs)

30. PERs must be completed for all prisoners before any escorted movement or transfer. They provide escort staff and receiving prisons with relevant information on a prisoner and the risks they may pose during and after the movement. The PER is not itself a risk assessment, however it conveys information about a prisoner's assessed risks to those who may need to know about them.

31. The Person Escort Record Policy Framework states that members of staff designated to dispatch a prisoner must ensure that "if risks have been identified, supporting information has been provided for escort". Correct completion and storage of the PER will help to prevent incidents of suicide/self-harm, escapes, assaults, releases in error and other serious incidents.

Adjudications

32. PSI 05/2018, Prison Adjudication Procedure framework requires that all adjudication punishments are fair, safe, and proportionate to the charge. Adjudicators should consider the seriousness of the offence, any punishment guidelines, the prisoner's previous disciplinary record, the likely effect of the punishment on the prisoner and any mitigation.

33. If the outcome of an adjudication hearing is thought to raise safer custody concerns, the appropriate staff must be informed to aid management of the impact on a prisoner's risk of self-harm. The cell sharing risk assessment may need to be reviewed if any indicators of heightened risk become evident during the adjudication process.

Early days in custody

34. The First Night in Process (FNIP) at Elmley involves a cell sharing risk assessment, medical screening by a member of the healthcare team and an introduction to Elmley by Insiders (fellow prisoners who have been selected and trained for the task). The FNIP is the same Monday to Sunday. Inductions take place the morning after arrival (except Sundays) and this should include an introduction to the wing, information about the support available and a meeting with partner agencies such as probation and housing.

Assessment, Care in Custody and Teamwork

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

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

Key Events

Medway Custody Suite

37. On 16 November 2023, Mr Simon Faherty was arrested and held in police custody. On Friday 17 November, Mr Faherty was charged with possession of class B drugs, criminal damage, affray, and possession of an offensive weapon. Mr Faherty spent his first two nights in custody at Medway Custody Suite. A nurse screened him and assessed that he had a standard risk of self-harm and that he was fit for detention in custody.

38. Mr Faherty was being supervised by the Probation Service (because of a previous conviction for possession of an offensive weapon, for which he received a community order). He disclosed that he was being assessed for bipolar disorder (a mental health condition that affects your moods). He had no recorded history of self-harm or suicidal thoughts/attempts. His community probation manager was not informed that he had been arrested and was in custody.

39. On Saturday 18 November, Mr Faherty appeared at Medway Magistrates' Court and was remanded to HMP Elmley to be sentenced at a future date. Mr Faherty's Person Escort Record (PER) form, completed by police staff, detailed that he was being assessed for bipolar disorder. Police staff stated there was no identified risk of suicide or self-harm, but that Mr Faherty should be checked at least every 30 minutes. (There are four levels of observation that can be set in police custody. The minimum requirement is that the detainee is checked at least every hour. Intermittent observation of at least every 30 minutes is the second lowest requirement.) Mr Faherty had never been to prison before.

HMP Elmley

40. At around 2.20pm, Mr Faherty arrived at Elmley. Upon arrival, prison staff had the following information available; his warrant, which detailed his offences and a flag for domestic violence, and his medical record which detailed a standard risk of self-harm following his health screening at Medway Custody Suite. As it was Mr Faherty's first time in prison, Reception staff did not have any historic prison records from which they could source further information. They told us that they did not see the digital PER when Mr Faherty arrived at Elmley and that they did not usually see this document (and did not expect to). No one at Elmley signed the handover sheet to indicate that they had received Mr Faherty from the escort contractor.

41. An officer completed Mr Faherty's first night interview in Reception. She completed his cell sharing risk assessment (CSRA – to determine the risk of violence to a potential cell mate that a prisoner presents) and concluded that he was a standard risk and suitable to share a cell. She noted that Mr Faherty was young, this was his first time in prison and that he had a mental health condition (bipolar). She stated in interview that she did not have access to Mr Faherty's PER and that she would not usually expect to have sight of this document. She said that Mr Faherty had no recorded history of self-harm and that no other documents suggested that his risk of suicide and self-harm was anything other than low. She determined that he was

suitable for cell sharing and she did not consider it necessary to start ACCT procedures.

42. In his first night health screening, the clinical lead for primary care reviewed Mr Faherty's medical record and noted his bipolar disorder. In her interview, she reported that Mr Faherty did not express any thoughts or history of self-harm and, due to their being no immediate concerns, she did not start ACCT procedures. She initiated an urgent referral to the mental health team on account of Mr Faherty disclosing that he had bipolar disorder. (Oxleas "Integrated Prison Mental Healthcare Model" sets out criteria for categorising referrals. Based on this guidance, Mr Faherty's referral would have been categorised as "Red" indicating this assessment was high priority due to his status as a young adult and being in prison for the first time. The guidance highlights that urgent assessments are to be carried out within 48 hours. However, the guidance does not specify if this 48-hour time period commences from the point of referral or the time of triage.)

43. Mr Faherty was unable to phone his mother on his first night at Elmley because he did not know her number. His mobile battery was flat and there were no chargers in Reception, so he could not access his contacts list. (We do not know whether Mr Faherty had previously telephoned his mother from police custody.) There is no evidence that anyone made a plan to allow Mr Faherty access to his phone and most staff we interviewed were not aware of any issues regarding Mr Faherty's phone.

44. Staff allocated Mr Faherty a shared cell on the induction unit (designed to accommodate prisoners on their first days in the prison). At around 5.00pm, shortly after being moved to his cell, Mr Faherty and his cellmate were found fighting. Mr Faherty explained to staff that he and his cellmate were acquaintances outside of prison and had some conflict. This was not known by prison staff and was not declared by Mr Faherty or his cellmate when they were allocated the cell. Mr Faherty was moved to a single cell, and he refused a medical assessment. Both Mr Faherty and his cellmate were charged with an offence against prison discipline. Prison staff did not have any further contact with Mr Faherty that evening.

Sunday 19 November 2023

45. Mr Faherty attended an induction with the chaplain and confirmed that he had no religious background. He told the chaplain that he did not have a pillow. At around 4.45pm, an officer issued adjudication paperwork to Mr Faherty in relation to the previous day's fight. The paperwork stated that his adjudication hearing would take place the following morning.

46. As 19 November was a Sunday, the standard induction programme run by prison Insiders for all new arrivals did not take place. Prisoners who arrive on a Saturday receive their prison induction on a Monday. There is no record that anyone explained this to Mr Faherty.

47. There is no record of prison staff having any other interactions with Mr Faherty on 19 November.

Monday 20 November 2023

48. Prison staff recorded that Mr Faherty did not attend his induction appointment that morning. A Supervising Officer (SO) informed us that the wing induction process is largely run by Insiders and an induction officer would have had responsibility for notifying Mr Faherty of his induction appointment that day. Despite several efforts to obtain information about who this was, we have not received clarification from Elmley. There is no record that Mr Faherty received any aspects of his induction on 20 November.

49. At 10.50am, Mr Faherty attended his adjudication hearing with the Deputy Head of House Block One. Mr Faherty accepted responsibility for initiating the fight. The penalties given were a revocation of gym access for 28 days, a 14-day forfeiture of access to the prison shop and a 14-day 60% reduction of earnings. The Head stated in his interview that Mr Faherty presented as polite and honest during the hearing and accepted the punishment given. He told us that he did not consider that Mr Faherty was at increased risk of suicide and self-harm.

50. An officer told us that she spoke with Mr Faherty at around 4.00pm and gave him a pillow. She said he thanked her and appeared to be in happy spirits. There were no other recorded interactions between staff and Mr Faherty on 20 November.

51. At around 7.22pm, Mr Faherty pressed his cell bell. CCTV shows that an officer attended and spoke to him for around 18 minutes. She stated in interview that Mr Faherty said that he missed his mother and grandmother. He told her that he had sent his mother a letter and she reassured him that it would reach his mother within a couple of days and that, once they had received a response, she could help him with a phone call. She said Mr Faherty agreed that the following day they would go through this process and Mr Faherty appeared satisfied with this help. He said to her that he would see her tomorrow and he raised no other concerns. The officer did not record the conversation in Mr Faherty's record.

52. At 8.22pm, an operational support grade (OSG) was completing the night routine check. He looked through the cell door observation panel and saw Mr Faherty at the end of his cell. He told us that he called twice to Mr Faherty and received no response, and therefore thought that something must be wrong. He shouted to an officer, who was on the landing below, for help to open Mr Faherty's cell.

53. The officer attended within 30 seconds and unlocked Mr Faherty's cell. They found Mr Faherty hanging from a ligature made from a bedsheet that he had attached to a fixed cupboard. A SO arrived and cut the ligature. The SO stated in interview that she instructed staff to sound the general alarm, and the OSG did so. No one radioed a medical emergency code blue (which should be used in a life-threatening situation, such as following a hanging, and alerts healthcare staff to attend the scene and control staff to telephone for an ambulance). The SO told us that healthcare staff attended both general alarms and code blue emergencies.

54. Officers reported that when they cut the ligature, Mr Faherty released a breath of air and so they placed him in the recovery position and searched for a pulse. They could not find a pulse and then began cardiopulmonary resuscitation (CPR), rotating at intervals. During this period, an officer radioed a code blue.

55. At 8.24pm, officers brought a defibrillator to the scene and applied the defibrillator pads. The defibrillator advised against shock and to continue with CPR.

56. At 8.25pm, control room staff requested an ambulance and advised the ambulance crew that this was a 'code blue'. The control room transferred the call to an officer on Houseblock One, who confirmed that Mr Faherty was not breathing. The officer who took the call did not mention that Mr Faherty had been found hanging. At around the same time, a GP at Elmley and two nurses arrived at the cell.

57. The officers continued to alternate CPR and give Mr Faherty air via the bag valve mask during the operation of the defibrillator. During this time, the healthcare team gave two doses of naloxone and two intramuscular adrenaline shots. Healthcare staff were unaware at the time that Mr Faherty had been found hanging and believed the emergency was substance misuse related.

58. At 8.47pm, paramedics arrived in the cell. They instructed the officers to continue CPR rotations before applying their own defibrillator pads. At 8.56pm, prison staff informed the paramedics that Mr Faherty had been found hanging. The attending paramedics recorded that they were not told this by the GP when he handed over on their arrival. Healthcare staff confirmed that they were not aware Mr Faherty was found hanging until later that evening.

59. Paramedics continued chest compressions but could not find a pulse. At 9.22pm, they confirmed that Mr Faherty had died.

Contact with Mr Faherty's family

60. At around 11.45pm, a prison family liaison officer (FLO) and another officer attended Mr Faherty's mother's address, but there was no answer. The FLO reported that he attempted to call Mr Faherty's mother on the telephone number available on Mr Faherty's electronic prison record (known as NOMIS), which was not recognised. We have been unable to identify where this number was obtained as there is no contact number recorded on NOMIS.

61. At round 9.40am on 21 November, the FLO and a prison chaplain attended Mr Faherty's mother's address again. Mr Faherty's brother answered and told the FLO that his mother was away and not due home until the following day. The FLO decided that he should deliver the news of Mr Faherty's death over the phone and rang her straightaway. Mr Faherty's mother gave permission for the FLO and chaplain to speak with her son. He appeared to be very upset, and the staff stayed with him to offer support until he left the property to a friend's house.

62. On 22 November, the FLO and chaplain visited Mr Faherty's mother and grandmother.

63. In line with Prison Service guidance, Elmley offered a contribution towards the costs of Mr Faherty's funeral.

Support for prisoners and staff

64. After Mr Faherty's death, a custodial manager 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.

65. Elmley facilitated reflective practice sessions for staff members, and members of the Trauma Risk Management (TRiM) team offered sessions to all staff affected.

66. The prison posted notices informing other prisoners of Mr Faherty'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 Faherty's death.

Post-mortem report

67. The post-mortem examination found that Mr Faherty died from hanging. There was nothing of note in his toxicology report.

Findings

Assessment of risk of suicide and self-harm

68. Prison Service Instruction (PSI) 64/2011, on prisoner safety, requires all staff who have contact with prisoners to be aware of the risk factors and triggers that might increase the risk of suicide and self-harm and take appropriate action. Any prisoner identified as at risk of suicide and self-harm must be managed under ACCT procedures. PSI 64/2011 also states that any information that becomes available which may affect a prisoner's risk of harm to himself must be recorded and shared to inform proper decision making.

69. PSI 07/2015 'Early Days in Custody' sets out guidance and mandatory actions for prison staff regarding reception, first night in custody and induction procedures. This includes a Reception and First Night Checklist. Staff are required to be aware that particular groups are at a higher risk of suicide/self-harm. Annex F to PSI 07/2015 identifies that the 'Introduction to custody' module (which includes basic information about prison life, including how to access support) would usually be completed on a prisoner's first full day in prison.

70. We have considered whether staff at HMP Elmley appropriately assessed Mr Faherty's risk and provided sufficient support during his first days in prison.

Reception

71. When Mr Faherty arrived at Elmley, he had some risk factors for suicide and self-harm that Reception staff should have considered. It was Mr Faherty's first time in prison and he had been convicted of a violent offence. He was a young man and disclosed that he was being assessed for bipolar disorder. PSI 64/2011 also recognises that prisoners are at increased risk of suicide and self-harm in their first days in prison. In addition, Mr Faherty was unable to call his mother (which we discuss in more detail below).

72. Reception staff confirmed that they did not see Mr Faherty's PER, which is an important document that should be considered when a prisoner first arrives in prison. There was no signature on this document to confirm receipt upon Mr Faherty's arrival at Elmley. The suicide and self-harm section in his PER stated that there was no identified risk of suicide or self-harm, but that Mr Faherty should be observed every 30 minutes. The PER also referenced that Mr Faherty was being assessed for bipolar disorder. While we consider it unlikely that the PER form in itself would have altered staff's decision not to start ACCT procedures, it provides objective information on risk and as per PSI 07/2015, staff are required to have regard to it on reception and first night. Reception staff told us that they do not normally see the PER, and do not expect to, indicating that this is a systemic issue at Elmley.

73. An officer recorded some risk factors but reported that Mr Faherty expressed no current thoughts of suicide or self-harm and so she did not consider ACCT procedures necessary. The clinical lead conducted the first night healthcare screening and initiated an urgent referral to the mental health team, based on the fact that Mr Faherty was young, and this was his first time in prison. While staff

74. recognised some risk factors, we did not find that they had regard to wider concerns and triggers that may have contributed to Mr Faherty's risk of suicide and self-harm. Furthermore, although the clinical lead identified that Mr Faherty met the criteria for an urgent mental health assessment, prison staff were not aware and there is no evidence that anyone considered the impact of this on his risk of suicide or self-harm.

18-20 November

75. Shortly after arriving 18 November, Mr Faherty and his cellmate had a fight and Mr Faherty was moved to a single occupancy cell. He was charged with an offence against prison discipline and subsequently found guilty at an adjudication hearing.

76. On Sunday 19 November, Mr Faherty spoke with the chaplain. Outside of this interaction there are no records of staff having any conversations with Mr Faherty. There is no evidence that anyone checked his well-being after the altercation and subsequent move to a more isolated cell at the end of a landing. Despite his other risk factors, notably his age and it being his first time in prison, no one considered whether the fight impacted his risk of suicide and self-harm or reviewed the decision not to start ACCT procedures. There is no evidence that any additional support was in place for prisoners arriving at the weekend when the regime, and therefore access to support, is limited.

77. On the morning of 20 November, Mr Faherty did not attend or receive the expected prison induction. We spoke to staff who worked on Houseblock One on 20 November but were unable to understand why Mr Faherty did not receive the induction. The induction process is particularly important for a young man on his first time in prison. Contact with staff during the induction process would have allowed for further opportunities to consider how he was settling and to monitor his wellbeing and risk to self.

78. In the evening, Mr Faherty told an officer that he was worried about not being able to speak to his mother. The officer spent 18 minutes talking to Mr Faherty and we note that this was the longest (and likely most supportive) contact any officer had with him. The officer said that she did not identify anything in Mr Faherty's presentation that made her concerned for his safety. However, Mr Faherty had not been able to contact his family since he arrived in prison, and this heightened his risk.

79. While Mr Faherty had risk factors for suicide and self-harm, we are concerned that some were not recognised by staff at Elmley, and other were treated in isolation. Some prison staff did not consider Mr Faherty to have any risk factors beyond the fact that he was young, and that this was his first time in prison. Several staff that we interviewed said that they did not consider Mr Faherty to have any risk factors at all.

80. No one appeared to consider Mr Faherty's significant risk factors holistically or that together they might increase his risk of suicide and self-harm. Once Mr Faherty left Reception (where processes to identify and consider his risk factors were poor), the very limited contact he had with staff meant that identifying his increasing risk was unlikely. There is no evidence of staff considering whether Mr Faherty would have

benefitted from ACCT monitoring or additional welfare checks. We make the following recommendations:

The Governor and Head of Healthcare should review the training for Reception and Induction staff to ensure they:

- **understand how to identify prisoners at risk of suicide and self-harm, and**
- **know how to provide appropriate support to those with risk factors and emerging triggers, including by starting ACCT procedures when required.**

The Governor should review the reception process to understand why staff did not see Mr Faherty's PER and ensure that reception staff understand how to use this information within the first night screening.

The Governor should ensure that all newly arrived prisoners receive an 'Induction to Custody presentation' in line with the expectations of PSI 07/2015 and that the local induction process is reviewed to ensure support is available for prisoners that arrive over the weekend.

Emergency Response

81. Prison Service Instruction (PSI) 03/2013, Medical Emergency Response Codes, requires all prisons to have a medical emergency response code protocol in place, the purpose of which is to ensure a timely, appropriate, and effective response to medical emergencies. When a medical emergency is discovered, staff should call the appropriate medical emergency code straightaway so that relevant staff, including healthcare staff, are alerted, the correct equipment is brought, and an ambulance is called immediately.

82. Staff did not immediately call a medical emergency code blue when they discovered Mr Faherty hanging in his cell. The SO stated in interview that she instructed staff to sound the general alarm due to the understanding that healthcare staff attend both general alarms and code blue calls at Elmley. She stated that her priority was getting Mr Faherty down and getting staff to their location.

83. The use of code blue is intended to efficiently and unambiguously notify all staff of the emergency and communicate to the control room that an ambulance is required. It is still necessary to call a code blue even if healthcare staff respond regardless of the code.

84. Communication at the scene was poor. Staff in the control room did not tell the ambulance operator that Mr Faherty had been found hanging, prison staff at the scene did not tell their healthcare colleagues when they arrived and no one told the paramedics immediately on their arrival, which impacted on the initial care he was provided by both healthcare staff and the paramedics. As highlighted by the clinical reviewer, the body worn camera footage shows a disjointed and chaotic approach in delivering emergency care with multiple staff members in the confinement of Mr Faherty's cell.

The Governor and Head of Healthcare should conduct a review of the emergency response to identify learning in relation to the errors and omissions identified and, facilitate training to rectify these issues.

Contact with family on reception

85. PSI 07/2015 states that all prisoners must be given access to a telephone in Reception. Mr Faherty was unable to make a phone call to his mother because his phone battery was flat, there were no chargers in Reception and so he could not access his contacts. Contacting family on a prisoner's first night in custody is an important measure to help reduce risk and prison staff should ensure that this is facilitated whenever possible. We recognise the actions taken by the Head of Safety since Mr Faherty's death to assist new arrivals in maintaining contact with their families including;

- Collaborating with the Chief of Police Custody for Kent to ensure a system for documenting key contacts in cases where phones are seized for evidence;

- Providing more charging cables in reception to ensure access to contact information for those whose phones are uncharged upon arrival.

Inquest

86. The inquest of Mr Faherty's death was opened on 1 December 2023 and concluded on 17 March 2025. The conclusion was that Mr Faherty's death was due to suicide. The Inquest found that there were failures in checking Mr Faherty's PER documentation and it cannot be established whether these failures contributed to his death.

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