

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Patrick Driver, a prisoner at HMP Elmley, on 5 October 2025

A report by the Prisons and Probation Ombudsman

Third Floor, 10 South Colonnade
Canary Wharf, London E14 4PU

Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk

T | 020 7633 4100

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



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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 Patrick Driver was found hanged in his cell at HMP Elmley on 5 October 2025. Staff and paramedics tried to resuscitate him but were unsuccessful. He was 69 years old. I offer my condolences to Mr Driver's family and friends.

Staff supported Mr Driver using suicide and self-harm procedures for around 11 weeks between August 2024 and February 2025, because he struggled with being in prison and feared a long sentence. He also spent a long period in the prison's inpatient department (IPD) after he stopped eating. He was discharged from IPD on 21 February and staff stopped ACCT monitoring on 26 February.

The investigation found that staff managed the ACCT procedures well and that the decision to stop ACCT procedures on 26 February was a reasonable one. There was no indication subsequently that Mr Driver's mental health had declined, though there were minimal records after 26 February.

The clinical reviewer found that the care provided to Mr Driver during his time in IPD and while subject to ACCT monitoring was equivalent to that which he could have expected to receive in the community. However, he found there was a lack of continuity of care following Mr Driver's discharge from IPD and that this aspect of his care was not equivalent to that which he could have expected to receive in the community.

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

May 2026

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Summary

Events

1. On 26 July 2024, Mr Patrick Driver was remanded in prison charged with sexual offences. He was sent to HMP Elmley. It was his first time in prison.
2. Mr Driver did not have a history of mental health issues.
3. A few days after Mr Driver arrived at Elmley, he stopped engaging in the prison regime and refused food and medication.
4. On 12 August, staff started suicide and self-harm procedures (known as ACCT) for Mr Driver after he told a GP that he did not want to be alive. Staff continued ACCT monitoring until 10 September and then from 22 September to 6 December. Mr Driver was worried he would not be granted bail and that he would get a long sentence.
5. Due to concerns about his physical health, Mr Driver was admitted to the prison's inpatient department (IPD) on 16 August and remained there until 27 January 2025. On 19 February, Mr Driver was readmitted to IPD due to refusing his food and medication. He was discharged two days later.
6. On 21 February, staff restarted ACCT procedures after Mr Driver said he had lost everything. They stopped ACCT monitoring on 26 February after Mr Driver told staff he was no longer feeling depressed.
7. There are no records of any meaningful interactions between staff and Mr Driver between 26 February and 5 October.
8. Mr Driver was due to attend court on 6 October for a six-week trial.
9. At around 5.04am on 5 October, during a routine check of all prisoners, an operational support grade (OSG) saw Mr Driver on the floor of his cell. After she knocked on the door but got no response, she radioed a medical emergency code. An officer arrived a few minutes later and entered Mr Driver's cell. He found Mr Driver unresponsive, with a ligature tied around his neck attached to the phone socket above. The officer cut the ligature, more staff arrived, and they started CPR.
10. At around 5.25am, paramedics arrived and applied a defibrillator which advised no shock. At 5.34am, they pronounced life extinct.

Findings

11. We found that the ACCT procedures were managed well and that the decision to stop ACCT monitoring on 26 February was a reasonable one.
12. Based on the prison records, there was no indication that Mr Driver was struggling with his mental health after 26 February. However, there was little evidence of any meaningful interaction with Mr Driver between 26 February and his death.

13. The clinical reviewer concluded that the care provided to Mr Driver during the ACCT process and his time in IPD was of a good standard. However, he found that Mr Driver received no mental health follow up after he was discharged from IPD and that this aspect of his care was not equivalent to that which he could have expected to receive in the community.

Recommendations

- The Head of Healthcare should ensure that all prisoners discharged from IPD following an ACCT, or who have presented with recent suicidal ideation or significant mental health vulnerability, have a documented mental health review prior to discharge and have a follow up appointment arranged when returned to the residential unit.

The Investigation Process

14. HMPPS notified us of Mr Driver's death on 5 October 2025.
15. 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. One member of staff contacted the investigator with information which is addressed in the report.
16. The investigator visited Elmley on 16 October. She obtained copies of relevant extracts from Mr Driver's prison and medical records. She also obtained CCTV footage, body worn video camera footage of the emergency response, the HMPPS Early Learning Review and Ambulance Service records.
17. NHS England commissioned an independent clinical reviewer to review Mr Driver's clinical care at the prison.
18. The investigator and clinical reviewer interviewed ten members of prison and healthcare staff at Elmley between 28 November and 18 December, both in person and by video call.
19. 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.
20. The Ombudsman's office contacted Mr Driver's sister to explain the investigation and to ask if she had any matters she wanted us to consider. Mr Driver's sister said she was concerned that the prison had leaked information about Mr Driver's death before she was told. We have addressed this issue in the report.
21. We shared our initial report with HMPPS and the prison's healthcare provider, Oxleas NHS Foundation Trust. HMPPS pointed out a factual inaccuracy with the clinical review. The investigator passed this onto the clinical reviewer who amended their report. The action plan is an additional annex to this report.
22. We sent a copy of our initial report to Mr Driver's sister. She did not notify us of any factual inaccuracies.

Background Information

HMP Elmley

23. 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.

HM Inspectorate of Prisons

24. The most recent inspection of HMP Elmley was in March 2025. Inspectors reported that key work was not offered to prisoners regularly or with the same officer and that it was often a task that was dropped when staffing was tight. In a sample completed, each prisoner received about three sessions over a three-month period, case notes were formulaic and there was no consistency in the officers taking the sessions which meant prisoners could not develop rapport and were less likely to discuss personal concerns with them. Inspectors reported that there was some evidence of recent improvement following increased oversight by leaders.
25. Inspectors found that the inpatient unit provided good care. The unit was clinically led and enabled operationally by a regular group of officers, facilitating continuity of care. Nursing admission and discharge procedures had been updated and documentation was of a reasonable standard. Inspectors found there was a weekly ward round, during which the GP, nurses and consultant psychiatrist reviewed every patient in a collaborative approach. This ensured holistic and joined-up care (recorded on SystmOne, the medical record system) and post-discharge follow-up of patients, which was good practice.

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 31 October 2024, the IMB reported that, on average, only 20% of expected key work sessions occurred on a weekly basis, usually because of low staff availability. Many prisoners with whom Board members spoke had little knowledge of who their key worker was or the purpose of key work.
27. The Board reported that a significant number of prisoners with mental health needs were placed in the inpatient department (IPD) and on occasion, Board members had witnessed prisoners displaying distress in a manner that made the atmosphere unsettling and frightening, both for the individual concerned and others located in IPD. The Board noted that it would like to see steps taken to improve mental health provision for those prisoners in IPD.

Previous deaths at HMP Elmley

28. Mr Driver was the eleventh prisoner to die at Elmley since October 2022. Of the previous deaths, four were from natural causes, three were self-inflicted and three were drug related. Up to the end of February 2026, there has been one further

death, which was from natural causes. There are no similarities between the findings from our investigation into Mr Driver's death and the findings from our investigations into the previous deaths.

Assessment, Care in Custody and Teamwork (ACCT)

29. ACCT is the care planning system the Prison Service uses to support prisoners at risk of suicide or self-harm. The purpose of the ACCT is to try to determine the level of risk posed, the steps that staff might take to reduce this and the extent to which staff need to monitor and supervise the prisoner. Checks should be made at irregular intervals to prevent the prisoner anticipating when they will occur.
30. Part of the ACCT process involves assessing immediate needs and drawing up support actions to identify the prisoner's most urgent issues and how they will be met. Staff should hold regular multidisciplinary reviews and should not close the ACCT plan until all support actions are completed. Guidance on ACCT procedures is set out in the Prison Safety Policy Framework (from January 2025, and prior to that Prison Service Instruction (PSI) 64/2011 on safer custody).

Key Events

31. On 26 July 2024, Mr Patrick Driver was remanded in prison charged with sexual offences. He was sent to HMP Elmley. It was his first time in prison.
32. During his initial health screen, Mr Driver told the nurse that he did not have any mental health problems and that he had no thoughts of suicide or self-harm.
33. Over the next few days, Mr Driver refused to engage in the prison regime and refused food and medication (prescribed to treat nerve pain and high blood pressure).
34. On 11 August, a nurse went to see Mr Driver. He told the nurse that he did not feel like taking his medication because he had not been granted bail. The nurse booked a GP appointment and arranged a welfare check for the next day.

ACCT – 12 August to 10 September 2024

35. On 12 August, a GP saw Mr Driver. Mr Driver told the GP that he did not want to be alive anymore. The GP offered Mr Driver antidepressants, but he declined and said he wanted to be left alone. The GP started suicide and self-harm prevention procedures (known as ACCT) for Mr Driver. An entry in Mr Driver's medical record says that during the ACCT review, he appeared low and said he was struggling to accept his circumstances. He said that he had given up on himself.
36. On 14 August, following Mr Driver refusing food for three days, wing staff opened a food refusal log and informed healthcare staff. Mr Driver told an officer that he did not want to live because he was looking at a lengthy sentence.
37. The same day, a mental health nurse went to see Mr Driver. Mr Driver told the nurse that he did not need medication and that he wanted to be left alone. The nurse recorded that Mr Driver did not engage enough to enable him to complete a full mental state examination. He recorded in the medical record that he would attend Mr Driver's ACCT review the next day to complete the mental health review.
38. On 15 August, during an ACCT review, staff recorded that Mr Driver said he wanted to die and that he would not self-harm or use a ligature around his neck but would starve himself to death. Staff noted that he presented as weak and frail due to his food refusal and that he refused all support from the mental health team. A mental health nurse attended the ACCT review to complete the mental health assessment. He referred Mr Driver back to the GP and for psychological support.
39. On 16 August, due to concerns about his physical health, Mr Driver was admitted to the prison's inpatient department (IPD).
40. On 19 August, during an ACCT review, Mr Driver told staff he had not eaten since he arrived in IPD and in total had not eaten for 11 days. He said that his intention was to end his life by starving himself. Mr Driver talked about his criminal case and said he was due to attend court on Friday and that if he got bail, it might change his mindset.

41. On 23 August, Mr Driver attended a court hearing. No outcome was recorded. Healthcare staff saw Mr Driver when he left for his court hearing and when he returned to IPD. They noted that he seemed low in mood and did not want to engage in conversation.
42. On 24 August, healthcare staff recorded that Mr Driver declined food and water and that he had not eaten for 17 days. Due to concerns about his minimal fluid intake, staff called a medical emergency code. Ambulance paramedics took him to hospital for medical examination and he returned the next day.
43. On 26 August, during an ACCT review held in Mr Driver's cell, Mr Driver told staff that he had been issued with further charges and been denied bail.
44. On 10 September, during an ACCT review, Mr Driver told staff that he still felt low and that his main concern was his court case and being charged with further offences. Staff recorded that he said he was coping at present and had started eating. They closed the ACCT as Mr Driver was no longer in crisis and was receiving support from IPD and healthcare staff.

ACCT – 22 September to 6 December 2024

45. On 22 September, the Head of Safety recorded in Mr Driver's electronic prison record that she saw him during governor rounds and that he was very low and had stopped eating again. He told her that he wanted to die and that he had nothing to live for anymore. The Head of Safety reopened the ACCT and notified healthcare staff. In an ACCT review the next day, staff noted that Mr Driver would remain in IPD until a reintegration plan had been put in place for his return to the houseblock.
46. On 22 October, during an ACCT review, staff recorded that Mr Driver was in a very low mood. He said he had received further charges from the police which had stressed him out further and made him sick.
47. On 29 October, staff noted that Mr Driver engaged well in his ACCT review and that he was eating and drinking small amounts. He declined medication for anxiety. Mr Driver said he had a meeting arranged with his solicitor that day and that he hoped to get bail. Mr Driver said that he felt supported and had good relationships with IPD staff so did not want support from other agencies.
48. On 6 November, during an ACCT review, Mr Driver spoke about his criminal case and said he felt sad, afraid and depressed. He said he had no appetite but that he was eating what he could each day. He said that he was concerned information about him was being leaked to the holiday camp where he lived and that he knew one officer from the community but would not name him.
49. On 13 November, staff went to Mr Driver's cell to complete an ACCT review. He told them that he had not been granted bail and this had made him feel lower than before. He said that he was concerned that his trial set for January would be cancelled and that a new trial date would be set. He told staff that he would not cope with being in custody for months and that if he was found guilty, he would have nothing to live for.

50. On 14 November, a further ACCT review took place due to concerns about his presentation the previous day. Staff increased his ACCT checks.
51. On 25 November, a best interests meeting was held during which Mr Driver expressed concerns about his mental state and talked about ending his life “in the long run”. Staff spoke to Mr Driver about an advanced directive (a legally binding document that outlines an individual’s wishes for their health if they are unable to communicate them), it was agreed he would need support and assistance with this to ensure his understanding. At the end of the meeting staff offered Mr Driver a cleaning job in IPD which he later accepted.
52. During the next ACCT review on 6 December, staff noted that Mr Driver’s work as IPD cleaner was keeping him busy, he was now eating and drinking and had no recent thoughts to end his life. Staff stopped ACCT monitoring.

January to February 2025

53. On 20 January 2025, an officer spoke to Mr Driver about returning to Houseblock 6. The electronic prison record noted that Mr Driver was “completely against this” however he agreed to attend the houseblock to look around. He told the officer that he had been assured he would return to a single cell. The officer agreed to look into this.
54. On 22 January, an officer and the manager from IPD went to see Mr Driver to talk about him returning to the houseblock. They told Mr Driver that he did not meet the criteria for a single cell and that he would be sharing. Mr Driver was not happy about this and said if he was made to share a cell he would refuse to eat so he could return to IPD. The manager told Mr Driver that this would be managed with a food refusal log on the houseblock. Mr Driver then said he no longer wanted the IPD cleaner job.
55. Over the next couple of days, staff issued Mr Driver with negative behaviour warnings for failing to attend work.
56. On 27 January, Mr Driver was moved to a shared cell on Houseblock 6.
57. On 2 February, Mr Driver told an officer that he was not eating as he had been promised a single cell. Staff noted on his electronic prison record that this was incorrect and that he had not been promised a single cell.
58. On 18 February, Mr Driver attended Maidstone Crown Court. Healthcare staff saw Mr Driver before he left the prison, and on his return, and noted no concerns.
59. On 19 February, Mr Driver was readmitted to IPD due to refusing to eat or take his medication.

ACCT – 21 to 26 February

60. On 21 February, staff restarted ACCT procedures for Mr Driver. He told staff that he had lost everything. He thought he would get a long sentence and said he did “not want to be here anymore”. Mr Driver told the staff he was happy to move to Houseblock 6 to his original cell with the same cellmate.

61. The GP noted a plan that included Mr Driver being placed back on an ACCT, that he had been offered mental health support but declined, to stop medication (pregabalin) as requested by Mr Driver, and for his sister to be contacted as his power of attorney.
62. A nurse phoned Mr Driver's sister to inform her of his food refusal and the current ACCT monitoring.
63. Mr Driver was discharged from IPD later that day, and he returned to Houseblock 6.
64. On 26 February, Mr Driver attended an ACCT review. He said he was no longer feeling depressed and found the staff on Houseblock 6 to be helpful and caring. When staff asked Mr Driver if he had any current thoughts of suicide or self-harm, he said he had never self-harmed and that he had "not got the guts to attempt to end his life". Mr Driver told the staff that he did not want to be on the ACCT and that he found it depressing and not very supportive. Staff stopped ACCT monitoring.

March to October

65. On 10 March and 1 May, Mr Driver attended Maidstone Crown Court. Healthcare staff saw Mr Driver before he left the prison, and on his return, and noted no concerns.
66. There were only three entries in Mr Driver's electronic prison record between 10 March and the day of his death. On 27 March, healthcare staff recorded that Mr Driver needed a single cell (he was subsequently moved to a single cell on the ground floor due to his poor mobility). On 16 May, there was an entry about a bail hearing. The last entry was on 14 August, about a cancelled move to Houseblock 1 (as he needed to remain in his ground floor, single cell which he had on medical grounds).
67. Between 10 March and the day of his death, there were several entries in Mr Driver's medical record which mainly related to routine appointments and medication. On 13 March, healthcare staff recorded that Mr Driver refused to attend an outside hospital appointment with dermatology due to being unwell. On 19 May, a mental health nurse responded to an email about a bail information report, confirming that Mr Driver was not under a nursing caseload with the mental health team and that he was on the waiting list for a psychology workshop. On 31 July, there is an entry saying that Mr Driver did not attend a vaccination clinic. On 29 August, healthcare staff recorded that Mr Driver was having nosebleeds and that he was suffering with low blood pressure which was monitored over the next couple of days.
68. Between 19 September and 3 October, Mr Driver made several calls to his sister. (All calls are recorded but prison staff do not routinely listen to them so they would have been unaware of the content of these calls.) The investigator listened to the calls. Mr Driver talked about his concerns about his trial (due to start on 6 October) and the logistics of how he would get there. During a call to his sister on 3 October, Mr Driver said "I just wish I wouldn't wake up, I really do".

Events of 5 October 2025

69. The investigator watched CCTV footage and body worn video camera (BWVC) footage from 5 October. She also obtained information from South East Coast Ambulance Service NHS Foundation Trust. The following account has been taken from all sources.
70. At around 5.09am, during a routine check of all prisoners, an operational support grade (OSG) went to Mr Driver's cell. CCTV footage shows the OSG at Mr Driver's cell door for around two minutes. In her statement she said that she could not see Mr Driver in his bed and then saw that he was on the floor. The OSG knocked on Mr Driver's cell door but Mr Driver did not respond. At around 5.11am, the OSG radioed a code blue (a medical emergency code used when a prisoner is unconscious or having breathing difficulties that alerts healthcare staff and tells the control room to call an ambulance immediately) and remained at the door trying to gain a response from Mr Driver.
71. Another OSG responded to the code blue. Her statement says that she looked through the observation panel and could see Mr Driver slumped against the cell door. Both OSGs continued to knock on the door to try to gain a response from Mr Driver while waiting for other staff to attend.
72. An officer arrived around three minutes later and entered the cell. He found Mr Driver unresponsive, sitting against the wall and door, with a shoelace tied around his neck and attached to the phone socket. The officer cut the ligature using his anti-ligature knife.
73. Other officers and healthcare staff arrived. They moved Mr Driver onto the landing and started CPR.
74. A member of staff in the control room called for an ambulance in response to the code blue. They were unable to say if the patient was breathing. After a couple of minutes, they transferred the call to the houseblock. An OSG confirmed to the ambulance call handler that Mr Driver was not breathing but was unable to confirm if CPR had started due to being located on another floor. Three minutes into the call, the ambulance service confirmed an ambulance was being arranged.
75. At around 5.30am, paramedics arrived and applied a defibrillator which advised no shock. Resuscitation attempts were unsuccessful and, at 5.34am, paramedics pronounced life extinct.

Information received after Mr Driver's death

76. A staff member contacted the investigator to inform her of a conversation with a prisoner about Mr Driver's death. A prisoner told the staff member that Mr Driver was concerned about which prison he would be transferred to for his trial, due to being told by other prisoners that they mixed vulnerable prisoners with the main population. The prisoner told the staff member that he thought this may have pushed Mr Driver over the edge, as he was already concerned about his trial.

Contact with Mr Driver's family

77. On 5 October, the prison appointed a family liaison officer (FLO). He and the prison chaplain visited Mr Driver's sister that day to break the news of his death.
78. Later that month, the FLO made arrangements for Mr Driver's family to visit the cell and have a meeting with the Governor.
79. The Prison Service contributed to the funeral expenses in line with national instructions.
80. Mr Driver's sister was concerned that the prison had leaked information about her brother's death as details had appeared in the public domain. We asked the prison about this. They told us they had investigated and were satisfied that standard procedures had been followed and there had been no unauthorised leaks. We have provided further details in a separate letter and are also satisfied that prison staff did not divulge any unauthorised information.

Support for prisoners and staff

81. Postvention is a joint HMPPS and Samaritans initiative that aims to ensure a consistent approach to providing staff and prisoner support following all deaths in custody. Postvention procedures should be initiated immediately after every self-inflicted death and on a case-by-case basis after all other types of death. Key elements of postvention care include a hot debrief for staff involved in the emergency response and engaging Listeners (prisoners trained by the Samaritans to provide confidential peer-support) to identify prisoners most affected by the death.
82. After Mr Driver's death, the Head of Security debriefed the prison and healthcare 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.
83. The prison posted notices informing other prisoners of Mr Driver's death and offering support. The prison also deployed Listeners to the wing to offer support. Staff reviewed all prisoners assessed as being at risk of suicide or self-harm in case they had been adversely affected by Mr Driver's death.

Post-mortem report

84. The post-mortem report gave Mr Driver's cause of death as hanging.

Findings

Assessment of Mr Driver's risk of suicide and self-harm

85. The Prison Safety Policy Framework, implemented on 1 January 2025, which superseded the Prison Service Instruction (PSI) 64/2011, Management of prisoners at risk of harm to self, to others and from others (Safer Custody), 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 or self-harm must be managed under ACCT procedures.
86. Mr Driver was supported using ACCT on three occasions during his time at Elmley. We consider that staff managed the ACCT procedures well. They held regular ACCT reviews, involved appropriate staff and arranged for Mr Driver to be cared for in IPD when they became concerned about his physical health due to his food refusal.
87. Staff stopped ACCT procedures on 26 February, after Mr Driver said he was no longer feeling depressed and had no plans to harm himself. We consider this was a reasonable decision. Although there are minimal records between February and October, there was no indication that Mr Driver was at imminent risk of suicide or self-harm. We therefore understand why he was not being monitored under ACCT when he died.

Key work

88. Mr Driver was not allocated a key worker and did not have any key worker sessions during his 14 months at Elmley. Following his discharge from IPD and the closure of the ACCT in February, prison staff recorded no meaningful interactions with Mr Driver.
89. In common with some other prisons, the key worker scheme had not been operating as it should at Elmley due to staffing issues. The Deputy Head of Residence at Elmley told us that the focus had been on delivery to priority cohorts including prisoners in segregation, vulnerable prisoners (despite his alleged offence, Mr Driver was not a vulnerable prisoner), self-isolators, first time in prison and those serving Imprisonment for Public Protection (IPP) sentences. He said that although key work delivery remained a challenge, the quality of sessions had improved and that this was an area being quality assured with feedback provided to officers.
90. The Deputy Head of Residence told us that since Mr Driver's death, they had introduced an early days in custody (EDIC) officer who will see every new arrival for an initial key worker session. In addition, there were plans to use officers in the workshop and in segregation to carry out key worker sessions with prisoners.
91. While we cannot be certain that Mr Driver would have shared his feelings and concerns in a key work session, ongoing one-to-one sessions with a key worker would have provided this opportunity, or for an officer to observe a change in his mood or presentation. Key worker sessions are important for building good

relationships between staff and prisoners and prisoners at Elmley should receive regular sessions as soon as staffing allows.

Emergency Response

92. Prison Service Instruction (PSI) 03/2013, Medical Emergency Response Codes, says that when staff radio a medical emergency code, they must also provide relevant information about the condition of the prisoner to the control room staff so this can be passed to the ambulance service for the triage process.
93. When control room staff called for the ambulance for Mr Driver, they were unable to answer the standard question, "Is the patient breathing?" or any other questions about Mr Driver including the circumstances of the emergency. After two minutes, the control room transferred the call to the houseblock. An OSG answered and told the ambulance service that the patient was not breathing but when asked if CPR had been started, they were unable to confirm and said that the patient was on a separate floor and that the phone could not be taken there. After three minutes the ambulance service confirmed that an ambulance was being arranged.
94. At interview, the Head of Safety told us that Elmley had recently issued guidance to all staff reminding them of the importance of providing relevant information about the condition of the prisoner to control room staff, so that they can pass it on to the ambulance service for use in the triage process. She said the guidance was being shared in daily briefings and she was in the process of developing a quality assurance process.
95. We have raised our concerns to HMPPS in previous investigation reports about the process for control room staff to pass vital information about a prisoner's condition to emergency operators. HMPPS reviewed the process in place and concluded that the focus of action was for control room staff. We continue to have concerns that such an approach is unlikely to drive effective change and issues such as those which arose at Elmley will continue until HMPPS finds a more effective solution.
96. The evidence, from this case and others like it, is that the processes put in place by HMPPS have made no difference. We have expended considerable energy trying to drive change in this area, including holding an emergency response round table with senior HMPPS colleagues in January 2024. We draw this issue to the attention of the Chief Operating Officer and Chief Executive Officer of HMPPS.

Clinical care

97. The clinical reviewer found that the care provided to Mr Driver in relation to the ACCT process and his admission to IPD was of a good standard and highlighted exemplary care provided which was compassionate, well-coordinated and delivered within a multidisciplinary framework. The clinical reviewer found the care provided during this period to be equivalent to that which he could have expected to receive in the community.
98. The clinical reviewer found that after Mr Driver's discharge from IPD, there was no clearly documented discharge plan and that a referral to mental health services, which would have meant he was seen within 72 hours following his discharge, was not completed. The clinical reviewer therefore found the care following his

discharge from IPD was not equivalent to that which he could have expected to receive in the community. We recommend:

The Head of Healthcare should ensure that all prisoners discharged from IPD following an ACCT, or who have presented with recent suicidal ideation or significant mental health vulnerability, have a documented mental health review prior to discharge and have a follow up appointment arranged when returned to the residential unit.

99. The clinical reviewer found that there was no documentation to confirm that an automated external defibrillator (AED) was used during the resuscitation attempt of Mr Driver. He made a recommendation on this which the Head of Healthcare will wish to address.

Inquest

100. At the inquest, held on 28 September 2026, the jury concluded that Mr Driver died by suicide.



Third Floor, 10 South Colonnade
Canary Wharf, London E14 4PU

Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk

T | 020 7633 4100