Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Norman Loseby, a prisoner at HMP Isle of Wight, on 7 November 2020

A report by the Prisons and Probation Ombudsman

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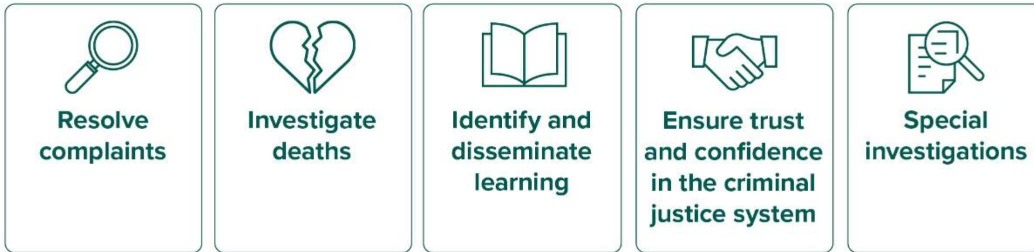
OUR VISION

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

WHAT WE DO



WHAT WE VALUE

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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 Norman Loseby died on 7 November 2020 having been found hanged in his cell at HMP Isle of Wight. Mr Loseby was 54 years old. I offer my condolences to Mr Loseby's family and friends.

I have concluded that Mr Loseby hid the full extent of his distress from staff, and they could not have been expected to predict or prevent Mr Loseby's actions that day. However, I am concerned that Mr Loseby's mental health care was inadequate, both at HMP Wormwood Scrubs and Isle of Wight, and he was not sufficiently assessed, supported or reviewed.

Another prisoner found Mr Loseby hanged after staff unlocked prisoners for lunch. He had clearly been dead for several hours when he was found. This is unacceptable. Prison staff remained unclear about the timing and expectations of roll checks and welfare checks.

I am very concerned that we have made recommendations in this report that we have made repeatedly following previous investigations into deaths at Isle of Wight. This suggests that lessons are not being learned. I have, therefore, asked the Prison Group Director to meet me to discuss what more can be done to reduce self-inflicted deaths at the prison.

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

Sue McAllister, CB
Prisons and Probation Ombudsman **November 2021**

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Summary

Events

1. Mr Norman Loseby had a history of suicidal thoughts and had previously been admitted to a psychiatric unit and was prescribed antidepressants in the community. In October 2019, he was convicted of rape and taken to HMP Wormwood Scrubs. It was his first time in prison.

2. Mr Loseby disclosed his mental health issues to a nurse when he arrived at Wormwood Scrubs and she referred him to the mental health team. He later told a nurse that he felt anxious and had thoughts of suicide but no intention of acting on these thoughts. He had no further appointments with the mental health team at Wormwood Scrubs.

3. In November, Mr Loseby was sentenced to six and a half years imprisonment. On 15 January 2020, he transferred to HMP Isle of Wight. He told a nurse about his mental health issues, but said he had no thoughts of suicide or self-harm. The nurse did not refer him to the mental health team. The next day, a prison GP assessed Mr Loseby and continued his prescription of antidepressants.

4. Over the following months, Mr Loseby seemed to settle and told staff he was keen to progress with his sentence. The COVID-19 pandemic meant that Mr Loseby's time out of his cell was very restricted. Staff regularly checked on his welfare and he did not raise any concerns with them.

5. During September and October, Mr Loseby had some ongoing issues with the family court as well as a court appearance for a further criminal offence. Prisoners told the investigator that he was stressed about these events. Another prisoner gave Mr Loseby his own antidepressant medication to help him cope. Staff did not know this until after Mr Loseby died.

6. On 6 November, staff and prisoners said that Mr Loseby seemed his usual self and had no concerns about him. An operational support grade (OSG) checked Mr Loseby that evening and at 5.10am the next day and noted nothing unusual.

7. At 11.40am, staff unlocked Mr Loseby for lunch. Another prisoner went into his cell and found him hanged from his bed. He alerted staff who quickly responded and cut Mr Loseby down. Since rigor mortis had set in, they did not attempt to resuscitate him. A prison GP pronounced him dead at 12.35pm.

8. Mr Loseby had been due to appear in court on 9 November charged with an outstanding sexual offence.

Findings

9. Mr Loseby had several factors which increased his risk to himself according to Prison Service guidance. However, he presented to staff as a settled prisoner who was keen to progress through his sentence. Both staff and prisoners had no concerns that he was a risk to himself and we are satisfied that this was a reasonable assessment.

10. We are concerned that the COVID-19 restrictions meant that Mr Loseby spent long periods in his cell and that staff had limited contact with him. In addition, information about factors that increased his risk – his family court issues and the fact that he was facing further serious criminal charges – was not shared.

11. The clinical reviewer concluded that both Mr Loseby's physical and mental health care were not of the required standard and therefore not equivalent to what he could have expected to receive in the community. Mr Loseby was not appropriately followed up by mental health services at Wormwood Scrubs and was not referred to the mental health team at Isle of Wight. Despite being prescribed antidepressant medication, Mr Loseby was not reviewed as he should have been.

12. After Mr Loseby's death, staff became aware that another prisoner gave Mr Loseby his own antidepressant medication in the last weeks of his life. We are very concerned that, despite this, the other prisoner was still being prescribed this medication and allowed to keep it in his possession when we interviewed him some weeks later. We have expressed concerns about the inadequate management of 'in possession' medication at Isle of Wight in previous investigations.

13. Local instructions about when prisoners needed to be checked in the morning were not clear at the time of Mr Loseby's death. In addition, staff did not check Mr Loseby when he was unlocked for lunch and gave different accounts of the expectations of roll checks. We have identified similar shortcomings in previous investigations.

14. Mr Loseby's death was the fourth self-inflicted death at Isle of Wight since November 2018 where we have concluded that the staff did not consider that the prisoner was at risk of suicide. Although it is the case that prisoners sometimes successfully hide their distress from staff, all the prisoners who died at Isle of Wight did have risk factors for suicide

Recommendations

To HMP Wormwood Scrubs

- The Head of Healthcare should ensure that mental health staff:
    - Appropriately assess a prisoner's clinical history and risk of suicide before deciding whether or not to accept the prisoner onto their caseload;
    - open an ACCT if a prisoner expresses suicidal thoughts or is assessed to be a risk to themselves: and
    - fully document reasons for any decision not to open an ACCT or accept a prisoner onto the mental health caseload.

To HMP Isle of Wight

- The Head of Healthcare should:
  - conduct a fresh review of in-possession medication risk assessments; and
  - ensure that staff know what events and triggers should prompt additional reviews.
- The Head of Healthcare should ensure that all healthcare staff make appropriate and timely mental health referrals having, reviewed all relevant records available to them.
- The Head of Healthcare should ensure that all prisoners with mental health issues are reviewed appropriately, including repeat prescription medication.
- The Governor should review the prison’s local instructions on roll checks and welfare checks to ensure that:
  - staff are clear about the type of check required, when they should do it, and how the check should be carried out;
  - a welfare check is carried out on all prisoners at or before unlock;
  - a morning welfare check takes place on all prisoners, regardless of whether they are being unlocked; and
  - they consider how best to ensure that staff understand what is required (as repeated written reminders do not seem to have been effective).
- The Prison Group Director for the Long-term and High Security Estate (South) should arrange a meeting with the Ombudsman to discuss what is being done to reduce the number of self-inflicted deaths at Isle of Wight.

The Investigation Process

15. The investigator issued notices to staff and prisoners at HMP Isle of Wight informing them of the investigation and asking anyone with relevant information to contact her.

16. Due to the COVID-19 pandemic, the investigator was unable to visit the prison. She obtained copies of relevant extracts from Mr Loseby's prison and medical records via post and email.

17. The investigator interviewed nine members of staff and four prisoners in December 2020. NHS England commissioned a clinical reviewer to review Mr Loseby's clinical care at the prison. The investigator and clinical reviewer jointly interviewed healthcare staff. All the interviews were conducted by telephone because of the COVID-19 restrictions.

18. We informed HM Coroner for the Isle of Wight of the investigation. She gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.

19. One of the Ombudsman's family liaison officers contacted Mr Loseby's sister to explain the investigation and to ask if she had any matters she wanted the investigation to consider. Mr Loseby's sister asked:

    - What happened before Mr Loseby died?
    - What information was there on Mr Loseby's state of mind?
    - What medication was he prescribed?
    - How was Mr Loseby assaulted when he was locked in his cell for most of the day?
    - Why was Mr Loseby sent to a category B prison when he was vulnerable due to his mental health issues?

20. We have found no evidence that Mr Loseby was assaulted. In July 2020, he fractured his collar bone falling over in the exercise yard. This was witnessed by staff. There are no other injuries reported in his medical records and both staff and prisoners said they never witnessed Mr Loseby being assaulted. In addition, the post-mortem examination found no evidence of recent or healing injuries.

21. Mr Loseby was transferred to HMP Isle of Wight due to the nature of his offences, his length of sentence and his security classification. He was a category B prisoner.

22. Mr Loseby's sister's other questions are answered in this report.

23. Mr Loseby's sister received a copy of the initial report. She did not make any comments.

24. 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 Isle of Wight

25. HMP Isle of Wight is an amalgamation of two former prisons, Parkhurst and Albany, and holds approximately 1,100 men, almost all of whom have been convicted of sexual offences. Care UK provides healthcare services at the prison. There is a healthcare inpatient unit at the Albany site, providing 24-hour care for prisoners.

HM Inspectorate of Prisons

26. The most recent full inspection of HMP Isle of Wight was in April and May 2019. Inspectors found that relationships between staff and prisoners were good and most prisoners said they had a member of staff they could turn to if they had a problem. They also found that clinical care was very good with effective physical healthcare, improved mental health services and good medicine management. They found that prisoners with long-term conditions were managed and reviewed as necessary and they had appropriate care plans.

27. However, inspectors found that prisoners had very poor perceptions of safety, with more than half saying that they had felt unsafe during their time at Isle of Wight. Violence had risen significantly, and staff's response was unsatisfactory and inconsistent. Inspectors found that levels of self-harm were high and some of the PPO's recommendations following deaths at the prison had not been implemented.

28. Inspectors noted that the prison had an 'in possession' medicines policy that reflected both the patient and the drug, and that 'in possession' risk assessments were completed and reviewed and that spot checks took place according to the policy.

29. HMIP carried out an Independent Review of Progress in January 2020 to review progress against 11 key recommendations from the 2019 inspection. They concluded that the outcomes were mixed. Local managers had worked well and made progress in some important areas, including ensuring that staff understood their roles and responsibilities in the event of a medical emergency and that an ambulance was called when an emergency code was used. However, they also found that HMPPS needed to ensure accommodation met basic standards and all prisoners received appropriate support and healthcare.

Independent Monitoring Board

30. 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 December 2019, the IMB reported several positive developments in support for prisoners with mental health difficulties, including increased cover of support. The IMB also reported a 10% increase in the number of self-harm incidents compared to the previous reporting year.

Previous deaths at HMP Isle of Wight

31. Mr Loseby was the thirteenth prisoner to die at Isle of Wight since November 2018. Of the previous deaths, eight were due to natural causes and four were self-inflicted. There has been one further self-inflicted death and seven due to natural causes since Mr Loseby's death.

32. We have recommended in previous investigations that welfare checks and roll checks are completed properly; that prisoners with long-term chronic conditions have appropriate care plans in place; and that assessments for 'in possession' medication need to take full account of risk factors.

Assessment, Care in Custody and Teamwork (ACCT)

33. 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.

34. Part of the ACCT process involves assessing immediate needs and drawing up a caremap 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, *Management of prisoners at risk of harm to self, to others and from others (Safer Custody)*.

Key Events

35. Mr Loseby's clinical records note that after one of his sisters killed herself in February 2019, he told his community GP that he was anxious, depressed, could not sleep and had thoughts of self-harm. He was prescribed sleeping tablets and antidepressants. In March, he was admitted to a psychiatric unit for two weeks after expressing suicidal thoughts.

HMP Wormwood Scrubs, 9 October 2019 – 15 January 2020

36. On 9 October, Mr Loseby was found guilty of rape and actual bodily harm and was remanded into custody and taken to HMP Wormwood Scrubs. On arrival, he told a nurse that he had generalised anxiety disorder and had psychotic symptoms, including hearing voices. Mr Loseby said he was anxious but had no thoughts of suicide or self-harm. He told the nurse that he had been admitted to a mental health unit in October 2018 (the correct date was March 2019) and was under the care of a community mental health team. Mr Loseby used a stick to help him walk, following a stroke. The nurse referred him to the prison's mental health team.

37. On 11 October, a prison GP continued Mr Loseby's prescription of amlodipine and lisinopril (to treat high blood pressure), atorvastatin (to lower cholesterol), clopidogrel (a blood thinner) and fluoxetine (an antidepressant).

38. On 29 October, staff from the mental health team assessed Mr Loseby. They noted that he said he felt anxious and worried about his future. He said he had thoughts of suicide but no plan or intention to take his own life. Mr Loseby did not have any further appointments with the mental health team at Wormwood Scrubs.

39. On 28 November, Mr Loseby was sentenced to six and a half years imprisonment. On return to Wormwood Scrubs, he told a nurse that he was expecting the sentence and felt "okay". Mr Loseby said he had no thoughts of suicide.

HMP Isle of Wight, 15 January 2020 – 7 November 2020

40. On 15 January 2020, Mr Loseby transferred to HMP Isle of Wight. During a reception health screen, he told a nurse that he had had a mental breakdown in 2018 and spent two weeks in hospital. Mr Loseby said he had no thoughts of suicide or self-harm. She told the investigator that she had no concerns Mr Loseby was a risk to himself.

41. On 16 January, a prison GP assessed Mr Loseby. He noted that Mr Loseby had hypertension, depression and anxiety and asked for something to help him sleep for the first few nights. He prescribed him sleeping tablets for three days. Mr Loseby said he had a partner and daughter who he hoped would visit him. The GP told the investigator that Mr Loseby seemed "quite anxious".

42. On 21 February, Mr Loseby met with his offender manager (probation officer). Th offender manager told the investigator that Mr Loseby seemed "fine" and was adjusting to being in prison. He said that Mr Loseby seemed motivated to progress through his sentence.

43. On 27 February, an officer held a key work session with Mr Loseby. On 11 March and 19 March, an officer met Mr Loseby as she had been allocated as his key worker. She told the investigator that, although it was his first time in prison, Mr Loseby did not seem worried and was focussed on getting through his sentence.

44. From mid-March, all face-to-face key working sessions had been stopped but officers were expected to do quicker welfare checks with prisoners. Officers were expected to record these monthly, but the key worker said that she saw Mr Loseby more frequently than this.

45. Between 25 March and 9 October, the key worker recorded 12 welfare checks with Mr Loseby, who raised no issues. She noted that he had a small group of prisoners he mixed with and seemed to be coping well with the limited regime. She said that, during the pandemic, prisoners had initially only been allowed out of their cells for exercise and a shower, but that this progressed to having 40 minutes out of their cell for association in cohorts of around 20 prisoners from their landing.

46. On 15 May, safer custody staff contacted Mr Loseby on the in-cell telephone system as part of a system of routine checks. He said that he was coping well, had enough distraction packs and was aware that he could contact the Samaritans on the in-cell telephones.

47. On 21 May, Mr Loseby had a videolink with the family court about his young son. On 22 July, Mr Loseby fell over in the exercise yard, witnessed by staff. He was taken to hospital where it was confirmed he had fractured his collarbone.

48. On 11 August, the offender manager met Mr Loseby to discuss his sentence plan. He told the investigator that he normally met prisoners on his caseload at least every three months but, due to COVID-19, he had not been allowed to travel to the prison. Mr Loseby said he was motivated to engage and understood the importance of evidencing changes in his offending behaviour. The offender manager said he seemed relatively positive. Mr Loseby said that he had had some thoughts of suicide in the past but that they were fleeting, and he would never act on them because of his son. The offender manager had no concerns that Mr Loseby was a risk to himself.

49. An officer who worked on Mr Loseby's wing said Mr Loseby was a polite and chatty prisoner, who spoke to staff if he needed to. Mr Loseby spoke to him around August about his ex-partner trying to stop him having contact with his children.

50. On 2 September, the offender manager organised a telephone call between Mr Loseby and the Child and Family Court Advice and Support Service (CAFCASS) about Mr Loseby's ex-partner trying to get his name removed from his son's birth certificate. He noted that Mr Loseby was going to seek legal advice before making any decisions and offered his assistance if Mr Loseby needed it.

51. On 7 September, the offender manager met Mr Loseby in passing, and Mr Loseby asked him to organise a telephone call with CAFCASS. He said he would see if it was possible. On 10 September, he facilitated a brief telephone call between Mr Loseby and CAFCASS. On 25 September, Mr Loseby had a videolink with the family court.

52. A prisoner who shared a cell with Mr Loseby from February until the beginning of October told the investigator that Mr Loseby was “alright” but became increasingly stressed about his conviction and being in prison. Mr Loseby told him that he had another court case outstanding, which the prisoner thought he was worried about. He told the investigator that they started to argue, and he moved to a different cell. Mr Loseby stayed in the same cell without a cellmate until his death. The prisoner said that they never physically fought each other.

53. On 1 October, Mr Loseby had a video link meeting with his solicitor. On 8 October, Mr Loseby appeared at Luton Magistrate Court via videolink regarding a further sexual offence. His case was committed to Luton Crown Court and adjourned for reports. This information was contained in videolink records but was not noted in Mr Loseby’s prison record.

54. On 12 October, the offender manager met Mr Loseby who said he was worried about his contact with CAFCASS. He said he would try and contact CAFCASS on Mr Loseby’s behalf.

55. On 21 October, the offender manager gave Mr Loseby documentation to complete for the family court. Mr Loseby said he would like to talk to CAFCASS and Mr Heath said he would try to arrange this the following week. He said he had no concerns about Mr Loseby.

56. A prisoner told the investigator that Mr Loseby was “quite stressed” about his outstanding court case and about his ex-partner trying to remove his name from his son’s birth certificate, although he never had any concerns that Mr Loseby was a risk to himself. He said that he was prescribed mirtazapine (an antidepressant which is also used to treat anxiety) which he did not feel he needed to take. Towards the end of October, he started giving this medication to Mr Loseby, seven tablets at a time (a week’s supply). He said that Mr Loseby did not pay for the medication and he gave it to him to try to help him as a friend.

57. Another prisoner told the investigator that he was good friends with Mr Loseby who told him that he did not want to mix with other prisoners. He said that he witnessed other prisoners calling Mr Loseby derogatory names related to his offence. He said this stopped after Mr Loseby confronted them around May or June. He said that Mr Loseby was upset that his ex-partner was trying to take his son’s name off his birth certificate. He was also concerned about his outstanding court case. He did not see Mr Loseby as much after mid-October as he was employed off the wing, but other prisoners told him that Mr Loseby was not coming out of his cell as much. The prisoner thought he was struggling to cope.

58. The prisoner told the investigator that on 4 November, Mr Loseby was stressed, and said he had been up all night and did not know whether to “hang myself off the telly or hang myself off the bed”. He also told the prisoner that he had taken three mirtazapine tablets which he had not been prescribed as he thought they would help calm him down. Mr Loseby told him that he had got the medication from another prisoner, who had just arrived at the cell and confirmed it. The prisoner did not think that Mr Loseby was genuinely having suicidal thoughts and so did not tell staff.

59. On 6 November, the key worker had a brief conversation with Mr Loseby in the morning to conduct her welfare check. He said that he was fine with the current restricted regime and was out of his cell collecting some more puzzles. She said they joked that they needed some new ones as he had done most of them. She told the investigator that she never had any concerns about Mr Loseby.

60. An officer was working on Mr Loseby's landing that day. He said he had no concerns about him. Mr Loseby was unlocked to collect his evening meal and locked back in his cell around 4.40pm. Two prisoners both saw Mr Loseby around this time. They said that he seemed "fine". Another prisoner also saw him, said he seemed his usual self and gave him seven mirtazapine tablets. Staff did roll checks at 5.00pm and 7.30pm.

61. Around 8.10pm, an Operational Support Grade (OSG) did the night roll check on Mr Loseby's wing. She told the investigator that she checked that every prisoner was in their cell and responding. She could not specifically remember checking Mr Loseby's cell but knows that she did. (There is no CCTV on the wing.)

Events of 7 November

62. On 7 November around 5.10am, the OSG did another roll check. She told the investigator that she checked every prisoner was in their cell and that there were no obvious issues. She said that she always uses a torch and the cell nightlights. She said that it was not always possible to tell whether a prisoner was breathing since most of them were in bed and under their covers at that time. Again, she could not specifically remember checking Mr Loseby's cell but said that she would have remembered if Mr Loseby was out of bed.

63. Officer A started work on the wing at 8.15am. Mr Loseby's time out of his cell was scheduled for the afternoon that day, so he was locked in his cell all morning. He wrote in his statement that it was not unusual not to see Mr Loseby until he collected his lunch.

64. Around 11.15am, Officers A and B started unlocking prisoners for lunch. By the time they got to Mr Loseby's landing it was around 11.40am. Officer B unlocked Mr Loseby's side. He told the investigator that he unlocked each cell door, opened it slightly and shouted for the prisoner to get their lunch.

65. After he was unlocked, a prisoner went to Mr Loseby's cell, knocked on the door and opened his observation panel. He could not see Mr Loseby initially, but then noticed him lying on the floor, looking like he was trying to reach something under his bed. He banged on his door and shouted to Mr Loseby, but he did not respond, so he went into the cell. He then noticed a ligature around Mr Loseby's neck. He went to the cell entrance and shouted to staff to come to the cell quickly.

66. Three officers went straight to Mr Loseby's cell. Officer A noted that Mr Loseby was lying on his right side with his feet at the back of the cell and his head and shoulders level with the bottom bunk. He initially thought that Mr Loseby had fallen. Officer C then realised that Mr Loseby was hanging from the top bunk by a dressing gown cord. He radioed a code blue (an emergency code which indicates a prisoner is not breathing or is having difficulty breathing). The officers cut the ligature from Mr Loseby's neck using an anti-ligature knife and lowered him to the floor. They

noted that Mr Loseby was pale and stiff. They did not try to resuscitate him as they believed he had been dead for some time and it would be futile and undignified. Officer C radioed that they believed the prisoner was deceased.

67. A nurse responded to the code blue. She assessed Mr Loseby and noted that he was cold with signs of rigor mortis. At 11.52am, the ambulance arrived at the prison and the paramedics agreed with the nurse's assessment. At 12.35pm, the prison GP confirmed that Mr Loseby had died.

68. In the days after Mr Loseby died, staff submitted intelligence reports that some prisoners alleged that Mr Loseby had been bullied by other prisoners and called derogatory names by prisoners working on the servery. They also alleged that prisoners had stolen a vape and television remote control from Mr Loseby. Another intelligence report was submitted with information from Mr Loseby's family that he had told them that he had been assaulted in the shower due to the offence he had committed but had not reported the assault. Staff also discovered that a prisoner had been giving Mr Loseby his medication.

69. On 9 November, Mr Loseby had a videolink appearance scheduled at Luton Crown Court for an outstanding sexual offence.

Contact with Mr Loseby's family

70. Due to restrictions on face-to-face contact during the COVID-19 pandemic, the Head of Safety telephoned Mr Loseby's sister to inform her of her brother's death and passed on his condolences. An officer was appointed as the family liaison officer. She remained in contact with Mr Loseby's sister and offered a contribution to funeral expenses in line with Prison Service policy.

Support for prisoners and staff

71. After Mr Loseby's death, the Head of Safety 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.

72. The prison posted notices informing other prisoners of Mr Loseby'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 Loseby's death.

Post-mortem report

73. The pathologist concluded that the cause of Mr Loseby's death was ligature suspension (hanging). The toxicology results indicated that mirtazapine was present in Mr Loseby's system at a raised level but below a level that would have contributed to his death. Fluoxetine, which Mr Loseby was prescribed, was also found in his system, but at a low level which seemed to indicate he was not taking it consistently.

Findings

Assessment of risk of suicide and self-harm

74. Mr Loseby had several factors which increased his risk to himself according to PSI 64/2011, *Safer Custody*, including his diagnosis of depression, family history of suicide, physical illnesses, separation from his partner and his son, and concerns about facing further charges which could have resulted in a longer prison sentence.

75. All the staff we spoke to said that Mr Loseby was a settled prisoner who seemed to be coping well and wanted to progress with his sentence. Officers checked regularly on Mr Loseby's welfare, including the day before he died, and he never raised any issues with them.

76. Prisoners gave the impression of a slightly more anxious prisoner who was concerned about his upcoming court case and issues with the family court and his ex-partner. Intelligence submitted after he died also alleged that he had been bullied but this was not known to staff at the time.

77. Mr Loseby had a court appearance for a further offence two days after he died. The offender manager told the investigator that he thought Mr Loseby would have known about this appearance either from his solicitor or wing staff. Prisoners said that this outstanding charge was a source of stress for Mr Loseby although he did not speak to staff directly about it.

78. We are satisfied that Mr Loseby hid the full extent of his distress from staff and other prisoners. In these circumstances, we do not consider that staff could have been expected to predict or prevent Mr Loseby's actions that day.

Clinical care

79. The clinical reviewer concluded that Mr Loseby's healthcare was not of the required standard and therefore not equivalent to that he could have expected to receive in the community.

Mental health care

80. The clinical reviewer noted that Mr Loseby had significant and chronic mental health issues (anxiety and depression with psychotic symptoms) and had been admitted to a psychiatric unit in March 2019 after expressing suicidal thoughts. When he was remanded to Wormwood Scrubs, he was referred to mental health services who assessed him but did not accept him onto their caseload. At this point he expressed thoughts of suicide to the nurse, although he said he had no intention of acting on them. The clinical reviewer concluded that Mr Loseby should have received further mental health input from the team. Given Mr Loseby's assertion that he was having suicidal thoughts, the nurse should also have opened an ACCT. We make the following recommendation:

    The Head of Healthcare at Wormwood Scrubs should ensure that mental health staff:

- **appropriately assess a prisoner's clinical history and risk of suicide before deciding whether to accept the prisoner onto their caseload;**
- **open an ACCT if a prisoner expresses suicidal thoughts or is assessed to be a risk to themselves: and**
- **fully document reasons for any decision not to open an ACCT or accept a prisoner onto the mental health caseload.**

81. When Mr Loseby transferred to Isle of Wight, he disclosed his mental health issues to a nurse. She did not refer him to the mental health team. This was another missed opportunity to assess and provide support to Mr Loseby. She told the investigator that she was new to reception processes and felt under pressure to process prisoners quickly. She was unaware of any guidance about who should be referred to the mental health team at the time.

82. A prison GP also assessed Mr Loseby the day after he arrived at Isle of Wight. He told the investigator that he did not believe Mr Loseby needed to be referred to mental health services. He said that "you deal with the patient that's in front of you" and since Mr Loseby did not seem to be in crisis, he did not believe a mental health referral was necessary.

83. It is not clear whether either the nurse or the prison GP reviewed Mr Loseby's previous clinical record when assessing him.

84. The Head of Healthcare told the investigator that Mr Loseby should have been referred to the mental health team when he arrived at Isle of Wight. Local policy indicates that staff should have reviewed Mr Loseby's previous mental health history including his risk to himself and referred him if there was any previous self-harm or suicide attempts.

85. The Head of Healthcare has since recruited a dedicated reception nurse who started at the prison in January 2021. She said she was also planning to recruit an 'early days in custody' mental health practitioner who would see all new prisoners, although, at the time of interview, this had been delayed due to COVID-19. She said that she had discussed the outcomes of the learning with the wider team, including the reception nurse.

86. We note that improvements have been made since Mr Loseby's death which we welcome. However, we make the following recommendation:

    The Head of Healthcare should ensure that all healthcare staff make appropriate and timely mental health referrals, having reviewed all relevant records available to them.

87. The prison GP said that, in usual circumstances, he would have reviewed Mr Loseby three to six months after his arrival at Isle of Wight. However, this had not been possible as the GP service was limited to emergency appointments only until mid-October 2020 due to COVID-19.

88. National Institute for Health and Care Excellence (NICE) guidance states that patients on long-term medication, including antidepressants, should be reviewed regularly. While we note the difficulties presented by COVID-19, the clinical

reviewer considered that this should not have “completely precluded follow up of a vulnerable patient”. In addition, the post-mortem report indicated that the levels of fluoxetine in Mr Loseby’s system suggested that he may not have been taking his antidepressant medication consistently.

89. After Mr Loseby’s death, the prison became aware that another prisoner had been giving Mr Loseby his own antidepressant medication. The prisoner told us that he was able to do so because he did not need it himself.

90. We have investigated three deaths at Isle of Wight since November 2018 in which a prisoner has killed himself using prescription medication which he had stockpiled. In response, we have repeatedly recommended that healthcare staff at the prison must do more to review and monitor ‘in possession’ medication. We were, therefore, very concerned to find that this prisoner was continuing to receive his medication weekly and to keep it in his own possession at the time of our interview some weeks after Mr Loseby’s death. This meant that he was potentially able to stockpile the medication, which put him and other prisoners at risk of overdose and also provided opportunities for illicit trading.

91. We make the following recommendations:

The Head of Healthcare should ensure that all prisoners with mental health issues are reviewed appropriately, including repeat prescription medication.

The Head of Healthcare should:

- **conduct a fresh review of in-possession medication risk assessments; and**
- **ensure that staff know what events and triggers should prompt additional reviews.**

Physical healthcare

92. The clinical reviewer concluded that Mr Loseby had several chronic diseases which were not managed appropriately. However, he did not consider that this contributed to Mr Loseby’s death.

93. The Head of Healthcare told us that in December 2020 she had recruited a long-term conditions nurse to assist the robust care planning for people with long-term conditions. We make no further comment.

Roll checks and welfare checks

94. PSI 75/2011, *Residential Services*, says:

“Reports from the Prisons and Probation Ombudsman on deaths in custody have identified cases in which a prisoner has died overnight, apparently from natural causes, but staff unlocking them have not noticed that the prisoner had died. This is not acceptable.

"The appropriate arrangements will depend on the local regime, but there need to be clearly understood systems in place for staff to assure themselves of the well-being of prisoners during or shortly after unlock ... Where prisoners are not necessarily expected to leave their cell, staff will need to check on their well-being, for example by obtaining a response during the unlock process."

95. Mr Loseby was found dead in his cell by another prisoner at about 11.40am on 7 November. Rigor mortis, which usually occurs within two to six hours of death was present, meaning Mr Loseby had been dead for some time when he was found.

96. Mr Loseby was last locked into his cell at 5.00pm on 6 November. An officer did a roll check at 7.30pm and an OSG did one at 8.10pm that night and at 5.10am the next morning. The OSG said that this check was to ensure all prisoners were in their cells and there were no obvious issues. A Custodial Manager (CM) told the investigator that this was appropriate for a roll check.

97. Mr Loseby was not checked by staff after this. Three officers all said that they were not expected to check prisoners in the morning unless they were unlocking them. On 7 November, there was no reason to unlock Mr Loseby until lunchtime, so he remained locked in his cell.

98. The CM recognised that since altering the regime due to COVID-19, it had not been clear whether staff were supposed to check all prisoners in the morning, regardless of whether they were being unlocked. He said that on 8 November, the day after Mr Loseby was found dead, he had emailed staff clarifying that day staff must do a welfare check on all prisoners when they start their shift around 7.30am.

99. While we cannot be sure whether a morning welfare check at 7.30am would have affected the eventual outcome for Mr Loseby, it is possible that it may have done.

100. Officer B was subject to a disciplinary hearing. This found that, as the officer who was on the early shift, he was responsible for completing the welfare check that morning. He received a formal warning.

101. We do not consider the lack of any morning check to be a failing on the part of any particular staff member. Rather, we found it to be a failing in the guidance provided to staff during COVID-19.

102. We are, however, concerned that when Officer B unlocked Mr Loseby for lunch around 11.40am, he did not look into the cell or try to get a response from him. Although he said that he would have returned to Mr Loseby's cell if he had not come out to collect his lunch, failing to check on Mr Loseby when he unlocked him was a clear breach of PSI 75/2011.

103. This is now the fourth investigation into a death at Isle of Wight since November 2018 in which we have found serious shortcomings in the quality of roll checks and welfare checks. Following these previous investigations, the Governor issued Notices to Staff (NTS) in May and November 2019 clarifying that a welfare check must be done on all residents at morning unlock to check the well-being of the prisoner and to obtain a response from them. These NTS also stated that a prisoner's well-being must be checked at roll check.

104. Following an investigation into a further self-inflicted death in November 2019, the prison told us that a new template was implemented in July 2020 which set out the times and expectations of both welfare and roll checks and was to be displayed in wing offices. The prison also said that an updated operational instruction would be issued to all staff to clarify the type of check required, the actions that must be taken and when it should be completed. We have not seen any evidence of this instruction, and ambiguity around both the time of checks and what was expected remained at the time of Mr Loseby's death.

105. Following Mr Loseby's death, an email was sent to all staff on 3 December 2020 clarifying procedures for welfare and roll checks. This stated that:

"All staff must ensure that whenever a cell is checked, they satisfy themselves of the safety and welfare of the resident and that there are no apparent immediate issues or concerns.

"This check can take the form of a verbal or physical acknowledgement, positive signs of breathing, the resident moving in the cell or in bed, or any other indication that the resident in question is not in a state of distress."

106. The email also reiterated that welfare checks must take place on all prisoners at 7.45am on weekdays and 8.45am at weekends, regardless of whether they are being unlocked, and that during COVID-19 restrictions these could take place through observation panel.

107. The investigator clarified the difference between a roll check and a welfare check with the Head of Safety. He said that both involved checking the well-being of a prisoner, but a welfare check would usually involve unlocking the door, although during COVID-19 restrictions, all checks could be done through the observation panel. However, the OSG and the CM did not understand that a check on the prisoner's wellbeing is required at roll check and we are concerned that staff are still unclear about this.

108. In addition, we note that at the early morning roll check (around 5.00am) most prisoners are asleep and covered by bedding, and it is therefore difficult for staff to check their well-being without waking prisoners up in most cases. We consider that at roll checks it is sufficient to ensure that a prisoner is in their cell and there are no obvious issues, as the OSG stated, and that it is not reasonable to expect staff to check their wellbeing as well. Making roll checks too onerous or disruptive may mean they are not properly carried out in line with local instructions.

109. We are very concerned that, despite repeated written reminders, staff at Isle of Wight are either still unclear about, or wilfully ignoring, the requirement to check the wellbeing of prisoners at key times. This lack of clarity puts prisoners' welfare at risk. We therefore repeat a previous recommendation:

The Governor should review the prison's local instructions on roll checks and welfare checks to ensure that:

- **- staff are clear about the type of check required, when they should do it, and how the check should be carried out;**
- **- a welfare check is carried out on all prisoners at or before unlock;**

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- **- a morning welfare check takes place on all prisoners, regardless of whether they are being unlocked; and**
- **- they consider how best to ensure that staff understand what is required (as repeated written reminders do not seem to have been effective).**

Bullying

110. After Mr Loseby died, some prisoners alleged that he had been bullied. Staff all said that they had never witnessed Mr Loseby being bullied or physically assaulted. They said he seemed to get on well with other prisoners. Staff also said that there was always someone located by the servery, so that if the bullying had taken place there as alleged, a member of staff would have witnessed it.

111. Following the allegations, the CM interviewed two prisoners. They both said that they used to call Mr Loseby "bacon" (a derogatory name for a sex offender) but that Mr Loseby would also use this name to them. They said that they had no intention of upsetting Mr Loseby. The ex-cellmate said that he had never physically fought with Mr Loseby and after they stopped sharing a cell, they did not speak to each other for around three weeks and then shook hands and agreed to be civil to each other. The CM reminded both men that prisoners should not call each other names as it could cause unnecessary stress and anxiety. In the circumstances, and given the lack of evidence, we consider that this was appropriate and make no further recommendation.

112. However, we note that the post-mortem toxicology tests suggested that Mr Loseby had not been taking his fluoxetine (antidepressant) medication consistently. This raises the question of what he had done with it if was not taking it. One possibility is that he was being bullied to give it to other prisoners. Although we cannot say if that was happening, it reinforces the need for regular monitoring of prisoners on long-term medication, and for regular reviews of 'in possession' medication.

Implementing PPO recommendations

113. We are very concerned that although we have made repeated recommendations to Isle of Wight about monitoring and risk assessing 'in possession' medication and about roll checks and welfare checks, we have identified the same concerns in this investigation.

114. We are also very concerned that Mr Loseby's death was the fourth self-inflicted death at Isle of Wight since November 2018 where we have concluded that the prisoner gave staff no indication that he was at risk of suicide. Although it is the case that some prisoners successfully hide their distress from staff, all the prisoners who killed themselves at Isle of Wight did have risk factors for suicide. We therefore make the following recommendation:

     The Prison Group Director for the Long-term and High Security Estate (South) should arrange a meeting with the Ombudsman to discuss what is being done to reduce the number of self-inflicted deaths at Isle of Wight.

Inquest

115. The inquest into Mr Loseby's death finished on 18 May 2026 and concluded that he died from a self-inflicted act but it was not possible to determine his intention.

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