PRISONS AND PROBATION OMBUDSMAN
for England and Wales
Independent Investigations

A Report by the Prisons and Probation Ombudsman Nigel Newcomen CBE

Investigation into the death of a man in December 2012 at HMP Isle of Wight

Our Vision

'To be a leading, independent investigatory body,
a model to others, that makes a significant contribution to
safer, fairer custody and offender supervision'

This is the report of the investigation into the death of a man at the Camp Hill site of HMP Isle of Wight in December 2012. He was found hanging in his cell. He was 23 years old. I offer my condolences to his family and friends.

A clinical review of the standard of healthcare the man received at HMP Isle of Wight was conducted.

The man was a vulnerable and complex young man who frequently self-harmed, particularly out of frustration at the difficulties he had in maintaining contact with his partner. In July 2012, he staged a rooftop protest at the prison, when he threatened to kill himself. He was taken to the segregation unit and suicide prevention measures were started. He was subsequently moved to the healthcare centre after further threats to kill himself and was subjected to constant supervision. His mental health was assessed and he was prescribed antipsychotic medication. In October, he was transferred to a secure mental health facility but when he got there he said he had invented his psychotic symptoms. When he returned to prison on16 November, his suicide prevention measures were not revisited or formally closed. On 16 December, he was found hanging in his cell.

The man was a very challenging and demanding young man. As a result, many staff and managers were involved in dealing with him and he was subject to a wide range of safety and disciplinary measures. However, the investigation has found that this investment of staff resources was undermined by the lack of a consistent and co-ordinated approach to address the underlying issues that lay behind his distress, poor behaviour and self-harm. While it would have been difficult to predict his actions on 16 December, it is a particular concern that, after so many interventions, monitoring and mental health input appeared to stop altogether after he returned to the prison from the secure mental health unit.

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

Nigel Newcomen CBE
Prisons and Probation Ombudsman **June 2014**

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SUMMARY

1. The man was released on licence from a prison sentence in November 2011, but was recalled to HMP Lewes on 18 February 2012 after being charged with further offences. He was sentenced to four years imprisonment on 2 July 2012 and on 10 July transferred to HMP Isle of Wight.

2. On 4 August, after an argument with his girlfriend, the man climbed onto the roof of the administration block and threatened to harm himself. He was taken to the segregation unit because of his actions. Suicide prevention measures were started but closed again four days later. On 14 August, his behaviour in the segregation unit was described as disruptive as he continually rang his cell bell and kicked his cell door. He also threatened to harm himself. Suicide and self-harm procedures were started again, and he was checked at least every two hours.

3. For two days from 13 August, the man covered his face with ink and refused to wash, threatened suicide, threw food around his cell, hid behind furniture and blocked the observation panel with his mattress. On 15 August, he was examined by the prison doctor, who thought he might have an underlying psychotic disorder. He was moved to the prison's healthcare inpatient unit for monitoring and observation that evening.

4. One afternoon, on 16 August, the man was found hanging from his cell door with his jogging bottoms tied around his neck. His risk of self-harm was reviewed and he was then constantly supervised. His clothes were taken from him and he was given protective clothing to wear (made from a fabric that cannot be torn). He said a voice had told him to kill himself and that he was being brainwashed. A psychiatrist reviewed him and prescribed antipsychotic medication.

5. Over the next six weeks, the man continued to self-harm by hitting his head against walls and doors, and setting light to his hair. He made nooses out of his clothing. He covered his face with ink, said he was hearing voices and spread jam and other items on his cell floor. Prison staff described his behaviour as manipulative, and considered it was linked to contact with his partner.

6. The man remained subject to constant supervision in the healthcare centre for nearly two months until 2 October. It is not clear from the records how long he wore protective clothing for, or how many times he was issued with it. He continually refused to take his medication and on 30 August, he was referred to a mental health secure unit. He subsequently transferred to Ravenswood House medium secure psychiatric unit in Hampshire on 2 October.

7. At Ravenswood House, the man's mental health was assessed and his response to medication was monitored. After two weeks, he said that he had made up his symptoms in order to get out of prison. He spent six weeks at Ravenswood House before being discharged back to prison.

8. The man returned to the Albany site of HMP Isle of Wight on 16 November and it was agreed that he would go to the Camp Hill site for a fresh start. The suicide prevention measures had never been formally closed, but were not continued when he returned to the prison from hospital. A mental health nurse assessed him twice before he was discharged from the mental health team's care on 21 November.

9. In December, at a routine roll check the man was found hanging in his cell at 8.40pm. Although there were signs of rigor mortis, prison staff tried to resuscitate him until the paramedics arrived and pronounced his death.

10. The man had a number of complex problems. While many staff were involved in trying to help him, his risk of suicide and self-harm should have been more proactively addressed, rather than contained, and the ACCT caremap did not address the causes of his distress. We make a number of recommendations about the way in which his vulnerabilities were assessed and managed.

THE INVESTIGATION PROCESS

11. The Ombudsman was notified of the man's death on 17 December 2012. The investigator issued notices informing staff and prisoners at HMP Isle of Wight of the investigation and asking anyone with relevant information to contact him. No one responded.

12. The investigator visited the prison on 9 January 2013 and met relevant prison staff as well as prisoners who had known the man. He obtained copies of the man's medical and prison records, and visited the wing where he had lived.

13. The local Primary Care Trust (PCT) appointed a clinical reviewer to review the man's clinical care.

14. The investigator carried out 12 interviews with prison staff in January and March 2013, and one interview with a prisoner. He fed back to the Governor throughout the investigation about the initial findings and followed this up in writing.

15. The investigator informed HM Coroner for Isle of Wight of the investigation and a copy of the report has been sent to the Coroner.

16. One of this office's family liaison officers contacted the man's partner and his aunt to explain the purpose of the investigation. The man's partner said that he was not mentally ill, but said he had pretended to be to get out of prison. She said that he had self-harmed before, but the extent of his self-harm during this sentence was out of character, and he responded badly because it was his first time in an adult prison. She said that he spent all of the money she sent him on telephone calls, and he wrote to her about their future. He was upset if letters or telephone calls were delayed. His family had not thought he was at risk of suicide, and asked the investigation to establish whether he was being bullied.

17. The man's family received the draft report as part of the consultation period. They agreed with the findings.

HMP ISLE OF WIGHT

18. HMP Isle of Wight is an amalgamation of three prisons, Parkhurst, Camp Hill and Albany.

19. At the time of the man's death health services at HMP Isle of Wight were commissioned and provided by the local Primary Care Trust (PCT). An inpatient healthcare unit (IHU) at the Albany site caters for prisoners with a wide range of mental health, general medical, rehabilitative and health-related respite needs.

20. Camp Hill, where the man died, was closed in March 2013. It was a category C training prison for sentenced adult men mostly from the local prisons of Winchester, Lewes and the London area. Camp Hill had nine residential units.

HM Inspectorate of Prisons

21. The last inspection of HMP Isle of Wight was in June 2012. It highlighted that in general the arrangements for dealing with suicide and self-harm risks were managed well. Mental health services had improved with the introduction of a primary mental health team. There was a suitable range of mental health interventions, although there was no independent counselling service for prisoners with emotional difficulties and too few officers had been trained in mental health awareness.

Independent Monitoring Board

22. Each prison has an Independent Monitoring Board (IMB) made up of unpaid volunteers from the local community who monitor all aspects of prison life to help ensure that proper standards of care and decency are maintained. The most recent IMB annual report for the period ending December 2011, identified that it had been more than two and a half years since the three Island prisons became HMP Isle of Wight, and it was still a long way from being 'one jail'. The IMB was positive about the establishment of a primary mental health team. The report identified logistical problems with holding one safer custody meeting to cover the three sites.

Previous deaths at Isle of Wight (Camp Hill)

23. We have investigated a number of previous deaths at HMP Isle of Wight, most of which were a result of natural causes. There were no other recent self-inflicted deaths at Isle of Wight.

Assessment, Care in Custody and Teamwork (ACCT)

24. Assessment, Care in Custody and Teamwork (ACCT) is the Prison Service process for supporting and monitoring prisoners at risk of harming themselves. The purpose of ACCT is to try to determine the level of risk posed, the steps that might be taken to reduce this and the extent to which

staff need to monitor and supervise the prisoner. Checks should be irregular to prevent the prisoner anticipating when they will occur. Part of the ACCT process involves drawing up a caremap to identify the prisoner's most urgent issues and how they will be met. Regular multi-disciplinary reviews should be held. The ACCT plan should not be closed until all of the actions on the caremap have been completed.

KEY EVENTS

25. The man had a criminal record for theft and burglary. He was given his first custodial sentence when he was 15 years old and served several short sentences in young offender institutions. On 29 March 2010, he was sentenced to 14 months for burglary.

26. An OASys[1] report written in April 2011 recorded that the man had self-harmed several times in custody and that an Assessment, Care in Custody and Teamwork document (ACCT) had been opened for a short time in October 2009, when he had threatened to strangle himself with his clothes because he was frustrated that he could not contact his mother and he had no tobacco. In March 2010, he barricaded his cell and was found with a noose around neck. An ACCT was opened and then closed two days later. Less than two weeks afterwards, another ACCT was opened because he threatened to harm himself while he was damaging his cell. The OASys report noted that during his previous spells in prison there had been no evidence to suggest he needed mental health support.

27. The man was released on licence in November 2011. While he was on licence, he was charged with further offences and was recalled back to prison on 18 February 2012.

HMP Lewes

28. The man was taken to HMP Lewes. It was recorded on his Person Escort Record (PER)[2], completed at a Police Station, that he had tried to harm himself in 2009 and that he had tied a shirt around his neck in police custody.

29. During the man's reception screening and induction, an officer recorded that he was "very anxious, threatening and non compliant". He refused to share a cell with another prisoner and said he would pour boiling water over anyone he shared a cell with. He was frustrated at being in custody and said he had thoughts of self-harm, but that he had no physical or mental health issues. He said he would not harm himself if he was given a single cell. The officer did not open an ACCT document but as she considered him at high risk for sharing a cell she allocated him a single cell. She referred him to the mental health team because of his behaviour.

30. A nurse from the mental health team assessed the man shortly afterwards. He said he was happy to have a single cell. The nurse recorded that there was no evidence of low mood, agitation or psychotic behaviour. His body language and speech were calm and appropriate. The nurse concluded that no further action or input was required from the mental health team.

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[1] OASys (Offender Assessment System) is an electronic tool used by the Probation and Prison Services to identify, assess and manage the risk of harm (including serious harm) and likelihood of re-offending, an offender poses.

[2] The PER form accompanies prisoners on all journeys from and between prisons. It serves as a communication tool about risks a prisoner poses on escort or transfer.

31. The man's personal officer entries over the next few months were positive about his behaviour and work ethic. He gained enhanced status in the prison's Incentive and Earned Privilege (IEP)[3] scheme.

32. On 2 July 2010, the man was sentenced to four years' imprisonment for burglary. Afterwards, he was assessed by a mental healthcare nurse. He told the nurse that he had expected the sentence and would be able to cope in prison. The nurse noted that no mental healthcare input was needed.

HMP Isle of Wight

33. The man transferred to the Albany site of HMP Isle of Wight on 10 July 2012 for reception and induction. It was noted on his exit record that his last ACCT was closed in April 2010. His behaviour was described as volatile. He moved to the Camp Hill site on 13 July and was assigned a personal officer. He said that he wanted to work in the prison's spray workshop. Within hours he was issued with an IEP warning for smoking in the showers.

34. The next day, the man began to be monitored under violence reduction procedures because he was suspected of involvement in an assault on three prisoners at Albany on the 12 July. He was told that if there was further evidence of his involvement in the incident, he would be downgraded to the standard level of the IEP regime.

35. On 21 July, the man was given another IEP warning because he refused to comply with an officer's instructions to return to his cell. He was charged with a disciplinary offence and moved to the segregation unit at the Parkhurst site, for an adjudication[4] (disciplinary hearing). His privilege level was reduced to basic. A nurse assessed him as suitable for segregation. The next day, segregation officers described him as disruptive, because he persistently rang his cell bell, then ignored or argued with officers.

36. On the morning of 23 July, a doctor saw the man in the segregation unit and noted that he was coping well. An operational manager adjudicated his disciplinary charge, for which he received a caution. He was told that his behaviour would be monitored for a period of three months and would return to Camp Hill in the next two days. In the meantime, the manager decided that he should remain in the segregation unit under Prison Rule 45 by which prisoners can be kept apart from others for the maintenance of good order and discipline or in their own interests. His IEP level was returned to enhanced. The manager became concerned about him during the adjudication because he was saying strange things. He said he would only speak to the prison doctor, and an appointment was made for 25 July. He declined the opportunity to speak to a Listener or the Samaritans. He was

[3] Every prison has an IEP scheme, whereby prisoners are given additional privileges or have them removed according to their behaviour.
[4] An internal hearing into breaches of prison discipline. .

given telephone PIN[5] credit and given a smokers' pack because he had missed his opportunity to order from the canteen (prison shop) when he was moved to Parkhurst.

37. The next day, the man raised no concerns with the nurse on duty during the segregation round. On 25 July, he told prison staff that he had been sexually assaulted while he was at Albany. Staff helped him to report the incident to the police. A doctor examined him and he told her that he had been attacked by two prisoners. He said he had fought them off and sustained no injuries. She confirmed that he had no physical injuries. He said that he had smoked cannabis since the age of 15 and his schooling had suffered because of his poor behaviour. He said that he had never been in an adult prison before and during previous sentences, he had smashed up his cell and tied nooses around his neck. He said he had never felt suicidal, but was frustrated with the prison system. She recorded that he seemed content now that he had reported the assault to the police and needed no treatment, care or support from the doctor.

38. Prison staff conducted an investigation and found no evidence to support the man's allegation of sexual assault. In fact, he was not at Albany on the day the alleged assault had taken place.

August 2012

39. When the man's punishment of cellular confinement ended on 23 July, he originally refused to leave the segregation unit. On 3 August he finally agreed to leave the segregation unit and went to the Camp Hill site. An officer told him that he needed to demonstrate an improvement in his attitude and behaviour. He was given phone credit so that he could contact his partner.

40. On 4 August, the man climbed onto the roof of the administration block at Camp Hill, held a noose near his neck and threatened to harm himself. Officers recorded that he wanted phone credit, because he had used his most recent allowance quickly. He was taken to the segregation unit at Parkhurst again because of his disruptive behaviour. An ACCT was opened because he said he was thinking of harming himself. He was to be observed hourly and a Senior Officer (SO) referred him to the mental health team. An officer completed his ACCT assessment. He told her that he had been arguing with his partner for the previous three days. He said that he had no issues, but wanted to move back to Camp Hill as soon as possible to get on with things. There is no evidence that a caremap was started, as ACCT procedures require, to identify measures that could help reduce his risk of self-harm.

41. At an ACCT case review on 5 August, the man told a SO and an officer that he had resolved the issues he was having with his partner, and he had only threatened to self-harm to get what he wanted. The review panel considered his risk of self-harm to be low but the ACCT remained open and a further

[5] PIN phones are used in prison and provide individual electronic prisoner telephone accounts accessed by a personal identification number (PIN). The system works on a credit basis and prisoners buy credit from the prison shop, and the cost of the calls are automatically deducted from their PIN account.

review was scheduled for 8 August. His IEP level was reduced to basic because of poor behaviour.

42. An operational manager chaired the ACCT review on 8 August which was also attended by a SO, a nurse from the primary mental health team and a member of the IMB. In his record of the review, the manager wrote that the man had admitted that he had only threatened to hang himself to get his own way. It was recorded that his caremap was reviewed (although we have seen no evidence that there was a caremap at this point).

43. A nurse assessed the man's mental health after the case review. He told him that he had jumped on the roof out of frustration, and he had no intention to kill himself and he had no history of mental illness. The nurse recorded that there were no concerns about his mental health. The ACCT review panel reconvened and agreed to close the ACCT that day. An ACCT post-closure interview was scheduled for 15 August.

44. On 12 August, the man's partner visited him. On the same day, he blocked his cell door observation panel and was given an IEP warning. Healthcare staff continued to see him on their daily segregation rounds and no healthcare concerns were recorded.

45. In the early hours of the morning on 13 August, the man threw some liquid onto the wing landing and was placed on a disciplinary charge. An officer spoke to him later that morning, but he refused to explain what he had done. He had coloured his face with black ink from a ballpoint pen and said he was expressing himself. He refused the offer of a shower and was told he could not leave his cell until he had removed the ink.

46. Later that day, the man blocked his cell observation panel again and told officers that he had taken seven grams of heroin. The duty governor and a nurse went to the segregation unit and tried to speak to him through his door, but eventually went into the cell. He was on his bed, his face covered with ink and the floor covered with food. He spoke to the duty governor at length and said that nothing could be done for him while he remained on such a restricted regime. He was recorded as alert, spoke clearly and displayed no symptoms of being under the influence of drugs. Later that evening, he told prison staff that he had not taken any drugs and had just wanted to be difficult. He cleaned his cell thoroughly, took a shower and was given a telephone call to speak to his girlfriend.

47. An officer recorded that the man appeared to be trying to be as disruptive as possible from about 11.00pm on 14 August until the early hours of 15 August. He repeatedly rang his cell bell and banged and kicked his cell door. The night duty manager was called to the segregation unit three times because he had hidden behind furniture and could not be seen. He threatened to kill himself and blocked his observation panel with his mattress. Staff entered his cell and removed a towel which was tied to his bed. He was given an anti-ligature blanket. (Anti-ligature clothing and blankets are made from material that is extremely hard to rip.) He continued to threaten to kill himself. The

ACCT document was reopened with two observations every hour. There was still no caremap, and he remained segregated and on the basic regime. There was no record to indicate that an alternative to segregation had been considered.

48. Around 10.00am, a doctor reviewed the man, who sat with his back towards the doctor rocking on the bed. She described him as dishevelled and distressed and he said that he had been hearing voices since he was 18. She suggested he might have an underlying psychotic disorder and agreed with another prison doctor that he should be moved to the inpatient unit on the Albany site for monitoring and assessment.

49. An operational manager chaired the man's ACCT review that afternoon, attended by a nurse from the mental health in-reach team, a member of the substance misuse team, a SO and a member of the IMB. He refused to attend. It was agreed that his risk of self-harm was raised and his observations remained twice hourly. It was suggested that another prisoner had encouraged him to act strangely, but there were still concerns about his mental health. The manager recorded that it was difficult to complete a caremap without him at the review. A caremap was opened but just reflected that he refused to engage with the ACCT process and should be encouraged to do so. It included no other actions to help reduce his risk.

50. A review of the man's continued segregation took place at the same time as the ACCT review. There were growing concerns about his behaviour. He had been observed acting strangely, for example spreading jam and porridge around his cell. He also engaged less with officers and sat in his cell a lot with his head covered. It was agreed that transferring him to the inpatient unit for an assessment should be discussed with the mental health team, to identify his needs, remove negative influences from other prisoners in the segregation unit and increase his activity and support. His transfer was discussed with a doctor and other healthcare staff that evening. These agreed actions were not included on an ACCT caremap.

Inpatient unit

51. The man was admitted to the inpatient unit at the Albany site on the evening of 15 August. A nurse started a care plan to provide a safe environment for him and to enable staff to monitor and observe his behaviour. His ACCT remained open and observation levels remained at two an hour. He was still subject to the basic regime. He said he was okay, was calm and had no thoughts of self-harm. He was allowed to have his own clothing, apart from his shoes which were retained as a precaution. He asked to have his own pictures and letters with him.

52. The next morning, the inpatient unit manager held an ACCT case review. No healthcare staff were present. The man refused to attend. The manager recorded that he did not appear to be suicidal, but was manipulative. The senior officer noted that he had no caremap. He decided that he was still a raised risk, but his observations were reduced to once every hour.

53. Shortly after the case review, the man agreed to speak to a mental health nurse. He told the nurse that both his parents were deaf and that his first language had been sign language. He said he first started to hear voices when he was 15 when he smoked cannabis. The voice was worse when he was in prison and he now heard it twice a day. The voice told him to do things such as mess up his cell. She discussed relaxation strategies with him. He said he did not want to die as he had a lot to live for, including a supportive partner and a young baby. He also said he wanted to return to the segregation unit. She discussed his case with a prison GP and a psychiatrist. It was agreed that as he was now engaging with staff, his mental health would be monitored, and he could be transferred back to the segregation unit which he was pleased about.

54. At around 1.10pm, on 16 August, a prison officer found the man hanging with his jogging bottoms around his neck and attached to the cell door. He was immediately cut down. He needed no treatment and was conscious throughout. The officer in charge of the prison and the healthcare team were alerted to the incident. He was given anti-ligature clothing. It was agreed that he should remain in the inpatient unit and was moved to a gated cell under constant supervision[6]. As officers were leaving the cell, he started to headbutt the wall.

55. Prison Service Instruction (PSI) 64/2011 – Safer Custody, requires that an enhanced case review is held whenever a prisoner is given anti-ligature clothing. The duty governor chaired the man's first enhanced case review around 3.15pm, which was attended by a nurse, a psychiatrist and a SO. He explained that a voice in his head had told him to kill himself. He was assessed as at raised risk of self-harm and remained constantly supervised. The duty governor updated his caremap to reflect that his negative thoughts and medication needed to be addressed. The SO agreed to provide in cell activities, such as writing and a radio. (He said he did not want a television.) The psychiatrist agreed to consider medication.

56. The psychiatrist recorded that the man's ongoing risk of self-harm was high and suggested he might be psychotic. He prescribed 5mg olanzapine[7] and noted he would continually be assessed as an inpatient.

57. An operational manager chaired the ACCT review on 17 August, attended by two nurses, an officer and a SO. The man said his mood was unpredictable and he did not want to mix with other prisoners. He said he had had no thoughts of self-harm in the last 24 hours. He was still considered at raised risk of self-harm and it was agreed that he was to stay subject to constant supervision over the weekend at least. No actions were added to his caremap and it was not updated.

[6] Constant Supervision is where a prisoner is supervised by a designated member of staff on a one to one basis, remaining within eyesight at all times and within a suitable distance to be able to physically intervene quickly.

[7] An antipsychotic.

58. The ACCT review on 18 August was chaired by a SO. It was attended by the duty governor and an officer and a nurse who had not been to any previous reviews. It recorded that the man had received a visit from his partner and was in a good mood. He was to remain in anti-ligature clothing for at least another 24 hours. He remained on the basic level of IEP and was allowed out on exercise but was unlocked separately from other prisoners on the unit because of his refusal to integrate. He was also allowed to have some personal photos and letters in his cell. He remained subject to constant supervision.

59. The next case review on 19 August was chaired by a SO, attended by a nurse, senior officer and an officer. The man's face was covered in ink which he said was because the voice had been reciting the name of his daughter and told him that it would only stop if he covered his face with ink. He said he did not want to harm himself but could not trust himself. Later, his mood was described by healthcare staff as up and down.

60. On 20 August, an operational manager recorded that the man refused to leave his cell for his ACCT review. A nurse talked to him through the cell gate when he sat on his cell floor and made very little eye contact. He said the voice had got worse, and again had told him to cover his face with blue ink. He said the medication had improved his sleep. He continued to be constantly supervised.

61. On 21 August, two consultant forensic psychiatrists reviewed the man's mental health. He said that the voice had instructed him to do strange things. He blamed his mental state on his previous cannabis use. He said he had no current thoughts of self-harm, but could not rule it out if the voice told him to. One psychiatrist still considered that he was a significant risk of self-harm and considered that he had an emerging psychotic illness. It was agreed that his mental health would be closely monitored.

62. An operational manager chaired an ACCT review after his mental health assessment, at which staff agreed to encourage the man to mix with others and go outside for at least 30 minutes twice a day for some fresh air. He was later observed playing pool on the landing and no concerns were recorded for the remainder of the evening.

63. On 22 August, around 2.00am, the man asked the prison officer observing him if he could use the telephone as the voice in his head had told him that if he did not contact his daughter, she would be harmed. The officer said he could not use the phone at that time. At 6.30am, officers recorded that he had placed all his personal photos on his cell floor and had used salt to draw a cross around them.

64. An operational manager chaired the next ACCT review at 10.40am, on 22 August. It was noted that the man had refused to take his medication when he was told he could not speak to his daughter. He agreed that he would take his medication as he had now called her. He was now socialising with other

prisoners on the unit and appeared settled, but it was agreed that he should still be supervised constantly as he remained a raised risk of self-harm.

65. On the morning of 23 August, the man refused to see a doctor or take his medication. His ACCT review in the afternoon was chaired by a manager and a nurse attended. It was recorded that he looked tired and made no eye contact. He said he was still hearing voices. Although his face was no longer coloured with ink, he had made a ring of toilet paper around his bed and placed photos of his family on the floor with a thick line of salt around them leading to a cross. He had cut up some of the photos and used the pieces to spell out the words "keep safe". He described the voice in his head as a spirit voice and explained that he had stopped taking the medication as he was not mentally ill and the spirit voice was real. He said he would tell staff if the voice told him to harm himself again. It was agreed that he was at high risk of self-harm and he would continue to be subject to constant supervision, although a full review was not needed until the next week. The caremap was not updated.

66. A psychiatrist recorded that the man continued to have symptoms of psychosis, and increased his dose of olanzapine to 10mg. If he continued to refuse his medication, the doctor considered that he would need to be transferred to a specialist mental health unit. That evening he took his new dose of medication and slept well.

67. No concerns were recorded about the man on 24 August. It was noted that he had taken his medication.

68. On 25 August, the man telephoned his partner. He spent the remainder of the morning looking at photographs of her, which he had placed on the floor and said he was concerned about his lack of phone credit. In the afternoon he banged his head continuously on his cell wall. He then hid behind the privacy screen in the toilet area of the cell but could be seen with a noose (made from his tracksuit bottoms) round his neck, which officers took from him. He was given anti-ligature clothing. (There is no record of when he stopped wearing this previously.) The removal of his clothes appeared to make him more agitated. He was verbally aggressive, and threatened to throw faeces at staff. He repeatedly pressed his cell bell and was rude to staff when they responded.

69. At an ACCT review chaired by an operational manager, the man said the voices in his head had told him to harm himself or his daughter would be killed. He said he wanted to go back to the segregation unit. He was still assessed as at high risk of self-harm and constant supervision continued. There is no evidence that his caremap was updated. He remained on the basic regime.

70. In the evening, the man shouted and persistently pressed his cell bell. Staff told him that if he did not behave properly they would remove his photos from his cell. He eventually broke the cell bell. When he was taken to a different gated cell so that the bell could be repaired, he was not given his photos. He

continued to be verbally aggressive towards staff and to bang his head on the wall.

71. At about 10.30pm, the clinical team manager had a long conversation with the man, who he recorded engaged well. He said that he was frustrated about being constantly watched. He said he did not want to harm himself but felt it was the only way of keeping his daughter safe as he continued to believe the voices could harm her. He said he used his anger to manipulate staff to get what he wanted and he believed that his negative behaviour would lead to his return to the segregation unit. The manager suggested some distraction techniques that he could use.

72. On 26 August, officers and healthcare staff encouraged the man to leave his cell. He was given a radio and he was calmer than the previous day. He tried to telephone his partner but got frustrated when he was unable to talk to her. He made a noose out of the anti-ligature blanket and put it around his neck but officers went into the cell and removed it. He again said the voice had told him to do these things so that his daughter would be safe. He managed to speak to his partner later in the day and his mood improved.

73. The next day, the man telephoned his partner three times. In his ACCT ongoing record, it was recorded that, after one of the phone calls to his partner, he said he would kill himself by banging his head on the wall all day, and started to bang his head. He told a doctor that he was still hearing the voice. The doctor recorded that he showed no evidence of thought disorder and believed that he had behavioural issues rather than being psychotic.

74. At the ACCT case review on 28 August, an operational manager recorded that the man still had ongoing psychotic symptoms. He believed that, if he killed himself, his family would be safe. He repeatedly telephoned his partner to check that she was okay, but this made him worse. His case review and mental health care plan was updated to say that he should have a free five minute telephone call to his partner (Monday to Thursday) provided that he did not telephone her at other times on those days. It was agreed that if he contacted her outside those times, he would forfeit his next free call. His caremap was not updated to reflect this new arrangement. He remained on the basic regime.

75. During an extensive mental health review, the man told a psychiatrist and a community psychiatric nurse that the voice was commanding his behaviour in order to protect his family. The doctor increased his medication to 15mg olanzapine, although his compliance with taking medication was still erratic. They discussed distraction techniques to keep him busy in his cell.

76. The psychiatrist recorded that the man's mental illness did not excuse his behaviour but drove it to a degree. He felt that being in the prison might not meet his mental health needs, especially if he did not comply with his medication, so referred him for assessment at Ravenswood House, a medium secure psychiatric hospital in Hampshire.

77. When the man received his phone credit later in the day, he used the entire amount immediately in a phone call to his girlfriend. In the evening, he asked for his free five minute telephone call which was refused in line with what had been agreed at the ACCT case review. He later refused to take his medication. During the night, he repeatedly placed a blanket over the gate of his cell so he could not been seen. Nurses recorded that his behavioural deterioration was linked to his telephone calls to his partner.

78. That evening, the man asked to use the Samaritans telephone. He told the night prison officer that he was hearing voices telling him to cut his throat. The Samaritans phone on the unit was not working. A phone was brought from another wing, but this did not work either. Shortly after he appeared to fall asleep without speaking to the Samaritans.

79. On 30 August, a psychiatrist faxed a referral to Ravenswood House. On the same day, the man gave up a shard of plastic to nurses. He said that the voice had instructed him to swallow it but that he had resisted. He was given his free call to his partner and appeared to be in a good mood.

80. Over the next two days, the man appeared more settled. The manager, who chaired his ACCT review on 31 August, recorded that he felt better and had changed the way he was thinking. He had behaved positively and had adhered to the arrangement of contacting his girlfriend at planned times. He was still constantly supervised and his assessed risk of self-harm was lowered from high to raised. Late that night, he arranged toilet roll around cell. He also obscured the camera in his cell which was used if he hid out of view.

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81. On 1 September, officers recorded that the man had had a good day, playing pool with officers and prisoners. During the night, the nurse on duty recorded that he had replaced the toilet paper circle around his bed with a writing paper circle.

82. The next day he told staff that he did not want to be on the basic regime any longer because it meant he had fewer visits. The duty governor told the man that his IEP status would be reviewed when his behaviour showed sustained improvement. The governor arranged to give him some tobacco in recognition of his improved behaviour. That night he refused to take his medication.

83. During the day on 3 September, no concerns were recorded about the man's behaviour and mood. He was said to be cheerful, eating well and socialising with other patients on the healthcare unit. In the evening, he refused his medication again and hid in the toilet area of the cell. When he came into the main area of the cell, he removed the laces from his trainers and refused to give the laces to the prison officer who was watching him. He later insisted that healthcare staff contact his girlfriend to make sure she was safe. While staff waited for a senior officer to attend, he hid again behind the toilet area.

He made ligatures out of his sweat shirt and jeans, pressed his cell bell continuously and started to bang his head on the wall. He asked for the Samaritans phone, but it was still not working. When a SO arrived, he said he was okay and did not mention contacting his partner. Despite making ligatures, no case review was held that night. After the SO had left the unit, he told staff that he did not feel safe in his own clothing. His clothes were later removed and he was given anti-ligature clothing.

84. The next day, 4 September, the man refused to leave his cell or attend his ACCT review. Two psychiatrists reviewed his mental health at his cell gate. He said the name of the voice in his head was “Roy”. One psychiatrist recommended that the constant supervision should continue and they agreed that he was at high risk of self-harm. He said the necessary legal paperwork would be drawn up for him to transfer to Ravenswood House. That night he took his medication.

85. On 5 September, the man told staff he could see shadows coming through the cell window and floating around, but the shadows would not cross the border of paper he had placed around the edges of the floor. Staff later recorded that he had become agitated during a phone call to his partner. When their call ended, he wanted staff to give him emergency phone credit. Officers could not arrange this immediately and he became abusive towards them. He then sat in the shower cubicle crying and was taken back to his cell. Soon afterwards, he was given more phone credit and called his partner. After this call, he wanted to contact her because they were having relationship difficulties.

86. Around 5.00pm that evening, the man told a nurse that he would take his life the next day if he could not speak to his partner. Thirty minutes after this, staff activated the camera in his cell because he was sitting in the toilet area out of view and not moving. He told a nurse, who was standing outside his cell, that he had written a letter to his partner. He read out part of the letter of which it said “tell her that I’m sorry and that I can’t take it no more and that I love [their daughter] with all my heart”. The nurse tried to talk to him but he said very little. He said he would kill himself before he went to Ravenswood House.

87. Shortly afterwards, the man left the toilet area and started to eat the foam from his pillow causing him to choke, so his pillows were taken away. He smashed the base of his radio in an attempt to harm himself, so it was also removed from his cell. An operational manager spoke to him and agreed to telephone his partner on his behalf to make sure she was okay. After she had telephoned his partner, the manager spoke to him and agreed to give him an additional telephone call to his partner the next morning. That evening he stood in his cell pouring cold water over himself with the window open. He told staff that he wanted to catch pneumonia. He repeatedly said he intended to kill himself, but again, no case review was convened.

88. The next morning, 6 September, the man continually pressed his cell bell, banged his head on the wall and demanded to speak to his partner. The duty

governor told him that the prison intended to contact his partner first to check that she was happy to speak to him. If she agreed and his behaviour improved, he was told he would be allowed a free five minute telephone call. In the meantime, he was not allowed to associate with other prisoners because of his poor behaviour. He refused food and fluids and said he was on hunger strike. He later calmed down and was allowed to associate with other prisoners again. He apologised to prison staff. For the remainder of the afternoon, staff had no concerns about his behaviour. When contacted, his partner said that she was happy to speak to him. He telephoned her around 6.00pm and took his medication that night.

89. On 7 September, the prison doctor examined the man and found no signs of dehydration as a result of his food and fluid refusal. The doctor recorded that he engaged appropriately but would not accept that his antipsychotic medication could help. Later that day, the community psychiatric nurse reminded him of the agreement to contact his girlfriend once in the evening. She also produced written guidance for all prison and healthcare staff who came into contact with him, outlining his behavioural and mental health issues to help ensure consistency of treatment. He later mixed with other prisoners and played pool with an officer.

90. An operational manager chaired an ACCT review that afternoon. It was noted that the man would be assessed by staff from the Ravenswood House soon and that he had accepted his lunch and some water. He used part of a broken plastic spoon to scratch his left wrist that evening. The nurse who was supervising him alerted officers, who removed all items they considered could pose a risk from his cell. He required no treatment. There was no ACCT case review.

91. The community psychiatric nurse saw the man and recorded that he had no money to buy tobacco because he had used it all on phone credit. He had been reminded at the time that he would not have enough money for other items such as tobacco, but that this was his choice. A multidisciplinary meeting agreed that giving him tobacco would be counterproductive and would encourage further disruptive behaviour.

92. On 8 September, it was recorded that the man had started to eat and drink normally. He had made a small superficial graze to his wrist with a broken plastic spoon. He made a soggy mass of toilet tissue into a sausage shape and asked staff how long it would take to choke himself if he swallowed it. Both items were removed from his cell, but there was no ACCT case review.

93. The next day the man continually pressed his cell bell, tore his blanket into strips and threw his personal belongings around his cell. He was moved to a new cell which he then tried to flood by leaving the tap on. He was then returned to his original cell. Officers recorded that he was extremely argumentative when he did not get his own way.

94. An operational manager recorded that the man refused to participate in his ACCT review on 10 September. He told staff that he was depressed and had

no money to buy tobacco because he had used it all on telephone credit. The community psychiatric nurse asked him if he had any questions about his forthcoming assessment for Ravenswood House, but he did not. His risk of self-harm was recorded as raised, and he remained on constant supervision. In the evening staff described his behaviour as increasingly bizarre. He took a shower with his clothes on and when told to return to his cell, began banging his head against the glass observation panel. He injured his head and said this was because he had been refused tobacco.

95. On 11 September, the man was assessed by staff from Ravenswood House and told prison staff that he felt better about the prospect of transferring there. ACCT reviews on 12 September (chaired by a manager) and 14 September (chaired by a manager), noted that he had been calmer and his behaviour had improved. He was now eating and mixing well with others on the unit. It was agreed that his next ACCT review could be held on 17 September. His risk of self-harm however was still considered to be high and his constant supervision continued.

96. At the ACCT review on 17 September, chaired by a manager, the man again said he felt much better and acknowledged he needed help to get better. He also agreed to start taking his medication again. His assessed risk of self-harm was lowered from high to raised. At the start of the night shift, he asked for a haircut but when he was told he would have to wait until the next day and set fire to his hair with a cigarette lighter.

97. At the ACCT case review the next day which was chaired by a manager, the man said he had been frustrated about not being able to get a haircut straight away, but regretted his actions. An appointment was made for him to have his hair cut that afternoon. The prison received notification that he had been accepted by Ravenswood House but would have to wait for a bed to become available. He said he was keen to go Ravenswood House because it was nearer to his partner. The manager suggested that his level of observation during the day could soon be reduced but his behaviour was still considered unpredictable. In the meantime, daily ACCT case reviews would continue.

98. On 19 September, the man placed lots of paper around the outside of his cell. He told prison staff that when he did this, the voice in his head would not say his daughter’s name as frequently. He continued to take his medication.

99. An operational manager chaired ACCT reviews on 21 and 22 September when the man said he was still hearing voices, which had caused him to destroy his pillow. He was reminded to abide by the agreed protocol for telephoning his partner, which he sometimes still disregarded. His risk of self-harm remained raised and constant supervision continued.

100. The man refused to attend his ACCT review on 24 September. The review on 25 September recorded no additional concerns, although he remained at raised risk and subject to constant supervision. That day, officers found he had hidden a plastic knife in his cell, which was removed and his cell searched. No other unauthorised items were discovered. He said that he

would probably have to assault a member of staff to be moved to the segregation unit.

101. On 26 September, the man again tried to hide plastic cutlery in his cell. He covered his face with ink and asked to go to the segregation unit. At his ACCT review, chaired by a manager, he said he was still hearing voices, felt paranoid and believed others were laughing at him. It was agreed to keep a close eye on his cutlery. Officers said that they thought he was goading them, so he would have to be physically restrained and moved to the segregation unit. News about the availability of a bed at Ravenswood House was still awaited. In the meantime, he remained constantly supervised. His risk of self-harm was considered to be raised.

102. Daily ACCT case reviews between 27 September and 1 October recorded that the man's mood was fairly stable. His risk of self harm remained raised. On 28 September, a bed became available at Ravenswood House.

October 2012 – the man's time at Ravenswood House Medium Secure Unit

103. On 2 October at 8.30am, the healthcare unit manager, and another senior officer reviewed the man and recorded that he was being discharged to Ravenswood House. He said he was not worried about the transfer and his risk of self-harm was recorded as low.

104. Later that day, the man was transferred to Ravenswood House. After initial assessment, he remained on a constant watch regime in view of the perceived risk of self-harm.

105. After he had been at Ravenswood House for two weeks, the man said that he had made up his symptoms in order to get out of prison. Hospital staff were initially sceptical and continued to prescribe antipsychotic medication, but he refused to take it. After a further two weeks it was agreed that there was no deterioration in his mental health. Without medication he remained well, did not self-harm or threaten to do so and none of his previous psychotic behaviour was observed.

106. While he was at Ravenswood House, the man could be polite, chatty and engage well with staff and fellow patients, but he was occasionally difficult, rude and aggressive, including threatening to assault a member of staff. On another occasion, he gave another patient, who was considered at high risk of suicide, a shoelace which might have led to significant harm had it not been intercepted. Hospital staff recorded that his poor behaviour was usually triggered when he had difficulty contacting his partner or arranging a visit.

107. On 5 November, Ravenswood House contacted the prison to say that the man had no mental health issues, and had remained free of symptoms despite not taking medication. On 14 November, the community psychiatric nurse and a psychiatrist attended a meeting at Ravenswood House to discuss his planned discharge. Hospital staff said that he had admitted making up his symptoms in a deliberate attempt to be transferred to hospital. They

concluded that there was no evidence that he suffered from psychosis or any other severe mental illness. A plan of action was agreed on how to manage him upon his return to custody.

The man's return to HMP Isle of Wight

108. On 16 November, the man returned to HMP Isle of Wight. At his initial health screen, no physical or mental health concerns were noted, and he was no longer prescribed medication. The community psychiatric nurse from the mental health team assessed him, who was quiet and raised no concerns about his move back to prison. It was agreed he would be seen once more by the mental health team and if there were no further concerns, he would be discharged from their care.

109. An operational manager, a SO Bignell, two officers, a nurse Young and a psychiatrist met the man on 16 November to agree a management plan. It was agreed that he would go to the Camp Hill site as a fresh start. They reminded him of the support available and he agreed to speak to staff if he had any thoughts of self-harm. He was encouraged to apply for work and education. He was regarded as too high a risk to others to share a cell, which would be kept under review. He was placed on the standard level on the IEP scheme. There was no discussion about his ACCT, or whether his risk of self-harm had reduced, although the ACCT had never formally been closed.

110. The man was later moved to St Thomas' wing at the Camp Hill Site on 19 November. He applied for employment and telephoned his partner to let her know he was now at Camp Hill.

111. On 21 November, a nurse assessed the man and concluded there was no evidence of mental illness. He told him he did not know why he had made up his mental illness and he was discharged from the mental health team's caseload.

112. The man repeatedly asked officers to retrieve photographs he had left at Ravenswood House, and they asked the hospital for them twice. The pictures eventually arrived at the prison on 27 November. He was assigned a personal officer.

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113. The man's personal officer described him as a quiet prisoner, who mixed with selected prisoners on the wing and did not cause staff any concerns. His main issue was trying to get his photographs from reception, which had been returned from Ravenswood House. The personal officer told the investigator that normally such packages were distributed at weekends, but there were some delays at the time caused by staff shortages.

Day of the incident

114. On the morning of the incident the man made four unsuccessful attempts to telephone his partner. He eventually managed to speak to her at 9.21am and 10.46am. He seemed okay during these conversations but he was concerned that he had still not received his photos or some money that his partner had sent him. (She said that she was concerned that he was being bullied for the money that she sent him. His records show that he spent almost all of his money on telephone calls. There was no security information to suggest that he was a victim of bullying.)

115. In the afternoon, the man spoke to his partner again at 2.46pm and 3.07pm. He was upset because of some relationship problems, but at the end of their conversation, both said they were sorry and that they loved each other a lot.

116. Prisoner A told the investigator that he had seen the man just before all prisoners were locked in their cells for the evening at about 5.00pm. The man told him he was okay, although the prisoner described him as looking fragile.

117. Starting at about 6.45pm, an officer completed a roll check of the man's wing and the wing next door, which took him about 20 minutes. He told the investigator that all prisoners were responsive when he checked. He briefed the night operation support grade (OSG) when he came on duty at 8.25pm.

118. The OSG started a further roll check at 8.30pm to check all prisoners were present in their cells. When he checked the man's cell, he noticed the observation glass was obscured by toilet paper on the inside. He repeatedly shouted and kicked the cell door but the man did not respond. At 8.43pm, he radioed the orderly officer in charge of the prison that night and asked him to come to the wing immediately. While he waited for the orderly officer to arrive he continued the roll check.

119. The orderly officer arrived within a minute accompanied by two officers. As the man had still not responded the orderly officer opened his cell door. The officers saw that he was behind the toilet privacy screen, slumped to one side. There was a torn bed sheet hanging from the toilet pipe and the other end was tied around his neck. The orderly officer supported his body while the two officers, who had also arrived, cut through the sheet. At 8.44pm the OSG radioed a code blue[8] emergency and asked for an ambulance to be called. He went to meet the ambulance at the prison gate. The orderly officer also contacted the duty governor, chaplain and police.

120. The control room were told by the ambulance service office that there were no ambulances available, but one would be sent as soon as possible. The ambulance control room records show that the emergency call was received at 8.45pm, and they were told that a prisoner was unconscious.

[8] A Code Blue is a serious emergency where someone is not breathing.

121. The man was placed on the floor with his head towards the door. Although he had not received any recent first aid refresher training, the orderly officer checked him for signs of life but found none. The man appeared lifeless and was described by the officers as not breathing. His skin had a waxy appearance and his lips were purple. Despite signs of rigor mortis, the senior officer started cardiopulmonary resuscitation (CPR) assisted by both officers, both of whom had first aid training. Each officer took it in turn to administer CPR. The police had also been notified of the emergency and arrived at 9.03am.

122. CPR continued for approximately 45 minutes before a paramedic arrived at the cell at 9.20pm. The paramedic took over CPR from one officer but pronounced the man dead at 9.22pm.

123. A suicide letter written by the man was found on his bed. It was addressed to his partner who he identified as his next of kin.

Support for prisoners

124. Notices were displayed in the prison to let prisoners know of the man's death and the support that was available to them. All prisoners subject to suicide and self-harm monitoring procedures were reviewed in case they had been adversely affected by his death.

Support for staff

125. A manager held a debrief meeting at just after midnight to support the prison's staff involved in the emergency response. Staff were offered the help of the care team.

Family liaison

126. The prison appointed two officers as the prison family liaison officers (FLOs). The FLOs left the prison at 11.00pm to break the news of the man's death to his partner who lived in Chichester. With police assistance, the FLOs found her at about 5.00am .

127. The FLOs then went to Southampton to the man's mother's home, and then on to his father's. The FLOs were accompanied by a police sign interpreter as both parents are profoundly deaf. The FLOs left the man's father's house at 1.05pm.

128. On each visit to the man's family members, the FLOs offered advice and assistance. The prison offered to pay reasonable funeral expenses in line with national guidance.

Post-mortem report

129. The cause of death recorded in the post-mortem report was ligature suspension. No alcohol or drugs were found in the man's blood.

ISSUES

Clinical care

130. The clinical review found that the clinical care received by the man while he was in HMP Isle of Wight was comparable with the care he could have expected to receive in the community.

Mental health

131. During his stay at Camp Hill the man received extensive input from the mental health team and was admitted to the inpatient healthcare unit for long periods to assess his complex needs. It was agreed that he would be better supported and cared for in a secure psychiatric hospital. A psychiatrist referred him to the mental health unit on 30 August, he was assessed by nurses from Ravenswood House on 11 September and he transferred there on 2 October.

132. The clinical reviewer records that the care the man received at HMP Isle of Wight before he transferred to Ravenswood House was equivalent to that he could have expected to receive in the community. In particular, the referral to Ravenswood House was appropriate and well managed by the healthcare team.

Medication

133. The clinical reviewer considered that it was appropriate to prescribe the man an antipsychotic with the plan to titrate the dose upwards, as there was evidence at the time that he had symptoms of a psychotic illness. His non-compliance with his medication was well recorded in his notes and effectively monitored.

Ravenswood House

134. The man spent around six weeks at Ravenswood House medium secure unit. Once there, he said that he had fabricated his mental health symptoms. After monitoring him for some time when he was not taking medication, staff at Ravenswood House eventually concluded that he had faked his symptoms and was not mentally ill. The clinical review records that the level of care that he received at Ravenswood House was appropriate. He was discharged because he did not have an enduring mental illness.

135. The Mental Health Act requires that a planning meeting takes place when someone is discharged from a mental health unit. The prison’s psychiatrist and mental health nurse attended the meeting and were given a detailed discharge summary to share with the medical team. The clinical reviewer considers the communication between the prison and the mental health unit to be appropriate.

136. The man arrived back at HMP Isle of Wight Albany on 16 November. A multidisciplinary staff meeting was held with him. He was assessed by a mental health nurse when he arrived, who agreed that there was no evidence of mental illness, but it was agreed that a member of the mental health team should review him again in the first week. A nurse reviewed him and discharged him from follow up care by the mental health team. The clinical reviewer's opinion is that in the absence of any deterioration in his mental health, it was appropriate for him to be discharged from the mental health team caseload at that time.

Assessment of risk and management of the man's risk of self-harm in custody

137. The man's behaviour was often described as poor and disruptive. His self-harm was described by everyone, including himself, as manipulative. He presented a huge challenge to the medical and discipline staff from August 2012 to the time he was transferred to Ravenswood House.

138. While it would have been difficult to predict the man's actions on 16 December we have a number of concerns about the management of the suicide and self-harm prevention arrangements at the prison under ACCT procedures. There appears to have been too much attention on containing his risk and supervising him rather than a concerted attempt to identify and deal with the underlying risk factor by a structured caremap which was actively reviewed and updated at each ACCT case review. To some extent this was not helped by the frequency of the reviews and the fact that he was constantly supervised for such a long time. His risk to himself seems to have been conflated with whether or not he was suffering from a mental illness. In the six weeks or so leading up to his admission to the medium secure unit his risk was regarded as so high that he was constantly supervised and this continued at least initially after his transfer. However, on his return from the unit six weeks later he was not subject to any monitoring at all. The details of our concerns about aspects of the ACCT procedures are set out below.

<u>Enhanced case management</u>

139. Under Prison Service procedures to manage prisoners regarded as at risk of suicide and self-harm, prisons have the discretion to manage the most severely disruptive, volatile and difficult to manage prisoners under an enhanced case review process. Enhanced case reviews are designed to allow staff to respond to more effectively to the prisoner's individual needs to provide a flexible but consistent approach to changing the prisoner's behaviour and managing their risk. When prisoners are placed in alternative clothing (anti-ligature clothing) it is a Prison Service requirement that this triggers an enhanced case review which is required to include a duty operational manager. While many of the reviews during the time that the man was constantly supervised were chaired by, or attended by, the duty operational manager there is little evidence that the case reviews were managed in such as way as to achieve the desired changes in his behaviour or that there was a consistent enhanced case management approach. The reviews appeared to be principally about containment of his risk with little

evidence of agreed strategies being developed to respond to his difficulties, or that psychological help was sought.

140. There is no evidence that the man's family was involved in enhanced case reviews, although the guidance to prisons suggests that this can be beneficial. This was despite the fact that contact with his partner appeared to me one of the major issues for him. No particular member of staff was identified as a key worker to help engage with him and build a positive relationship with him to help identify the underlying cause of his distress and deal with his associated behaviour. We make the following recommendation:

The Governor should ensure that the enhanced case review process is effectively used to manage the most severely disruptive and difficult to manage prisoners and to help identify and address the root cause of their behaviour and distress.

Constant Supervision

141. The man was subject to constant supervision from 16 August until he was transferred to Ravenswood House on 2 October, more than six weeks later. The use of constant supervision is an intrusion into the privacy and dignity of an individual, and resource intensive. PSI 64/2011 requires that constant supervision is used only at times of acute crisis and for the shortest possible time. It notes that an acute suicidal crisis is often temporary. While he was constantly supervised, he had 32 case reviews chaired by many different managers. At eight case reviews, he was considered high risk, but at 23 case reviews he was considered to be at raised risk of self-harm. Despite his apparently varying level of risk, his supervision remained at the same constant level day and night. Throughout this time there was little evidence of work being done to help reduce his level of risk and supervision. We make the following recommendation.

The Governor should ensure that prisoners subject to constant supervision remain so for the shortest possible time and that staff aim to reduce the level of supervision required progressively, substituting alternative supports, as the prisoner's condition improves.

ACCT and Segregation

142. On the second occasion the man was segregated in August 2012, an ACCT was opened at the same time because of his roof top protest and his threat to self-harm. There is no evidence that consideration was given to alternative accommodation when he was segregated. His threat to self-harm was considered an act of manipulation, rather than an indication of his risk. The operational manager decided to keep him in the segregation unit where he remained for 11 days. There was no clear evidence at any of the reviews why the segregation unit was considered an appropriate location for someone at risk of suicide and self-harm.

143. PSI 64/2011 Safer Custody strongly discourages the use of segregation for prisoners managed under the ACCT process stating,

> "Prisoners on open ACCT plans must only be located or retained in Segregation Units only in exceptional circumstances. The reasons must be clearly documented in the ACCT Plan and include others options that were considered but discounted."

144. We therefore make the following recommendation.

The Governor should ensure that prisoners on open ACCTs are held in the segregation unit only in exceptional circumstances with the reason fully recorded in the ACCT document.

IEP and ACCT

145. The man was segregated after a rooftop protest, and his incentives and earned privileges status was reduced to basic from enhanced as a result of his disruptive behaviour. The day after he was placed on an ACCT because of the same incident.

146. PSI 11/2011 notes that "If the prisoner's behaviour or lack of progress demonstrates that he or she cannot sustain his/her current privilege level, he or she may be downgraded to the level below". The fast tracking of prisoners from enhanced to basic should be avoided except in the most serious cases such as assault. Despite this, the man was placed on basic regime on 5 August after he was also regarded as a high risk of suicide and self-harm.

147. The man remained on the basic level of the IEP until his transfer in October to Ravenswood House. Requirements of the PSI state that prisoners on basic level must be reviewed within seven days and given realistic targets to get back to standard level. There is no evidence to suggest this review took place. After this, reviews should take place monthly. Again there is no evidence that any reviews took place.

148. As the man was on the basic regime for such a long time, he had fewer visits and time out of his cell. A trigger for his disruptive behaviour and self-harm was identified as contact with his partner or not getting what he wanted when he wanted it. There were also concerns about his mental health. He was told often that his behaviour needed to improve before his IEP status could be reviewed. This approach appeared to focus on the symptoms rather than the cause of his behaviour and did very little to change or manage his behaviour.

149. PSI 11/2011 requires prisons to ensure that they implement local IEP schemes which consider the needs of prisoners, such as the man, who are at risk of suicide or self-harm and also have complex behaviour issues. The decision to withdraw privileges should also be considered on a case by case basis alongside the ACCT process. There was no evidence this happened. We made the following recommendation:

The Governor should ensure that staff adhere to the principles for IEP schemes laid down in PSI 11/2011 and that decisions to place prisoners at risk of suicide and self-harm are decided individually and alongside the ACCT processes and documented in the ACCT.

ACCT case reviews

150. PSI 64/2011 requires that a case review is held when self-harming behaviour changes or escalates, to consider whether to carry out another assessment or whether a prisoner's caremap needs updating. Under previous guidance, a case review was required only following an actual act of self-harm.

151. ACCT case reviews were held following most of the man's acts or threats of self-harm, but there were some occasions when a review did not take place until the next day. On 26 August, he made a noose out of the anti-ligature blanket and put it around his neck. The next day, he threatened to kill himself by banging his head on the wall, and then started to do so. Despite these two incidents, a case review was not held until 28 August. On 3 September, he made a ligature out of his sweat shirt and jeans, but a case review was not held until the next day. On the evening of 5 September he was seen eating foam from his pillow causing him to choke. He also smashed the base of his radio in an attempt to harm himself. Shortly after this, he stood in his cell pouring cold water over himself with the window open stating he wanted to catch pneumonia, but his next case review was not until 7 September.

152. We accept that the man was reviewed very frequently but it is important for the continual monitoring and assessing of risk that any episode of self-harm should prompt a case review. In accordance with PSI 64/2011, we therefore make the following recommendation:

The Governor should ensure that an ACCT review is undertaken after any act of self-harm.

Caremaps

153. Despite being managed as a prisoner in acute crisis from 16 August to 2 October, the man's caremap was poorly completed. The first action was assigned to him to engage with the ACCT process. PSI 64/2011 requires that the caremap reflects the prisoner's needs, triggers for self-harm and their level of risk. None of the four issues identified related to the triggers for his self-harm identified at the beginning of his ACCT as not being able to talk to his girlfriend and not having visits. He told officers that it was his first time in adult prison, and officers noticed that he was being influenced by another prisoner. There were other possible risk factors which could have been noted.

154. The record of case reviews rarely reflected a discussion of the man's needs, or an attempt to reduce his level of observation. There is no evidence that the enhanced case review gave staff an overview of his behaviour and often at reviews the caremap was not referred to, added to or updated.

155. The man’s caremap should have been started when his ACCT was opened, and should have been a more in-depth record of staff’s attempts to manage and reduce the risk that he posed to himself.

The Governor should ensure that ACCT caremaps address the cause of the individual’s distress, that realistic goals are set that meet the individual’s needs and that these are reviewed and updated at each ACCT review.

Closure of ACCT

156. ACCT procedures are not a fail-safe and while their purpose is to safeguard prisoners, this is not always possible. They require a multidisciplinary approach if vulnerable prisoners are to be supported successfully.

157. When the man was located in the mental health unit, he had been on constant supervision for six weeks. When he returned from Ravenswood House, there is no evidence that his ACCT document was revisited. The ACCT document was never actually formally closed. Although he was assessed as not at risk of self-harm by a nurse in reception, this did not discharge the prison’s obligation to conduct a final case review to ensure that all of his risk factors had been addressed. As the ACCT was never properly closed there was no post-closure review to determine whether he had settled back into prison, or whether he required more support. In effect he went from having intensive attention and interaction to having very little at all, so it is hard to gain any clear picture of his state of mind in the weeks and days before his death.

158. Although the mental health unit had concluded that the man did not have a mental illness, this does not necessarily mean that the high risk he posed to himself before he left custody had disappeared. An ACCT case review after his return to the prison would have enabled him to reflect on his previous self-harm behaviour and allowed measures to be introduced to support him as he adjusted back to life in prison. Even if the ACCT had been formally closed after his return to prison a post-closure review would have allowed a further check of his wellbeing.

159. The ACCT document requires that an ACCT is closed at a case review, after a prisoner has been encouraged to build up their own support networks and coping strategies. At the closing case review, the case manager should be satisfied that the prisoner’s problems have been resolved and he has access to some resources that he finds life-promoting. The failure to hold an ACCT case review when the man returned from Ravenswood House meant that none of these supportive measures were put in place.

The Governor should ensure there is a multidisciplinary approach to the management of prisoners subject to ACCT procedures and that ACCTs are closed only with the full agreement of a multidisciplinary case review panel, who have fully taken into account all indicators when assessing the risk of self-harm.

Anti-ligature clothing and removal of possessions

160. PSI 64/2011 sets out anti-ligature clothing should only be used as a measure of last resort, the reasons for which should be documented in the ACCT record. It also requires ACCT reviews to consider and agree when any items a prisoner might use to self-harm should be removed from them, noting that they should be kept to a minimum.

161. The man's ACCT document occasionally refers to anti-ligature clothing, but its use was not well recorded. He was given anti-ligature clothing on 17 August, and then was given it again on 3 September. There is no record of when or whether he was given back his normal clothing in the interim, and there is no recorded explanation for its use on either occasion, so we cannot be sure that the decision was reasonable. We would question whether it was necessary to use anti-ligature clothing when he was also being constantly supervised. However, the justification for these decisions were not documented in the ACCT or discussed at ACCT case reviews. There were other occasions when items were removed from him, apparently appropriately to protect him from self-harm, but there was no record of considered discussion about the risks at ACCT case reviews.

The Governor should ensure that the use of anti-ligature clothing is recorded and reviewed on the prisoner's records each time that it is used and that ACCT case reviews consider and agree what items should be removed from prisoners at risk of self-harm.

Samaritans phone

162. The man asked for the use of a Samaritans phone on two separate occasions during periods of crisis. The phone did not work either time and it does not appear that he was offered an alternative arrangement, such as by letting him out of his cell to use the unit telephone or offering him the support of a Listener.

The Governor should ensure that prisoners are able to contact the Samaritans by telephone at anytime.

Emergency response

163. When the man was discovered, an ambulance was called without delay and the administering of CPR was done quickly. However an ambulance did not arrive for 45 minutes. Information provided to the clinical reviewer from the Ambulance Service indicates that the emergency call they received described the patient (the man) as unconscious rather than in a life-threatening condition. It was therefore not prioritised, which would have meant a quicker response.

164. The clinical reviewer notes that that the control room should have given more accurate information about the man's circumstances. Even if that is not

always possible straight away, the emergency services should be updated as more information becomes available. We accept that in this case he showed signs of rigor mortis when he was found so any resuscitation attempts were likely to be futile. It is commendable that the staff present made the resuscitation attempts they did. However emergency services must be given accurate information about incidents to ensure an appropriate response. We therefore make the following recommendation:

The Governor should ensure that staff provide emergency services with accurate information about emergency incidents to enable an appropriately prioritised response.

RECOMMENDATIONS

1. The Governor should ensure that the enhanced case review process is effectively used to manage the most severely disruptive and difficult to manage prisoners and to help identify and address the root cause of their behaviour and distress.

2. The Governor should ensure that prisoners subject to constant supervision remain so for the shortest possible time and that staff aim to reduce the level of supervision required progressively, substituting alternative supports, as the prisoner's condition improves.

3. The Governor should ensure that prisoners on open ACCTs are held in the segregation unit only in exceptional circumstances with the reason fully recorded in the ACCT document.

4. The Governor should ensure that staff adhere to the principles for IEP schemes laid down in PSI 11/2011 and that decisions to place prisoners at risk of suicide and self-harm are decided individually and alongside the ACCT processes and documented in the ACCT.

5. The Governor should ensure that an ACCT review is undertaken after any act of self-harm.

6. The Governor should ensure that ACCT caremaps address the cause of the individual's distress, that realistic goals are set that meet the individual's needs and that these are reviewed and updated at each ACCT review.

7. The Governor should ensure there is a multidisciplinary approach to the management of prisoners subject to ACCT procedures and that ACCTs are closed only with the full agreement of a multidisciplinary case review panel, who have fully taken into account all indicators when assessing the risk of self-harm.

8. The Governor should ensure that the use of anti-ligature clothing is recorded and reviewed on the prisoner's records each time that it is used and that ACCT case reviews consider and agree what items should be removed from prisoners at risk of self-harm.

9. The Governor should ensure that prisoners are able to contact the Samaritans by telephone at anytime.

10. The Governor should ensure that staff provide emergency services with accurate information about emergency incidents to enable an appropriately prioritised response.

PRISONS AND PROBATION OMBUDSMAN for England and Wales
Independent Investigations

ACTION PLAN: The Man – HMP Isle of Wight December 2012

No	Recommendation	Accepted/Not accepted	Response	Target date for completion	Progress (to be updated after 6 months)
1	The Governor should ensure that the enhanced case review process is effectively used to manage the most severely disruptive and difficult to manage prisoners and to help identify and address the root cause of their behaviour and distress.	Accepted	The enhanced case review process is already used to manage the most challenging prisoners in HMP Isle of Wight. In order to support this and ensure that their management is consistent and effective specific management plans are drawn up by Custodial Managers. Operational and Custodial Managers will be written to in order to re-emphasise the importance of not only managing behaviour but also addressing the issues that are the root cause of this behaviour/distress.	All CMs written to by Dep Gov 12/13 and again by HOSC&E Jan 14.	Evidence letter from Deputy Governor on file

			Assurance checks are part of the safer custody coordinators role and are monitored through the establishment Safer Custody Meeting.	Completed. Now part of the normal agenda	
2	The Governor should ensure that prisoners subject to constant supervision remain so for the shortest possible time and that staff aim to reduce the level of supervision required progressively, substituting alternative supports, as the prisoner's condition improves.	Accepted	Head of Safer Custody and Equalities has written to all CM advising them of the requirements of PSO 64/201. Assurance checks are part of the safer custody coordinators role and are monitored through the establishment Safer Custody Meeting.	Completed Jan 2014.	Evidence; Constant supervision policy re-issued
3	The Governor should ensure that prisoners on open ACCTs are held in the segregation unit only	Accepted	Prisoners subject to ACCT procedures will only be held in segregation in exceptional circumstances. Operational Managers will be reminded of the	Complete	Evidence letter from A smith Head of Res on file.

	in exceptional circumstances with the reason fully recorded in the ACCT document.		requirement to evidence this in ACCT documents if segregation is required and subsequently at segregation reviews. Safer Custody Managers are to check 100% of ACCT documents for prisoners who are located in segregation. This is to be monitored through the establishment Safer Custody Meeting.	 Complete. Now on the agenda for safer custody meeting.	
4	The Governor should ensure that staff adhere to the principles for IEP schemes laid down in PSI 11/2011 and that decisions to place prisoners at risk of suicide and self-harm are decided individually and alongside the ACCT processes and documented in the	Accepted	The local IEP policy has been reviewed and includes the following: *Prisoners Assessed to Be Vulnerable or at Risk of Suicide or Self Harm* 1. *Operational Managers/Custodial Managers/Case Managers must ensure that all decisions including the withdrawal of privileges should be considered on a case-by-case basis alongside the ACCT*	Complete	

	ACCT.		*process. Prisoners who are vulnerable and who are on basic level may be allowed in cell TV if this is deemed appropriate, in order to reduce their risk.* 2. *Where a prisoner is subject to basic regime and ACCT procedures, case reviews must record decisions with regard to prisoners remaining on basic, including the withdrawal of privileges. This must be recorded in the ACCT document.* Operational/Custodial/Case Managers have been reminded of this requirement. Assurance checks are part of the safer custody coordinators role and are monitored through the establishment Safer Custody Meeting.		
5	The Governor should ensure that an ACCT	Accepted	All staff will be reminded of the requirement to immediately report	Completed	

	review is undertaken after any act of self-harm.		any act of self harm to the Orderly Officer. Supervising Officers, Custodial Managers and Operational Managers have all been advised of the requirement to ensure that they ACCT review takes place after any act of self harm. Assurance checks are part of the Safer Custody Coordinators role and are monitored through the establishment Safer Custody Meeting.		
6	The Governor should ensure that ACCT caremaps address the cause of the individual's distress, that realistic goals are set that meet the individual's needs and that these are reviewed and updated at each ACCT review.	Accepted	Case Managers/Custodial Managers/Operational Managers will be provided with additional guidance and support in the use of the care map process. Particular attention will be given to the identification of needs, a range of appropriate considerations, setting (SMART) goals and reviewing the care map at each ACCT review. Assurance checks are part of the	Completed	

			Safer Custody Coordinators role and are monitored through the establishment Safer Custody Meeting.		
7	The Governor should ensure there is a multidisciplinary approach to the management of prisoners subject to ACCT procedures and that ACCTs are closed only with the full agreement of a multidisciplinary case review panel, who have fully taken into account all indicators when assessing the risk of self-harm.	Accepted	This is current practice. In this case the ACCT was not fully closed due to the man being transferred to a secure mental hospital. Prisoners returning from secure hospital will have their last ACCT document reviewed as part of the handover and returned to prison. This will be to confirm both whether the act document was closed prior to transfer or not, and to ensure that an assessment takes place to consider whether it would be appropriate to reopen the ACCT document on return to prison custody. The mental health team will be requested to inform safer custody managers of all such returns so that this can be part of the return to	Completed	

			custody plan. Compliance will be monitored through the establishment Safer Custody Meeting.		
8	The Governor should ensure that the use of anti-ligature clothing is recorded and reviewed on the prisoner's records each time that it is used and that ACCT case reviews consider and agree what items should be removed from prisoners at risk of self-harm.	Accepted	Case Managers/Custodial Managers/Operational Managers will be provided with additional guidance and support in the use of anti-ligature clothing. Particular attention will be given to the necessity for reviewing the ACCT document each time this clothing is used, as well as any other items that could be removed in order to reduce the risk of self harm. The use of anti-ligature clothing and/or the removal of other items deemed to present a risk of self harm will be recorded at subsequent reviews. Assurance checks are part of the Safer Custody Coordinators role and are monitored through the establishment Safer Custody	Completed	Evidence letter from Deputy Governor 12/13 and by SC&E Jan 14

			Meeting.		
9	The Governor should ensure that prisoners are able to contact the Samaritans by telephone at anytime.	Accepted	Operational/Custodial/Case Managers have been reminded of this requirement. Daily assurance checks are made in order to ensure that Samaritans phones are working appropriately. Additional instructions will be issued to ensure that in the event of a Samaritans phone not working alternatives will be offered. If in exceptional circumstances establishment is unable to facilitate a phone call to the Samaritans, listeners will be offered and a record will be made in the ACCT document. Managers will also be required to report this to the Duty Governor. Assurance checks are part of the safer custody coordinators role and will be monitored through the establishment Safer Custody Meeting.	Completed	

10	The Governor should ensure that staff provide emergency services with accurate information about emergency incidents to enable an appropriately prioritised response.	Accepted	An updated operational instruction will be issued which reflects the need for staff to accurately reflect the prisoner's condition in an emergency situation. Emphasising the need to identify where the condition is life-threatening. This will include advice to control room staff to provide similar emphasis when communicating with the ambulance service. The Head of Safer Custody and Equalities has contacted the Ambulance service to develop a 'crib' sheet of essential information required. This has then been distributed to all control rooms, first on scene and all Custodial managers	January 31 2014.	Operational instruction In development. Evidence; Operational instruction 9/2013 ref medical emergency codes re-issued.