Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Taylor Atkinson, a prisoner at HMP Eastwood Park, on 9 July 2022

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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

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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.

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.

Mr Taylor Atkinson, who was a transgender man, died on 9 July 2022, after he cut his neck in his cell at HMP Eastwood Park. He was 50 years old. I offer my condolences to Mr Atkinson's family and friends.

Mr Atkinson had lived as a male for several years. He had a significant history of substance misuse and mental health difficulties and frequently harmed himself, particularly when he felt emotionally overwhelmed. He also had number of physical health problems, for which he received medication.

Staff managed Mr Atkinson under suicide and self-harm prevention procedures (known as ACCT) on several occasions at Eastwood Park. While they showed concern and correctly started and re-started ACCT procedures following incidents of self-harm and associated thoughts, there were a number of failings in the management of ACCT.

Staff failed to develop an appropriate ACCT care plan, did not consider involving Mr Atkinson's next of kin in the ACCT process and did not always allocate a case co-ordinator or hold multi-disciplinary case reviews. They also failed to complete properly the process for closing and re-starting ACCT procedures. I am particularly concerned that staff did not fully assess Mr Atkinson's increased risk in the time leading up to his death and monitor him under constant supervision.

It is disappointing and concerning that we identified similar failings in the management of ACCT procedures in our investigation into the death of a prisoner who took their own life at Eastwood Park two days before Mr Atkinson. The Director of Women will need to address this.

The clinical reviewer considered that healthcare staff did not display adequate clinical enquiry when they attended to Mr Atkinson on 9 July and found that they should have started cardiopulmonary resuscitation (CPR). I am particularly concerned that prison nurses did not start CPR, despite telling an ambulance call handler that they could not be sure if Mr Atkinson had died.

The clinical reviewer also considered that the care Mr Atkinson received at HMP Eastwood Park before the emergency response was equivalent to that which he could have expected to receive in the community. However, she identified two areas for improvement, namely that healthcare staff did not review Mr Atkinson's blood thinning medication prescription following an incident of self-harm five days before his death and they did not complete an appropriate mental health care plan.

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 **September 2024**

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Summary

Events

1. On 5 March 2010, Mr Taylor Atkinson received an Imprisonment for Public Protection (IPP) sentence for aggravated burglary, with a minimum term to serve of three years and nine months.

2. Mr Taylor Atkinson was a transgender man, who had lived as a male for several years. He had a history of substance misuse and was prescribed methadone to treat opiate dependence. He had a diagnosis of emotionally unstable personality disorder and a significant history of self-harm and suicidal ideation. He also had several physical health problems, including deep vein thrombosis (DVT).

3. On 17 September 2019, Mr Atkinson was transferred to HMP Eastwood Park. A prison GP liaised with the mental health team and prescribed several medications including methadone, quetiapine (an antipsychotic) and rivaroxaban (a blood-thinning medication to treat DVT). A mental health nurse conducted an initial assessment and noted that Mr Atkinson would be managed under the Care Programme Approach (CPA).

4. Over the next two and a half years, healthcare staff reviewed Mr Atkinson frequently and discussed his care at multi-disciplinary meetings. Although Mr Atkinson's ability to manage his emotions improved, staff monitored him under suicide and self-harm monitoring procedures (known as ACCT) on several occasions. The Parole Board held a review and concluded that the best way to manage Mr Atkinson's risk was to transfer him to open conditions. Prison staff subsequently moved him to Residential Unit Seven (Res 7), which is set up to reflect open conditions. He left the prison three times subject to an assisted Release on Temporary Licence (ROTL).

5. On 20 May 2022, Mr Atkinson left the prison on ROTL and failed to comply with the instructions of the accompanying officer. When he returned to prison, he became angry when staff told him that he had broken the rules of ROTL and would not return to Res 7. Prison staff started ACCT procedures. They stopped monitoring him under ACCT procedures on 24 May.

6. On 8 June, prison staff re-started ACCT procedures after Mr Atkinson made a cut to his neck. There is, however, no record that they considered an assessment or added any actions to his care plan. Staff stopped ACCT monitoring on 21 June.

7. On 4 July, a prisoner found Mr Atkinson in his cell with self-inflicted wounds to his neck and one of his arms. Prison staff re-started ACCT procedures and set his observation requirement at four an hour. However, there is, again, no record that they considered an assessment or added any information or actions to his care plan.

8. At 11.45am on 8 July, an officer noted in the ACCT record that Mr Atkinson had asked about ending ACCT monitoring, obtained books on human anatomy from the library and said that that he had struggled with the recent death of a prisoner. The officer recorded that Mr Atkinson had discussed his recent self-harm with another

prisoner and said that the next time he harmed himself, no one would find him. At 3.45pm, a supervising officer (SO) chaired an ACCT review without Mr Atkinson. The SO recorded that Mr Atkinson was not taking his medication and a nurse, who was present, noted that Mr Atkinson wanted his observation requirement reduced but also reported suicidal thoughts. Attendees kept his observation requirement the same but there is no record that they considered constant supervision or removing razors.

9. At 9.50pm on 9 July, an officer conducted his sixth ACCT check of the evening on Mr Atkinson. He told us that during his checks, he observed Mr Atkinson in various positions, including behind a makeshift curtain covering the toilet area at the back of his cell.

10. At 10.04pm, an operational support grade (OSG) looked through Mr Atkinson's cell observation panel and saw him sitting in the toilet area, which was shielded by a privacy screen and a curtain, with his head visible and blood on the floor. She notified a nearby officer and radioed an emergency code red. The officer entered the cell, found Mr Atkinson was unresponsive and with a significant cut to his neck. He did not move him or start CPR.

11. At 10.07pm, a mental health nurse entered the cell. He checked Mr Atkinson for a pulse but found no evidence of life. A minute later, another mental health nurse arrived and noted that it was hard to assess Mr Atkinson due to his position. They did not move him, apply a defibrillator or start CPR. One of the nurses then spoke to an ambulance call handler and told them that they could not be sure if Mr Atkinson had died. At 10.27pm, ambulance paramedics arrived at Mr Atkinson's cell and moved him onto the floor. At 10.33pm, a critical care doctor pronounced that Mr Atkinson had died.

Findings

Risk management

12. Mr Atkinson had a significant history of self-harm, particularly when he felt emotionally overwhelmed. We are satisfied that staff showed concern and appropriately opened and re-started ACCT procedures following incidents of self-harm and associated thoughts. However, we found a number of failings in the management of ACCT procedures.

13. Staff did not develop an appropriate ACCT care plan. They did not always allocate a case co-ordinator or hold multidisciplinary case reviews and failed to invite Mr Atkinson to a case review the day before he died.

14. Prison staff did not conduct the ACCT post-closure process in line with national policy and did not record whether they considered the ACCT assessment and care plan when re-starting ACCT procedures.

15. Prison staff did not consider Mr Atkinson's access to razors after he cut his neck on 4 July. We are particularly concerned that staff misinterpreted Mr Atkinson's risk the day before he died and, despite several indicators of increased risk, did not monitor him under constant supervision.

16. Staff did not fully consider the positive impact an enhanced regime had on Mr Atkinson's level of risk. While his behaviour did not meet the criteria, staff should have at least explored the possibility of reinstating his enhanced prisoner status to manage his risk.

17. Prison staff did not always provide a detailed record of conversations and failed to consider the risk of Mr Atkinson having a curtain that covered the toilet area of his cell despite a recent episode of serious self-harm.

18. We identified similar failings in the management of ACCT procedures in our investigation into the death of a prisoner who took their own life two days before Mr Atkinson. We therefore consider that urgent action is now required to ensure that ACCT procedures at Eastwood Park improve.

Emergency response

19. Prison and healthcare staff checked Mr Atkinson's vital signs but did not move him onto the floor or start CPR. The clinical reviewer considered that taking his pulse and blood pressure was not enough to verify that Mr Atkinson was dead. While we cannot say whether this affected the outcome for Mr Atkinson, we are concerned that staff did not start CPR despite telling an ambulance call handler that they could not be sure if Mr Atkinson had died.

20. The clinical reviewer also considered that healthcare staff did not sufficiently justify their reasoning for not starting CPR in Mr Atkinson's medical record. She found that the level of life support training held by the emergency response nurses on 9 July was not adequate.

Clinical care

21. The clinical reviewer considered that the care Mr Atkinson received at HMP Eastwood Park before the emergency response was equivalent to that which he could have expected in the community. However, she identified areas for improvement.

22. The clinical reviewer found that although Mr Atkinson was managed under the CPA framework and had regular CPA reviews, he did not have a formal care plan in place.

23. The clinical reviewer considered that although Mr Atkinson presented an increased risk of excessive bleeding due to taking rivaroxaban, healthcare staff did not always take his clinical observations following his self-harm. She concluded that while it was not within her expertise to determine if rivaroxaban contributed to excess bleeding, staff should have considered a medication review after he cut his neck on 4 July.

Recommendations

- The Governor and Head of Healthcare should ensure that staff manage prisoners at risk of suicide and self-harm in line with national instructions, including that:
  - a case co-ordinator is appointed at the first ACCT case review;

- ACCT support actions are specific and meaningful, consider all of the issues identified at assessments and case reviews, and are updated at each review.
- ACCT case reviews are multidisciplinary and include healthcare staff where relevant, and that prisoners are invited to contribute to all case reviews;
- case reviews consider and document all relevant information that affects risk, including the removal of razor blades, items that might impact staff's vision of a prisoner, and other items when relevant;
- staff review the risk of suicide and self-harm whenever an event occurs which indicates an increase in risk, including starting constant supervision when necessary;
- observations and comprehensive conversations are carried out as directed and documented in the ACCT record;
- staff review the previous ACCT document when re-starting ACCT procedures and include all important information relevant to the assessment of risk; and
- staff complete the seven-day post closure monitoring form and ensure that post-closure reviews take place at the proper time and consider events following the closure of the ACCT.

- The Director of Women for HMPPS should write to the Ombudsman to set out what action she has taken to satisfy herself that meaningful improvements have been made to the assessment and management of the risk of suicide and self-harm at HMP Eastwood Park.
- The Governor and Head of Healthcare should ensure that staff are aware of their responsibilities in medical emergencies, including that;
  - staff apply a defibrillator and start CPR when appropriate if there are not clear signs of irreversible death; and
  - when healthcare staff decide not to start CPR, they evidence their decision-making in the medical record.
- The Head of Healthcare should undertake a review of the concerns raised by the clinical reviewer of Nurse A and Nurse B to ensure that appropriate actions are taken, including consideration of a referral to the NMC.
- The Head of Healthcare should ensure that:
  - all prisoners managed under the CPA framework have a formal mental health care plan; and
  - when a prisoner is prescribed anticoagulant medication and bleeds, staff take their clinical observations, record a National Early Warning Score and arrange a medication review.

- The Governor and Head of Healthcare should ensure that a copy of this report is shared with the staff named in this report and that a senior manager discusses the Ombudsman’s findings with them.

The Investigation Process

24. 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 him. One prisoner responded.

25. The investigator obtained copies of relevant extracts from Mr Atkinson's prison and medical records.

26. The investigator interviewed eight members of staff and three prisoners at Eastwood Park between 20 and 22 September. He also interviewed six members of staff by telephone and video conference between 3 and 17 October.

27. NHS England commissioned a clinical reviewer to review Mr Atkinson's clinical care at the prison. She and the investigator jointly interviewed healthcare staff.

28. We informed HM Coroner for Avon of the investigation. The Coroner gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.

29. A senior investigator contacted Mr Atkinson's friend, his nominated next of kin, on behalf of the Ombudsman's family liaison officer, to explain the investigation and to ask if they had any matters they wanted us to consider. Mr Atkinson's friend did not ask any specific questions but shared concerns about the ACCT and emergency response processes. She also said that she felt that the care Mr Atkinson received Eastwood Park was not appropriate.

30. Mr Atkinson's next of kin received a copy of the initial report. The solicitor representing his next of kin wrote to us pointing out some factual inaccuracies and/or omissions. The report has been amended accordingly. They also raised a number of questions that do not impact on the factual accuracy of the report. We have provided clarification by way of separate correspondence to the solicitor.

31. 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.

Background Information

HMP Eastwood Park

32. HMP Eastwood Park is a closed prison in Gloucestershire which holds up to 442 women. It has 10 residential wings, two of which provide specialist substance misuse services. At the time of Mr Atkinson's death, integrated healthcare services at Eastwood Park were provided by Inspire Better Health (part of Avon and Wiltshire Mental Health Partnership NHS Trust). Practice Plus Group took over the contract on 1 October 2022 but have partnered with Avon and Wiltshire Mental Health Partnership NHS Trust, who continue to provide psychosocial and mental health services.

HM Inspectorate of Prisons

33. An inspection report of HMP Eastwood Park followed an inspection in May 2019. (Inspectors subsequently completed an inspection in October 2022. This report had not yet been published when we issued our investigation report.) Inspectors found that relationships between staff and prisoners remained a strength, and prisoners reported that staff were supportive. Inspectors noted that prisoners in crisis received good care, including excellent peer support, but the quality of recording in case management documents for prisoners at risk of suicide and self-harm was not sufficiently good. Inspectors reported that healthcare staff responded to all emergencies, had received life support training, officers were familiar with the emergency codes protocol and emergency ambulances were called promptly.

34. In the inspection report following the October 2022 inspection, published in February 2023, inspectors found that safety had declined considerably and gave it their lowest judgment 'poor'.

35. Inspectors carried out a review in September 2023. They found that the prison had the highest rates of self-harm in the women's estate, but incidents were slowly reducing. There was some improvement in how ACCTs were carried out (such as more consistent case management), but some women remained frustrated at how difficult it was to get basic requests dealt with. Staffing levels on residential units had improved giving women more time out of their cells with staff able to deliver more regime.

Independent Monitoring Board

36. 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 while the management of suicide and self-harm prevention procedures had improved, the care planning aspect continued to be a weakness. They also reported that there continued to be an inward flow of illicit items, including lighters, mobile phones and drug paraphernalia.

Previous deaths at HMP Eastwood Park

37. Mr Atkinson was the third prisoner to die at Eastwood Park since July 2020. Of the previous deaths, one was self-inflicted, and one was due to natural causes. We have previously made recommendations about suicide and self-harm monitoring procedures.

Assessment, Care in Custody and Teamwork (ACCT)

38. 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.

39. Part of the ACCT process involves assessing immediate needs and drawing up a support plan 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 the actions of the caremap are completed. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011 on safer custody.

Parole Board

40. The Parole Board for England and Wales is an independent public body. Its role is to make risk assessments about prisoners to assess their suitability for transfer to open conditions and to decide whether they can safely be released into the community once they have served the minimum sentence imposed by the courts.

Release on temporary licence (ROTL)

41. Release on temporary licence (ROTL) facilitates the rehabilitation of offenders by helping to prepare them for resettlement in the community once they are released. This includes, among other examples, finding work and rebuilding family ties. ROTL is mostly used in open prisons, but closed prisons can release eligible prisoners if they have suitable resourcing and infrastructure in place.

Imprisonment for Public protection (IPP)

42. Sentences of Imprisonment for Public Protection (IPP) were first used in April 2005 and allow the court to set a minimum term of imprisonment, after which the offender will be released once they can satisfy the Parole Board that their risk of reoffending has sufficiently reduced.

Key Events

43. Mr Taylor Atkinson was a transgender man, who had identified as male for several years. He had not had gender reassignment surgery or hormone therapy and did not have a gender recognition certificate (which is necessary to obtain a new birth certificate recognising the acquired gender).

2010 to 2020

44. On 5 March 2010, Mr Atkinson received an Imprisonment for Public Protection (IPP) sentence for aggravated burglary, with a minimum term to serve of three years and nine months. He was sent to HMP Bronzefield.

45. Mr Atkinson had a history of substance misuse problems and was prescribed methadone to treat opiate dependence. He had a diagnosis of emotionally unstable personality disorder and had a significant history of self-harm and suicidal ideation, which increased in frequency when he felt stressed and/or overwhelmed. Mr Atkinson often made cuts to his neck and on one occasion, in 2018, following a refusal from the Parole Board, he made a cut that required surgery. He also had several physical health problems, including epilepsy and deep vein thrombosis (DVT).

46. On 5 June 2019, due to repeated episodes of self-harm at HMP Peterborough, Mr Atkinson was admitted to Littlemore Mental Health Centre, Oxford, under Section 47 of the Mental Health Act 1983, which allows health professionals to transfer prisoners to hospital for treatment.

HMP Eastwood Park

47. On 17 September 2019, Mr Atkinson was discharged from Littlemore and transferred to HMP Eastwood Park. A nurse conducted an initial health assessment and made mental health and substance misuse referrals. A prison GP liaised with the mental health team and prescribed several medications, including methadone, quetiapine (an antipsychotic), trazadone (an antidepressant), zopiclone (to assist sleep), pregabalin (to treat epilepsy and nerve pain) and rivaroxaban (an anticoagulant to treat DVT).

48. A mental health nurse conducted an initial assessment. He noted that Mr Atkinson had agreed to return to prison as he did not want to engage in therapy at Littlemore. He also noted that Mr Atkinson had a history of self-harm and needed to be allocated to the Care Programme Approach (CPA, a package of care for people with mental health problems).

49. On 10 November, an officer met with Mr Atkinson to complete a Transgender Case Board – Advanced Disclosure document. He recorded that Mr Atkinson's legally recognised gender was female and that Mr Atkinson saw himself as "gender fluid". On 15 November, an officer and a nurse visited Mr Atkinson to find out why he had decided not to attend a Transgender Board meeting, but he refused to engage. The nurse noted that Mr Atkinson had told wing staff that he did not want to go as he had been "screwed over by mental health" in the past. There is no evidence that Mr Atkinson was invited to, or attended, another Transgender Board before his death.

50. Over the next 15 months, healthcare staff reviewed Mr Atkinson frequently and discussed his care at regular multidisciplinary team meetings. Prison records show that although Mr Atkinson's ability to manage his emotions improved, he continued to harm himself when under increased stress and staff monitored him under suicide and self-harm monitoring procedures (known as ACCT) on several occasions.

2021

51. On 22 February 2021, the Parole Board wrote to Mr Atkinson advising him of the result of a parole hearing that took place on 5 January. While they acknowledged that he had worked hard and that his emotional management had improved, they noted that he continued to have periods of emotional instability. The Parole Board concluded that the best way to manage Mr Atkinson's risk was for him to transfer to open conditions. At interview, the Head of Offender Management Delivery told the investigator that the initial plan was for Mr Atkinson to transfer to one of the two female open prisons. However, neither prison assessed him as suitable due to concerns about his medication and the provision of appropriate mental health care.

52. On 20 May, as a response to Mr Atkinson's recommended progression to open conditions, staff moved him to Residential Unit Seven (Res 7) which aims to resemble an open environment within a closed setting. Over the following six months, prison records show that Mr Atkinson found it difficult to adjust to the regime on Res 7 and received several entries for negative behaviour as a result of forming a relationship with another prisoner. However, he remained stable on his medication and incidents of self-harm decreased substantially.

53. Between 5 November and 15 December, Mr Atkinson twice left the prison on assisted Release on Temporary Licence (ROTL). Mr Atkinson's licence stipulated that he had to comply with the instructions of the accompanying officer, which included staying within their proximity. The Head of Offender Management Delivery told the investigator that although the ROTLs went well, it later transpired that the officer accompanying Mr Atkinson on the second ROTL let him go off on his own, unsupervised. She said that she told Mr Atkinson that it should not have happened, but that as the ROTL had gone well, he could continue to apply for ROTL.

2022

54. On 17 March 2022, Mr Atkinson went on assisted ROTL to Bristol City Centre. The Head of Offender Management Delivery told the investigator that, again, she was subsequently made aware that the accompanying officer had allowed Mr Atkinson to spend time unsupervised. She said that she raised her concern with the prison and that it became apparent that the escorting officer may have been instructed to allow Mr Atkinson to leave their supervision. She added that as the ROTL had, in principle, gone well, she agreed for Mr Atkinson's ROTLs to continue as he managed himself well in a city that he did not know and returned at the agreed time.

55. On 21 March, Mr Atkinson's allocated Prison Offender Manager (POM) met Mr Atkinson for an additional engagement session to review his recent ROTL. She recorded that Mr Atkinson seemed pleased that it had gone well. (Due to his complex needs, she met Mr Atkinson on a mostly weekly basis for an additional engagement session instead of him having a keywork session with an officer, as outlined in the Prison Services Custodial Policy Framework 2018.)

56. On 9 May, the Head of Offender Management Delivery contacted the prison's mental health staff advising them that there was intelligence to suggest Mr Atkinson was selling pregabalin. On 13 May, a consultant psychiatrist re-prescribed pregabalin but noted that her intention was to start reducing Mr Atkinson's dose as soon as possible.

57. On 16 May, Mr Atkinson's allocated mental health keyworker reviewed him on the wing. She noted that Mr Atkinson said that the Parole Board had moved the time period for his next review and that it would now take place between September 2022 and March 2023. Mr Atkinson said that he felt the process was "setting him up to fail", but that he was looking forward to an overnight ROTL at a Probation Approved Premises (AP) in Birmingham, which had been scheduled for 24 May.

Events of 20 May

58. At around 10.00am, Mr Atkinson left the prison on ROTL to Bristol City Centre accompanied by an officer. The Head of Offender Management Delivery told us that the officer contacted her beforehand to check the requirements of the escort and that she confirmed that Mr Atkinson should remain in her sight at all times. She also said that prison staff gave the same message to Mr Atkinson. However, prison records show that Mr Atkinson failed to comply with the instruction and went missing for several hours. He later re-established contact with the officer by going to a shopping complex contact point and asking them to put a message out over the public announcement system.

59. At around 3.50pm, Mr Atkinson returned to the prison. An officer recorded that Mr Atkinson became angry and refused to leave Reception after staff told him that they would need to put the items he had bought on his property card before he could have them. Staff placed Mr Atkinson in a holding cell, and he became angry again when staff told him that he had broken the rules of ROTL and would not return to Res 7. Prison records state that Mr Atkinson stormed out of the holding cell and tried to grab a plant pot, which resulted in staff using force to escort him to Res 8 (a standard residential unit). They also charged him with breaching prison rules because of his actions.

60. At 5.00pm, an officer completed a concern form and recorded that, due to Mr Atkinson's history of self-harm, staff had decided to start ACCT procedures. At 5.15pm, a Supervising Officer (SO) completed an immediate action plan and set Mr Atkinson's observation requirement at four an hour.

Events from 21 to 31 May

61. At 12.05pm on 21 May, a prison offender manager (POM) conducted an ACCT assessment and noted that although Mr Atkinson said he continued to feel angry about what happened on ROTL, he did not intend to harm himself. She noted that although the regularity of Mr Atkinson's self-harm had reduced over the last 12 months, he had a significant history of throat cutting and said that he did it because he loathed himself. She also completed the risk, triggers and protective factors of the ACCT care plan and noted that Mr Atkinson's main risks were his continuing sentence, history of substance misuse, self-harm, adverse childhood experiences and paranoia that prison and probation staff were "setting him up to fail".

62. At 2.20pm, a SO chaired a first ACCT case review, which a mental health crisis support worker, attended. He recorded that Mr Atkinson said "a bomb went off in his head" when reception staff said that they would conduct a search and planned on charging him with a disciplinary offence. He also noted that Mr Atkinson said he was not happy about being on Res 8 and wanted to return to Res 7. Attendees decided that, in light of Mr Atkinson's past behaviour, he presented a risk of suicide and self-harm. They kept his observation requirement at four an hour. Two support actions were added to the care plan: for Mr Atkinson to see mental health staff and for him to speak to the Offender Management Unit (OMU) about his ROTL issues.

63. At 6.35pm, the mental health crisis support worker completed a mental health risk assessment and recorded that Mr Atkinson's risk of suicide and self-harm had increased in light of what happened while on ROTL. She identified that the move to Res 8 had reduced Mr Atkinson's support network and that he viewed it as a huge step backwards. She added that Mr Atkinson had been known to harm himself when experiencing emotional distress and that he would no longer have his medication in his cell with him.

64. On 23 May, a POM visited Mr Atkinson on Res 8, with the Head of Offender Management Delivery, to find out more about the ROTL incident. At interview, she told the investigator that Mr Atkinson said the "system had let him down" and that he felt it was the escorting officer's job to follow him, not the other way around. She also added that Mr Atkinson was strongly of the view that he had not done anything wrong, and that staff were punishing him for doing the right thing.

65. At 11.47am, the POM contacted the allocated mental health keyworker and informed her that Mr Atkinson's planned overnight ROTL for 24 May would not go ahead. She added that Mr Atkinson was due to have a disciplinary hearing later that day and that he was fully aware of the significance this was likely to have in terms of his application for release on parole later in the year.

66. The Acting Head of Safety chaired the disciplinary hearing following the ROTL incident. She noted that while the charge of failing to comply with a condition of temporary release could not be heard as it was not laid in the relevant timescales, the other charges of unauthorised items, insulting behaviour and damage were heard. As a consequence, Mr Atkinson was prevented from making canteen (prison shop) orders and using his private cash for seven days.

67. On 24 May, a Custodial Manager (CM) and a SO held an Incentives and Earned Privileges (IEP) review. (The IEP scheme aims to encourage and reward responsible behaviour, improve engagement in positive activity and create a safer environment. There are three levels: basic, standard and enhanced.) The SO noted that Mr Atkinson showed some remorse for the events on 20 May and did accept all of the facts as true. He added that they felt that Mr Atkinson should have been moved to basic IEP on the day of the incident but as this did not happen, they decided it was more appropriate to move him to standard IEP instead. (Mr Atkinson had previously been on the enhanced IEP level.)

68. At 3.00pm, a CM chaired an ACCT case review and recorded that Mr Atkinson did not appear to accept responsibility for what happened on 20 May. She added that Mr Atkinson felt like he had lost everything and had nothing to work for. Mr Atkinson also said that he had not harmed himself for over a year and that ACCT

procedures did not help him. Attendees decided to stop ACCT monitoring and noted that Mr Atkinson was receiving support from the mental health team and OMU. There is, however, no record that staff conducted the required seven-day post-monitoring review process.

69. Later that afternoon, prison staff moved Mr Atkinson to Res 5, a standard residential unit. (The reason for the move is not recorded.)

70. On 30 May, an administrator noted that she had received a voicemail message from Mr Atkinson's next of kin stating that she had heard that there had been a death at Eastwood Park and that she was worried as she had not heard from Mr Atkinson in a while. She liaised with prison staff before contacting his next of kin to say that there had not been a death and that Mr Atkinson was doing OK.

Events from 1 June to 3 July

71. On 1 June, a nurse and a substance misuse recovery worker saw Mr Atkinson for a substance misuse clinical management plan review. She recorded that although Mr Atkinson said he remained frustrated by his situation, he presented as positive about working towards returning to Res 7 and having ROTLs.

72. Later that day, a CM saw Mr Atkinson for an ACCT post-closure review and noted that he remained unhappy about what happened on ROTL but had started to settle on Res 5. She added that Mr Atkinson had friends on the wing, did not report any thoughts of suicide and self-harm and continued to engage with OMU.

73. Later, the allocated mental health keyworker saw Mr Atkinson for an assessment of needs as there had been issues with his compliance with quetiapine. Mr Atkinson said that he did not always attend to collect his medication because he did not like to take a morning dose if he felt he did not need it. Mr Atkinson did not report any thoughts of suicide or self-harm and said that he had met the Head of Offender Management Delivery and a prison manager, who said that he could apply for Res 7 and ROTLs after 42 days.

74. On 8 June, a nurse reviewed Mr Atkinson after officers found him with a cut to his neck. She noted that she stemmed the bleeding and tried to close the wound, but Mr Atkinson presented as agitated and declined treatment. He did, however, agree to tend to the wound himself and was given dressings.

75. In the meantime, a SO re-started the previous ACCT and recorded that Mr Atkinson had harmed himself with a razor due to an issue with his canteen order. He set Mr Atkinson's observation requirement at three an hour with three conversations daily (am, pm, and evening). He also noted that Mr Atkinson was asked to hand over any razors that he had. There is, however, no record that staff considered completing another assessment or added any support actions to the care plan.

76. In the evening, a nurse reviewed Mr Atkinson following a request from prison staff and recorded that that his wound had increased in size and was gaping. She transferred Mr Atkinson to hospital to have his wound sutured. He returned to the prison at around midnight.

77. On 9 June, the Acting Head of Safety chaired a safety intervention meeting. In the minutes, it is noted that Mr Atkinson was experiencing a period of instability and that there was intelligence about him trading medication.

78. An administrator took a call from Mr Atkinson's next of kin. She recorded that his next of kin was aware that Mr Atkinson had harmed himself and said that playing on his games console really helped during times of emotional instability. Mr Atkinson's next of kin said that he could not currently use the console as his games were in Reception. She subsequently contacted a CM and told her about Mr Atkinson's games.

79. A prison GP chaired a multidisciplinary team meeting and noted that staff discussed the risk of Mr Atkinson taking opiates in addition to his prescribed sedating medications, with particular focus on pregabalin. She noted that in light of the ROTL incident, a change of wing and recent self-harm, they did not want to add to the risk of self-harm by reducing Mr Atkinson's pregabalin. She recorded that attendees agreed to hold a joint meeting with the substance misuse team in a month to formulate a plan for reducing pregabalin slowly.

80. In the evening, the allocated mental health keyworker reviewed Mr Atkinson who gave several reasons for his self-harm. He said that he was concerned about his ROTLs being suspended, not having any computer games in his cell, a friend leaving prison on 10 June and his canteen not arriving. He added that although he continued to feel angry, he did not currently have any thoughts of suicide and self-harm.

81. On 11 June, the allocated mental health keyworker visited Mr Atkinson on the wing for a follow-up review. She recorded that he was mixing with his peers on the wing and declined a review. Mr Atkinson said that he felt better now that he had access to computer games and had obtained work as a wing cleaner.

82. On 12 June, a pharmacy assistant recorded that Mr Atkinson presented to collect his medication with slurred speech and pin-point pupils. She spoke to a nurse, who noted that Mr Atkinson presented "dazed" and that he did not think it was safe to issue his evening medication. On 13 June, an officer recorded that Mr Atkinson had received a negative IEP warning for being under the influence of illicit substances.

83. On 15 June, a CM chaired an ACCT case review without input from healthcare staff as she was unable to book in a multidisciplinary review. She noted that Mr Atkinson said that he was in a much better place and had not harmed himself since staff re-started ACCT procedures. Attendees agreed that ACCT monitoring should remain in place but reduced Mr Atkinson's observation requirement to three observations during the day and two at night.

84. That day, a nurse and a substance misuse recovery worker saw Mr Atkinson for a substance misuse clinical management plan review. The nurse recorded that Mr Atkinson was struggling with the move from Res 7, losing ROTL and his relationship with another prisoner being "in limbo". She noted that when asked about illicit substance misuse, Mr Atkinson said, "I would use heroin if there was some, but there ain't any, so no". She added that she and the recovery worker would continue to review Mr Atkinson frequently.

85. The allocated mental health keyworker visited Mr Atkinson for keyworker risk assessment review. She recorded that he looked drowsy, described his mood as "not too bad" and said that he did not always take his quetiapine as he felt stable and used his computer games as a distraction. She added that she was not sure about Mr Atkinson's reasoning and tried to explore this further, but he said that he could not explain it. She also noted that she tried to engage Mr Atkinson in a care planning discussion, but he said that he had a headache and returned to his cell.

86. On 16 June, Mr Atkinson phoned a friend who had recently been released from custody and with whom he had been in a relationship in prison. Mr Atkinson wanted to know whether his friend wanted to "call it quits". His said that she did not know how it was going to work over the phone. Mr Atkinson said that nothing bad was going to happen, but he wanted to know 'yes' or 'no' so that she could try to move on. (All prisoners telephone calls are recorded. Prison staff listen to some at random and others are listened to if security staff have intelligence that information about the safety of individuals or the prison might have been discussed. Mr Atkinson's telephone calls were not listened to before his death.)

87. On 21 June, a CM chaired an ACCT case review which a POM also attended. There is no record that healthcare staff attended. The CM recorded that Mr Atkinson presented as very positive and said he was ready to move on from where he was a few weeks ago. Mr Atkinson said that his goal was going to work and getting back to Res 7. Attendees decided that as Mr Atkinson appeared positive and had not harmed himself, they would stop ACCT monitoring. There is no record that staff completed the seven-day post-closure monitoring and final review process.

88. On 23 June, the Acting Head of Safety chaired a safety intervention meeting. Staff noted that Mr Atkinson's ACCT monitoring had stopped, that a parole review had not been set and that there was a lot of intelligence that Mr Atkinson used drugs. They removed Mr Atkinson from the list of prisoners discussed at the safety intervention meeting. At interview, the Head told the investigator that they decided to remove Mr Atkinson because there was no immediate concern about his risk.

89. On 25 June, Mr Atkinson phoned his friend, whom he had named as his next of kin. He told them that he had packed up his belongings and was waiting to move to a cell on Res 3. He appeared positive about the move and said that would put him in a good position for a move to Res 7. He also said that the Head of Offender Management Delivery had provided him with ROTL paperwork and said he could re-apply from 3 July. (Mr Atkinson moved to Res 3 later that day.)

90. On 2 July, an officer recorded that Mr Atkinson had received a negative IEP warning for being found lying on top of another prisoner, kissing her. Prison staff charged Mr Atkinson with a breach of prison discipline.

Events of 4 July

91. At 10.20am, a prison manager chaired a disciplinary hearing which a SO and Mr Atkinson attended. He noted that Mr Atkinson admitted to the charge and said that he cuddled the prisoner as he felt low and wanted to get back to his former self. Mr Atkinson lost seven days of canteen as a consequence.

92. At around 4.00pm, a prisoner found Mr Atkinson in his cell with self-inflicted wounds to his neck and one of his arms. They notified a SO, who radioed a medical emergency code red (which indicates that a prisoner is bleeding or has severe burn injuries). Two nurses responded, applied pressure to Mr Atkinson's wounds and took his clinical observations. Ambulance paramedics arrived and assessed Mr Atkinson, but he declined to go to hospital.

93. At 4.30pm, a SO re-started ACCT procedures and set Mr Atkinson's observation requirement at four an hour. However, the first part of the ACCT document was not completed, including the immediate action plan, assessment, care plan and key information sections.

94. At 5.56pm, a prison GP recorded that Mr Atkinson was discussed at a multidisciplinary team meeting. A nurse prescriber said that Mr Atkinson was not taking his morning dose of quetiapine and that it might be best to stop it. The allocated mental health keyworker said that it would probably be best to discuss this with him first. The GP noted that it was a delicate time to change Mr Atkinson's medication and left it unchanged.

95. At 7.15pm, a SO chaired an ACCT first case review which several members of staff, including the allocated mental health keyworker, attended. She recorded that Mr Atkinson said he felt like he had "gone backwards" with his sentence and was completely overwhelmed, which led to him harming himself. She added that Mr Atkinson said that he continued to struggle with his current situation and that attendees had decided to keep his observation requirement at four an hour. There is, however, no record that staff considered adding any support actions to the ACCT care plan.

Events from 5 to 7 July

96. At 10.35am on 5 July, a POM recorded in the ACCT ongoing record that she met Mr Atkinson having been informed about his act of self-harm. She noted that Mr Atkinson was low in mood and was preoccupied by what had happened to him recently. She added that Mr Atkinson did not express any thoughts of self-harm, but he had slurred speech and seemed tired.

97. At 12.09pm, Mr Atkinson phoned a friend and said, "I tried to kill myself yesterday". He said that he did it because he thought that he would have enough time, but another prisoner entered his cell and alerted staff.

98. At 3.25pm, the allocated mental health keyworker saw Mr Atkinson for a mental health review and recorded that he reported feeling drained [of energy] as a result of recent events and blood loss. She added that he felt despondent about the future and continued to dispute what happened on ROTL. She also made an entry in Mr Atkinson's ACCT record stating that he said he had intended to kill himself when he harmed himself on 4 July, but he did not have any current thoughts of suicide and self-harm.

99. On 6 July, a substance misuse recovery worker recorded that that Mr Atkinson attended an alcoholics awareness meeting and shared with the group that he was "in a dark place and that the only way out for him was in a body bag, where he

could be reunited with his partner and parents". She updated Mr Atkinson's ACCT record and noted that he said he found the meeting emotional but helpful.

100. At 11.13am on 7 July, a nurse and the substance misuse recovery worker met Mr Atkinson to review his substance misuse clinical management plan. The nurse noted that they spent time discussing the events of the previous week and that Mr Atkinson remained low in mood. She added that they would both review Mr Atkinson again in one week's time.

101. At 5.00pm, a SO chaired an ACCT case review following the death of another prisoner on the wing, which a mental health support worker attended. The SO recorded that Mr Atkinson took the opportunity to talk about ROTL and blamed the officer who accompanied him on 20 May for "ruining his hard work". Mr Atkinson said he wanted the ACCT stopped and the SO explained that the purpose of the review was to offer support and to see whether he had been affected by the day's events. Mr Atkinson said that he only said "hello" to the prisoner once and was not affected. Attendees kept his observation requirement at four an hour.

Events of 8 July

102. At 11.45am on 8 July, an officer noted in the ACCT record that Mr Atkinson had asked about stopping ACCT monitoring. She also noted that he had obtained books from the library on human anatomy. She noted that Mr Atkinson had told the safer custody orderlies (trusted prisoners who work with the prison's safer custody department) that he had struggled with the recent death of a prisoner and how that person was "in a better place". Mr Atkinson also told the orderlies that the next time he harmed himself, nobody would find him.

103. At 2.00pm, a SO chaired an ACCT case review which the officer attended. At interview, the SO told the investigator that healthcare staff did not contribute as she wanted to hold the review immediately. There is no record that Mr Atkinson attended the review. She recorded that staff had informed her that Mr Atkinson was trying to get his ACCT stopped. At interview, she said that she spoke to Mr Atkinson but could not recall when this took place. Attendees kept his observation requirement at four an hour.

104. At 3.07pm, a prison paramedic recorded that she reviewed Mr Atkinson through his cell door observation panel and that his wounds were swollen and red. She conducted a National Early Warning Score assessment (NEWS, a scoring system to assess clinical deterioration in patients). Based on Mr Atkinson's observations, she scored him '0' (low clinical risk). However, she could not take his blood pressure due to the prisoners being locked in their cells. At 3.19pm, she sent an electronic task to a GP, requesting antibiotics and a blood test.

105. At 3.45pm, the SO chaired a further ACCT case review which the Acting Head of Safety, a mental health nurse and the prison paramedic attended. As with the earlier ACCT review, Mr Atkinson did not attend. It is noted that he made a verbal contribution. The SO recorded that Mr Atkinson continued to present as angry about his ROTL and was not taking his medication. The nurse noted that Mr Atkinson wanted his observation requirement reduced but also reported suicidal thoughts. Attendees decided to keep Mr Atkinson's observation requirement unchanged. There is no record that staff considered removing razors from Mr

Atkinson's cell. Both the Acting Head of Safety and the SO told us that they discussed constant supervision but did not consider it appropriate for Mr Atkinson's needs as he was a private person who found the ACCT process intrusive. (There is no record of this discussion in the ACCT document.)

106. In the record of the evening conversation, the officer noted that Mr Atkinson had asked for some Velcro for his privacy curtain. (At interview, prison staff told us that prisoners often install their own curtains to increase the privacy of the toilet area as the wooden privacy screens provide minimal coverage.) The officer noted that she could not find any Velcro, so she gave Mr Atkinson a curtain pole instead.

Events of 9 July

107. At 11.30am, Mr Atkinson phoned a friend. He said that he was "pissed off" and wanted prison staff to "let him go" (implying that he wanted them to let him end his life). Mr Atkinson talked about getting an IEP warning for kissing another prisoner and said that once IEPs started, they kept coming. He said that 15-minute ACCT observations were "doing his head in" and that he spoke to a SO about it the previous day. He said that the SO said she would call him into a big meeting, but it never happened. He added that later that evening he spoke to the SO, who said she would not reduce his observations as his act of self-harm was serious.

108. Mr Atkinson then spoke about how bad it was in the jail and said that he was "banged up" (locked in his cell) all the time. He then said that he asked staff to go to the library and get him a book on human anatomy which they did. Mr Atkinson said, "are they for real" and added that he had gone through it, "looking up everything [he] needed to know". He then spoke about having spiralled out of control and going back to "square one". He said that the reason things had become so bad was because the officer on ROTL was a "barefaced liar" and he "cannot get his head around it". Mr Atkinson added that he felt he should have his enhanced IEP status back and be allowed to start again, but that when he spoke to anyone about what happened on the ROTL, they did not want to know.

109. An officer recorded in the ACCT document that Mr Atkinson said he felt he would never get enhanced IEP status again and needed to be around positive people who felt that progression was possible.

110. At 2.30pm, a prison GP prescribed Mr Atkinson antibiotics for a suspected wound infection. At around 3.00pm, the allocated mental health keyworker reviewed Mr Atkinson on the wing and recorded that she spent much of the session exploring his feelings about not having his medication in his cell with him. She noted that Mr Atkinson denied any thoughts of suicide and self-harm and said that he was frustrated that prison staff had not reduced his ACCT observation requirement. However, she added that she had to conclude the review after 20 minutes because Mr Atkinson had a social visit.

111. At interview, a prisoner and friend of Mr Atkinson's, who worked in the visits area cafe, told the investigator that she saw him during his visit from a friend... She said that she gave him a hug and he said, "I can't do this", "I'm tired" and "I have no way out this time". She said that Mr Atkinson said that he was getting lots of IEPs and that there was no way staff would let him go back to Res 7 and have ROTLs again. She added that when it was time to say goodbye, Mr Atkinson made a "big thing of

it" and kept saying "I'm sorry". She said that the "light in his eyes had gone" and that she told him to keep going but he replied, "there's no point".

112. At 8.40pm, following an ACCT check, Officer A noted in the part of the ACCT record on the evening summary of conversation that Mr Atkinson was resting on his bed, and he said he was "okay".

113. At 9.17pm, Nurse A, a mental health nurse, went to Mr Atkinson's cell to issue his antibiotic medication. At interview, she said that Mr Atkinson was behind a curtain that he had put up in his cell and told her to come back later as he was using the toilet. Around two minutes later, CCTV footage shows she returned to his cell. She said Mr Atkinson remained behind his curtain and declined the medication, stating that he had taken one earlier in the day and it had made him sick.

114. At 9.50pm, Officer A conducted his sixth ACCT observation of the evening. At interview, he told us that during his checks, he observed Mr Atkinson laying on his bed, standing up holding his in-cell phone, and in the toilet area. He said that he could not remember having a conversation with Mr Atkinson but that he thought he would have spoken to him.

115. At 10.04pm, an Operational Support Grade (OSG) looked through Mr Atkinson's cell door observation panel and saw him sitting on the toilet, which was shielded by a privacy screen and a curtain, with only his head visible and a pool of blood on the floor. CCTV footage shows that she ran to the wing office, located several metres away and returned with Officer A ten seconds later. In the meantime, she radioed a medical emergency code red and asked permission from a CM to enter the cell.

116. Officer A looked through the cell observation panel, broke the seal on his key pouch and went into the cell before the CM gave permission. He saw Mr Atkinson slumped on the floor, just inside the toilet area of the cell and with a pool of blood in front of him. He radioed a medical emergency code blue (which indicates that a prison is unconscious or has breathing difficulties). At interview, he told us that he moved Mr Atkinson into an upright position by placing his hands on his left arm and right shoulder. He said that Mr Atkinson had a substantial cut to his neck, was cold to touch and had fixed eyes. He then left the cell and made his way to the entrance of Res 3 to meet responding staff.

117. In the meantime, an OSG, who was working in the control room, phoned for an ambulance. In his prison statement, he said that an automated system put him on hold due to a high number of calls in the area.

118. At 10.07pm, Nurse B, a mental health nurse, went into the cell and saw Mr Atkinson sitting in an upright position, with a mirror in his hand and his head bent forward. At interview, he told us that he checked for a pulse but there was no evidence of life. He said that Mr Atkinson was not breathing and that it looked like he had "bled out". A minute later, Nurse A arrived at the cell. She told us that although there was no sign of life, it was hard to assess the extent of Mr Atkinson's injuries as he was in a confined space, and it was difficult to move him. She said that she checked his pulse and blood pressure but could not get a reading. There is no evidence that staff applied a defibrillator or started cardiopulmonary resuscitation (CPR).

119. At 10.09pm, the Ambulance Service log shows that the call from the prison was answered. The Ambulance Service's recording of the call states that when asked if the patient was breathing, the control room OSG said, "no, I think she's dead". When asked why he thought this, he said, "the throats slit open, there's a lot of blood and she is not breathing". The OSG transferred the operator to the wing and Nurse A spoke to her. When asked why they thought Mr Atkinson was dead, she said, "we're not sure if she is dead, but we can't check her pulse … we can't take her blood pressure and she is blue in the extremities".

120. At 10.14pm, an ambulance was dispatched, and the first vehicle arrived at the prison at 10.24pm. At 10.27pm, critical care paramedics arrived at Mr Atkinson's cell and moved him onto the floor in the corridor for easier access. They conducted an assessment and, at 10.33pm, a critical care doctor pronounced that Mr Atkinson died.

Contact with Mr Atkinson's family

121. At around 12.30am on 10 July, the prison appointed a family liaison officer (FLO). In the meantime, the Governor established that they only had a phone number for Mr Atkinson's friend, whom he had appointed as his next of kin, and left a voicemail message. A short while later, the Governor spoke to Mr Atkinson's next of kin by phone and broke the news.

122. At 10.10am, the FLO phoned Mr Atkinson's next of kin to introduce herself and to explain her role. She asked Mr Atkinson's friend whether she could visit her later that day, but she said she was going to the prison to visit another prisoner, so she arranged to meet her then. At 2.10pm, the FLO and a manging chaplain and family liaison officer met Mr Atkinson's next of kin and another friend of Mr Atkinson's, who was on his approved visitors list. They offered their support and went over the next steps.

123. The FLO provided ongoing support to Mr Atkinson's friend until his funeral, which took place on 15 August. The prison contributed towards the cost, in line with national policy.

Support for prisoners and staff

124. After Mr Atkinson's death, a prison 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.

125. The prison posted notices informing other prisoners of Mr Atkinson'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 Atkinson's death.

Post-mortem report

126. A post-mortem examination found that Mr Atkinson died of severe blood loss and an air bubble trapped in the right side of the heart caused by a slashed wound to the neck that involved the jugular vein. The pathologist noted that although there was a short cut in the jugular vein, it was possible that Mr Atkinson could have bled

from the neck wound for a considerable time and that he had already cut his neck when staff conducted an ACCT check at 9.50pm. The post-mortem report also stated that Mr Atkinson had concealed several unspecified tablets and razor blades in his vagina and anus.

127. Toxicology tests of Mr Atkinson's blood found methadone and paracetamol at levels higher than is considered therapeutic. However, the pathologist noted that the level of methadone was not high enough to result in toxicity and that paracetamol does not result in rapid death after overdose. The pathologist concluded that there was no evidence to indicate use of methadone, or any other medication accounted for Mr Atkinson's death.

Findings

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

128. Prison Service Instruction (PSI) 64/2011 on safer custody requires all staff in contact with prisoners to be aware of the risk factors and triggers that might increase a prisoner's risk of suicide and self-harm and to take appropriate action. Any prisoner identified as at risk of suicide or self-harm must be managed under ACCT procedures.

129. Prison staff at Eastwood Park responded appropriately when Mr Atkinson experienced periods of emotional instability or harmed himself and monitored him under ACCT procedures on several occasions. While we are satisfied that staff tried to engage with Mr Atkinson and completed a comprehensive ACCT assessment on 21 May 2022, we are concerned about the overall management of the ACCT process.

Care plans

130. PSI 64/2011 states that completing a care plan is an integral part of the ACCT process and that it must reflect the prisoners needs, level of risk and the triggers of their distress. The annex to PSI 64/2011 states that the care plan, including individual and meaningful support actions, must be updated following case reviews.

131. Staff only updated Mr Atkinson's care plan once, at the first case review on 21 May. The two support actions were specific to Mr Atkinson's needs but failed to address all the risks identified in the risks, triggers and protective factors section of the care plan. Staff did not review the care plan after they re-started ACCT procedures on 8 June or at following case reviews. The failure of the case review team to develop the care plan meant that there was no co-ordinated ongoing plan for monitoring the progress of Mr Atkinson's emotional stability, his re-application for ROTL and a return to Res 7. We are particularly concerned that staff did not identify that Mr Atkinson's parole review period was due to start in September and did not formulate a plan to address the impact this was likely to have on his risk of suicide and self-harm.

132. The sources of support section of the ACCT documents show that staff identified Mr Atkinson's friend and next of kin as a provider of ongoing support for him. However, they did not consider a support action to involve them in the ACCT process. PSI 64/2011 states that case co-ordinators should identify and discuss potential sources of support for the prisoner at case reviews. However, there is no record that staff discussed the possibility of involving Mr Atkinson's next of kin in the ACCT process despite them contacting the prison to raise concerns about his wellbeing. We consider that the involvement of Mr Atkinson's next of kin (which would have required Mr Atkinson's consent) might have added an extra layer of support for Mr Atkinson and should at least have been explored.

Case reviews

133. PSI 64/2011 states that a case co-ordinator must be appointed at the first case review. The case co-ordinator should lead all case reviews, where possible, to promote consistency in managing the ACCT plan, assessing risk and care planning.

134. We are concerned that there is no record that the prison appointed an ACCT case co-ordinator for the ACCT procedures started between May and July. While there was some consistency when staff started and re-started ACCT procedures, a different SO chaired each case review after staff re-started ACCT monitoring on 4 July. Our view, particularly when considering Mr Atkinson’s complex history, is that a consistent approach might have led to a better understanding of his risk and reasons underlying his deteriorating presentation.

135. PSI 64/2011 also states that ACCT case reviews should happen periodically, have multidisciplinary input that is driven by support actions and that, wherever possible, case review teams should agree the time and date of the next case review during the present one in order to ensure attendance.

136. On several occasions, prison staff held case reviews that may have benefitted from healthcare input, without their involvement. The Acting Head of Safety told us that at the time Mr Atkinson was monitored under ACCT procedures, Eastwood Park used a system that meant a member of staff from the healthcare team and/or the chaplaincy could only attend case reviews on set days. She said that this arrangement had since changed, and that the case review team now agreed the date of the next case review at the end of a review to ensure attendance. We are satisfied that this action is appropriate.

137. PSI 64/2011 instructs that the prisoner must attend case reviews unless unwilling or unable. It says that the prisoner should be encouraged to engage in the review, which includes being given the option of providing written input ahead of time. If a prisoner does not attend a case review, the case co-ordinator must update them about the outcome.

138. When a SO chaired an ACCT case review on 8 July, she did not invite Mr Atkinson to participate in person or by providing written input. While we appreciate that she spoke to Mr Atkinson before and after the review, we consider that Mr Atkinson should have been given the opportunity to participate in the review so that attendees could discuss his request to stop ACCT monitoring and explore the possibility of constant supervision with him. The SO told us that there was no particular reason for not involving Mr Atkinson in the review process and that it was just something they did at times.

Closing and re-starting ACCT procedures

139. PSI 64/2011 instructs that after stopping ACCT monitoring, prison staff must complete the seven-day post-closure monitoring form for a minimum of seven days to inform the post-closure review. When staff stopped ACCT monitoring on 24 May and 21 June, they did not complete a seven-day post monitoring review form or post-closure review. This meant that there was little consideration of how Mr Atkinson had progressed since the ACCT had been closed.

140. PSI 64/2011 states that an ACCT document can be re-started at any point during and up until six weeks post-closure if the level of risk is deemed to have increased. It requires prison staff to complete an immediate action plan within one hour of the decision to re-start ACCT monitoring and to determine whether the circumstances for re-starting are different to those addressed in the original plan. If they are, staff must complete a new assessment within 24 hours of the decision to re-start the ACCT.

141. When a SO re-started ACCT procedures on 4 July, he did not complete an immediate action plan or record whether he considered another assessment. While we do not consider that another assessment was required, we are concerned that he used a new ACCT document and did not include any information on risk from the previous ACCT. At interview, the Acting Head of Safety told the investigator that she expected staff who re-start ACCT procedures to obtain the original ACCT and to review it. This did not happen in Mr Atkinson's case, which meant that important information from the original assessment and the risk and triggers section was not available to staff at case reviews. We consider it vital that staff have access to as much relevant information from the original ACCT as possible so that continuity is maintained, and staff are able to make a more accurate assessment of risk.

Assessing the level of risk

142. PSI 64/2011 requires all staff who have contact with prisoners to be aware of the triggers and risk factors that might increase the risk of suicide and self-harm and take appropriate action. Staff judgement is fundamental to the ACCT system. The system relies on staff using their experience and skills, as well as local and national assessment tools, to determine risk. While a prisoner's presentation is obviously important and reveals something of their level of risk, it is only one piece of evidence in assessing risk. Staff should make a considered, objective evaluation of all risk factors when assessing the risk of suicide and self-harm.

143. We are concerned that despite Mr Atkinson making a significant cut to his neck on 4 July, staff did not place more emphasis on restricting access to razors. A SO told us that the case review team on 8 July did not consider removing razors from Mr Atkinson. She said that it was difficult to restrict razors from prisoners as they can get access to them from their peers on the wing. We consider that access to razors was a significant risk factor, and that staff should have put more stringent measures in place to restrict Mr Atkinson's access to them. While we cannot say whether it would have prevented Mr Atkinsons' death, particularly as he had concealed razors internally, it might have made it more difficult for him to harm himself.

144. Staff provided Mr Atkinson with a book about human anatomy shortly after he harmed himself by cutting on 4 July. While this was identified in the ongoing ACCT record, there is no evidence that staff considered this an indicator of potential future self-harm. We consider that as Mr Atkinson had recently made a significant cut to his neck, staff should have at least highlighted this as a risk and sought advice from the safer custody department before enabling him to have access to such material. The importance of this is evidenced by the fact that when Mr Atkinson spoke to his friend on 8 July, he appeared shocked and surprised that staff had enabled him to access the book.

145. We are also concerned that there is no record that the ACCT case review team on 8 July considered a period of constant supervision for Mr Atkinson. PSI 64/2011 states that constant supervision is a response to acts of self-harm or other behaviours which could lead to a prisoner accidentally or intentionally killing themselves, which staff can implement to reduce the risk and intervene in the case of an emergency. This includes self-harm that is likely to result in a high degree of harm and where there are credible and persistent plans to inflict acts of self-harm that are considered to be life-threatening.

146. Both the Acting Head of Safety and a SO told the investigator that they discussed constant supervision during the ACCT review on 8 July but did not feel that it was appropriate as Mr Atkinson was a private person and did not like the ACCT process which he found intrusive. They both said that they felt constant supervision would be negative for Mr Atkinson and that they could sufficiently manage his risk under his current observation requirement of four an hour. The SO added that when she spoke to Mr Atkinson on 8 July, he presented the same as always and despite his recent self-harm and high observation level, she did not detect a heightened level of risk.

147. While we appreciate that Mr Atkinson could display confrontational behaviour and did not like being observed, he had recently made a significant cut to his neck, continued to report feelings of hopelessness and had asked for a book about human anatomy. He also asked for ACCT monitoring to stop, which when considered along with the other risk factors, is an indicator of intention. Mr Atkinson had also been recorded as telling other prisoners that the next time he harmed himself, nobody would find him. We consider that Mr Atkinson's risk factors had increased and that as he was already subject to four observations an hour, the next step to manage his cumulative risk appropriately should have been a period of constant supervision.

Incentive and Earned Privileges

148. PSI 64/2011 states that there will be cases where it may be necessary for a prisoner receiving support through ACCT to be moved up or down an incentive level. Wherever there is a change in the incentive level for a prisoner receiving support through ACCT, the case review team must consider how this impacts the prisoner's risk of suicide or self-harm. Mr Atkinson's IEP status was not downgraded while subject to ACCT monitoring, but the removal of his enhanced status following the ROTL incident appears to have impacted negatively on his emotional wellbeing.

149. We appreciate that prison staff identified that having a computer games console was an important factor in reducing Mr Atkinson's risk and arranged for him to have access to his games while subject to a standard regime. However, we are concerned that staff did not appear to recognise or consider the positive impact of an enhanced IEP regime on Mr Atkinson's level of risk. This is evidenced by the fact that Mr Atkinson's ability to manage his emotions improved significantly during the 12 months he was an enhanced prisoner on Res 7 and that incidents of self-harm reduced significantly.

150. Eastwood Park's local incentives policy states that while it is separate to the disciplinary system, Governors have the authority to determine when the thresholds

for both processes are met. It states that to move up to an enhanced incentive level, prisoners must abide by the prison's behaviour principles and demonstrate the required types of behaviour to a consistently high standard, including good attendance at activities education/work and interventions.

151. While we accept that Mr Atkinson did not meet the criteria for enhanced status as he received two negative IEP entries between 13 June and 2 July, his rule-breaking was relatively minor. We therefore consider that staff should have at least explored the possibility of Mr Atkinson being given enhanced prisoner status as an exceptional circumstance because the benefit of the enhanced regime significantly outweighed the risk of him remaining on a standard regime.

Observations and conversations

152. PSI 64/2011 states that staff must follow the level of conversations stated on the ACCT document and must record these immediately or as soon as practical. PSI 64/2011 states that conversations with prisoners should be meaningful and that staff must be aware of what is contained in a prisoner's care plan to understand the context of any conversation. It also notes that written summaries also need to be meaningful and sufficiently detailed to convey the key details of what was discussed. HMPPS user guidance states that observations must be carried out in the least intrusive manner possible, while ensuring the individual's welfare.

153. Despite some evidence that staff completed detailed written summaries and held good quality conversations with Mr Atkinson, a lot of their recorded interactions with him were brief and descriptive. For example, on 5 July, Officer A recorded that he had a chat with Mr Atkinson and that he raised no issues. The conversation could well have been meaningful, but it is difficult to know, as insufficient detail was recorded. While we appreciate that there may be challenges in engaging prisoners in meaningful conversations, it is an essential part of the ACCT process and will help staff to understand and mitigate a prisoner's risk.

154. When staff conducted ACCT observations in the hours leading to Mr Atkinson's death on 9 July, they were not always able to see him because he was behind a curtain that he had made to cover the toilet area at the back of his cell. At interview, Officer A told us that prisoners often made their own curtain as the fixed screens offered very little privacy. While we appreciate that prisoners want increased privacy, we are concerned that this might have given Mr Atkinson the time he needed to cut himself without staff seeing him. This is evidenced by the post-mortem report which states that as there was only a short cut in the jugular vein, it was possible that Mr Atkinson had already cut his neck when the officer conducted an ACCT check at 9.50pm.

155. We consider that as Mr Atkinson was subject to four observations an hour, he presented a high risk of suicide and self-harm, and staff should have ensured that they had sight of him. This is particularly concerning when considering that Mr Atkinson had made a comment the previous day about staff being unable to find him in time when he next harmed himself and that he had asked them to stop ACCT monitoring. We cannot say whether the removal of his curtain would have changed the outcome for Mr Atkinson, but it would have made it more difficult for him to cut himself without staff seeing him. We make the following recommendation:

The Governor and Head of Healthcare should ensure that staff manage prisoners at risk of suicide and self-harm in line with national instructions, including that:

- **a case co-ordinator is appointed at the first ACCT case review;**
- **ACCT support actions are specific and meaningful, consider all of the issues identified at assessments and case reviews, and are updated at each review;**
- **ACCT case reviews are multidisciplinary and include healthcare staff where relevant, and that prisoners are invited to contribute to all case reviews;**
- **case reviews consider and document all relevant information that affects risk, including considering the removal of razor blades, items that might impact their vision of the prisoner, and other items when relevant;**
- **staff review the risk of suicide and self-harm whenever an event occurs which indicates an increase in risk, including starting constant supervision when necessary;**
- **observations and comprehensive conversations are carried out as directed and documented in the ACCT record;**
- **staff review the previous ACCT document when re-staring ACCT procedures and include all important information relevant to the assessment of risk; and**
- **staff complete the seven-day post-closure monitoring form and ensure that post-closure reviews take place at the proper time and consider events following the closure of the ACCT.**

156. Mr Atkinson was the second prisoner take their own life at Eastwood Park in a period of three days. In our investigation into the death of the prisoner who took her life two days earlier, we identified similar failings in the management of ACCT procedures. In their last inspection, HM Inspectorate of Prisons found that the quality of recording in ACCT documents was not sufficiently good. We are concerned that recording in some instances required improvement and that both Mr Atkinson's and the other prisoner's risks were inadequately managed. We consider that urgent action is now required to ensure that ACCT procedures at Eastwood Park improve as soon as possible. We make the following recommendation:

The Director of Women for HMPPS should write to the Ombudsman to set out what action she has taken to satisfy herself that meaningful improvements have been made to the assessment and management of the risk of suicide and self-harm at HMP Eastwood Park.

Emergency response

Management of incident

157. Prison Service Instruction (PSI) 03/2013 on medical response codes requires prisons to have a two-code medical emergency response system. Eastwood Park's local policy instructs staff to use an emergency code blue to indicate an emergency when a prisoner is unconscious, or having breathing difficulties, and a code red when a prisoner is bleeding or has severe burn injuries. Calling a medical emergency code should automatically trigger the control room to call an ambulance, and for healthcare staff to attend with the appropriate medical equipment.

158. The OSG responded promptly when she found that Mr Atkinson had cut himself. She alerted Officer A and radioed the correct emergency code. Officer A went into the cell without delay and radioed a code blue when he established that Mr Atkinson was unresponsive and not breathing. Control room staff called an ambulance immediately but there was a delay of around five minutes before the ambulance service answered the call due to an excess demand in the area. We are satisfied that prison staff took appropriate action.

Resuscitation

159. In September 2016, Professor Sir Bruce Keogh, the National Medical Director at NHS England, wrote to the Heads of Healthcare for prisons, introducing new guidance to support staff on when not to perform CPR. This guidance was designed to address the issue of inappropriate resuscitation following a sudden death in a prison and was taken from the European Resuscitation Council Guidelines 2015 (updated in 2021) which state, "Resuscitation is inappropriate and should not be provided when there is clear evidence that it will be futile".

160. In March 2020, the Nursing and Midwifery Council (NMC) and the Royal College of Nursing (RCN) issued a joint statement to reiterate their position about CPR discussions. The guidance states that, "where no explicit decision about CPR has been considered and recorded in advance, there should be an initial assumption in favour of CPR". It also states that, "there will be cases where healthcare professionals discover patients with irreversible features of death – for example, rigor mortis. In such circumstances, any decision not to start CPR should be supported by their senior colleagues, employers and professional bodies".

161. Officer A, who went into Mr Atkinson's cell, told the investigator that he could tell straight away from touching Mr Atkinson and looking at the extent of his injuries that he had died. He said that he did not consider moving Mr Atkinson onto the floor as he was concerned about the preservation of evidence and wanted a nurse to check him. Nurse B told us that when he examined Mr Atkinson, there was no evidence of life and that they left him in the position that they found him as they could not do anything. Nurse A told us that when she moved Mr Atkinson's head and saw the injury to his neck, she knew that he had died. She added that they did not move Mr Atkinson onto the floor as he was in an awkward position.

162. However, before any written clinical documentation of the events, Nurse A twice told an ambulance call handler that they could not be sure if Mr Atkinson had died. The clinical reviewer considered that the clinical assessment of taking his pulse and

blood pressure was not sufficient to verify that life was extinct and beyond attempting CPR. She said that the nurses should have conducted further clinical assessments and considered the use of a defibrillator to check for a shockable heartbeat.

163. The RCN and NMC joint guidance states that if a nurse determines that it is not in the patient's interests to attempt CPR, it is incumbent on them to document and explain how they made the decision. The clinical reviewer considered that while there was some reference to Mr Atkinson's presentation in the clinical notes, both nurses provided insufficient detail to justify their reason for not starting CPR.

164. The clinical reviewer concluded that, on the balance of probability, there was not a definitive recognition that Mr Atkinson had died when both nurses assessed him, and that they should have moved Mr Atkinson onto the floor and started CPR. Although we appreciate the distress of seeing a prisoner in such circumstances, we agree with the clinical reviewer.

165. We make the following recommendations:

The Governor and Head of Healthcare should ensure that staff are aware of their responsibilities in medical emergencies, including that;

- **staff apply a defibrillator and start CPR when appropriate if there are not clear signs of irreversible death; and**
- **when healthcare staff decide not to start CPR, they evidence their decision making in the medical record.**

The Head of Healthcare should undertake a review of the concerns raised by the clinical reviewer of Nurse A and Nurse B to ensure that appropriate actions are taken, including consideration of a referral to the NMC.

Clinical care

166. The clinical reviewer considered that the care Mr Atkinson received at Eastwood Park before the emergency response was equivalent to that which he could have expected to receive in the community. Mental health staff worked closely with substance misuse staff, and they reviewed and monitored Mr Atkinson frequently. Staff regularly discussed his care at multidisciplinary team meetings, attended ACCT reviews and took appropriate steps to address concerns about his compliance with prescribed medication. However, the clinical reviewer identified some areas that required improvement.

Mental health care

167. The clinical reviewer found that Mr Atkinson had been managed under the CPA framework for many years and had regular CPS reviews. However, he did not have a formal care plan. She considered that Mr Atkinson should have had a care plan in place that staff developed with him, which would have helped Mr Atkinson to see what future plans were in place to enable him to progress and to maintain good mental health. We consider that a CPA care plan would have also outlined risks and triggers that staff could have fed into the ACCT process and used to assist in the management of Mr Atkinson's risk of suicide and self-harm.

Physical health care

168. The clinical reviewer considered that Mr Atkinson was at increased risk of excessive bleeding due to taking rivaroxaban because it thins the blood. (Mr Atkinson was prescribed rivaroxaban to help prevent blood clots associated with DVT.) She noted that the National Institute for Care Excellence (NICE) clinical knowledge summary for rivaroxaban (2020) advised that immediate medical attention was required if bleeding occurred that could not be stopped.

169. When Mr Atkinson cut his throat on 8 June, healthcare staff reviewed him three times as his wound continued to bleed. The clinical reviewer found that staff did not take his clinical observations, which would have been recommended given the extent of the injury and Mr Atkinson's long-term prescription of rivaroxaban. The clinical reviewer also noted that healthcare staff only took Mr Atkinson's clinical observations on one occasion after he cut his neck and one of his arms on 4 July.

170. The clinical review concluded that while it was not within her clinical expertise to determine whether the long-standing prescription of rivaroxaban contributed to the excessive bleeding that led to Mr Atkinson's death on 9 July and that this was a matter for the Coroner, staff should have recorded that they considered the rivaroxaban prescription after Mr Atkinson harmed himself by cutting and set out a plan to monitor him. This view is supported by NICE guidance NG225 for self-harm: assessment, management and preventing recurrence (2020), which recommends that following an episode of self-harm, a person should have a medication review. We make the following recommendation:

    The Head of Healthcare should ensure that:

    - **all prisoners managed under the CPA framework have a formal mental health care plan; and**
    - **when a prisoner is prescribed anticoagulant medication and bleeds, staff take their clinical observations, record a NEWS score and arrange a medication review.**

Learning lessons

171. We have identified a number of concerns in this report. We consider it is important that staff learn from our findings. We recommend the following:

    The Governor and Head of Healthcare should ensure that a copy of this report is shared with the staff named in this report and that a senior manager discusses the Ombudsman's findings with them.

Inquest

172. At the inquest, which took place on 24 November 2025, the Coroner concluded that Mr Atkinson died as a result of suicide.

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