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 at HMP Elmley in January 2013

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 investigation report into the death of a man in January 2013, at HMP Elmley. He was found hanging in his cell in the prison's healthcare inpatient unit. He was 26 years old. I offer my condolences to his family and friends.

A clinical reviewer was appointed to conduct a review of the man's clinical care whilst in prison. Elmley cooperated fully with the investigation.

The man had a history of mental health problems and had been sectioned under the Mental Health Act 1983 eight times before he was remanded to Elmley in August 2012. Each time he had been discharged with a diagnosis of 'malingering'. When he arrived at Elmley, he was found to have symptoms of psychosis and was admitted to the inpatient unit, where he remained until his death. He was treated with anti-psychotic medication and his psychotic symptoms appeared to diminish by mid-October. He was assessed for transfer to hospital in November but found not to warrant admission. He was monitored under suicide and self-harm prevention procedures between 1 September and 30 December 2012 because staff were concerned about his risk to himself. His main concern in prison appeared to be that he did not want to move to a standard prison wing. Whenever this was suggested he threatened to harm himself or tied a noose in front of staff. In the days before he died, he had been upset that his girlfriend had given evidence against him in court but they appeared to have decided to stay together.

The clinical reviewer found that the man's mental health care was equivalent to that he would have received in the community and he remained in the inpatient unit after his psychotic symptoms were brought under control.

Although the man had significant input from staff and was well cared for in the inpatient unit, the investigation identified a number of concerns about the operation of suicide and self-harm prevention procedures. Prison and health processes were not well integrated and staff were not always vigilant for known indicators of risk. I am also concerned that suicide prevention monitoring ceased on 30 December when there was little indication that his risk to himself had substantially reduced. However, his actions on 10 January appear to have been impulsive rather than planned and it would have been difficult for staff to have foreseen what he would do. The emergency response when he was found was prompt and efficient. Sadly, despite a commendably sustained attempt by staff and paramedics, he could not be resuscitated.

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 **September 2013**

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SUMMARY

1. The man had a history of substance misuse including cannabis, heroin and crack cocaine. In 2007, he was remanded to HMP Brixton and subsequently sentenced.

2. The man was transferred to hospital from HMP Brixton in May 2008 but was discharged with a diagnosis of malingering to avoid prison. He was re-admitted to the Maudsley on six further occasions between May and July 2011 from police stations or the community and each time was discharged with a diagnosis of malingering.

3. The man was admitted to hospital for an eighth time and stayed as an inpatient from July to December 2011. He was diagnosed variously with schizo-affective disorder, psychosis, anti-social personality disorder and malingering. On release, he was supervised by a community mental health team but was discharged from their caseload in March 2012 with a diagnosis of malingering.

4. On 16 August 2012, the man was remanded into custody at HMP Elmley. He was assessed as presenting with psychotic symptoms in reception and admitted to the inpatient unit in the healthcare centre. A doctor diagnosed acute psychosis on 17 August and thought that he lacked mental capacity. He was prescribed olanzapine (an anti-psychotic). For some time he was held in a safer cell to reduce his risk to himself but was not subject to Prison Service suicide and self-harm prevention procedures (ACCT).

5. On 1 September, an ACCT was opened after the man told a nurse he had thoughts of suicide and self-harm and had attempted to hang himself. He continued to present in a paranoid and thought disordered way and was prescribed clopixol (an anti-psychotic) on 4 September.

6. He was constantly supervised in a gated cell between 6 and 11 September after he was seen trying to tie a sheet to his cell light. On 6, 7, 8, 9 and 10 September he made several attempts to tear clothing and bedding to make a noose and threatened to kill himself.

7. The man's psychotic symptoms gradually diminished but he was considered to be sufficiently unwell for a referral to hospital. He was given promethazine (an anti-histamine with sedative properties used to treat insomnia) on 27 September. His ACCT was closed on 30 October after a period of stable behaviour but another was opened the next day when he was seen again attaching a sheet to his cell strip light.

8. On 12 November, a psychiatrist assessed him for hospital and decided he was did not require admission. The man was seen with another noose on 16 November. He made a number of threats the same month to hang himself if he was moved from the inpatient unit. The ACCT was closed on 30 December. He remained in the inpatient unit.

9. The man attended court for his trial on 8 and 9 January. During the evening of 8 January, he rang his cell bell and told a nurse that he had made a superficial cut to his wrist with a small metal clip. He said he just wanted to talk. He had been upset that his girlfriend had given evidence against him at his trial but said they had since talked and decided to stay together. He spoke about their future together. The nurse did not feel it was necessary to open an ACCT but increased the required frequency of observations by the night nurse.

10. The man attended court again the next morning, 9 January. A nurse saw him in reception before he left and described him as calm and relaxed. He was convicted of threats to kill, ABH, two counts of battery and damaging property. When he returned to Elmley he told the same nurse he expected to be sentenced in a month. He appeared calm and relaxed. He said he had felt low the previous day but said he did not feel suicidal. The nurse rang the inpatient unit and reported the conversation. He was noted to be unsettled until about midnight, talking to himself and trying to get the attention of the prisoner in the adjoining cell.

11. At 2.40pm the next day, a nurse unlocked the man's cell after the lunchtime break and discovered him hanging from a noose made from a bed sheet tied to the cell light fitting. She pressed the general alarm bell. Staff responded and attempted cardiopulmonary resuscitation. An ambulance was called promptly but did not arrive at the prison for 20 minutes. There was no delay getting into the prison and paramedics were with him five minutes after arrival at the gate. He was pronounced dead at 3.42pm.

12. We conclude that the man's clinical care was at least equal to that he would have received in the community, but we are concerned that there was sometimes confusion between healthcare systems for support in the inpatient unit and the Prison Service suicide and self-harm prevention procedures. We are concerned that targets set to help reduce risk did not take sufficient account of his assessed need and that the ACCT was closed prematurely on 30 December when his risk had not sufficiently diminished. Nevertheless, we accept that his actions would have been difficult to predict. The emergency response was prompt and efficient. We make a number of recommendations about suicide and self-harm arrangements.

THE INVESTIGATION PROCESS

13. The Ombudsman was notified of the man's death on 11 January 2013. The investigator issued notices about the investigation to staff and prisoners at HMP Elmley inviting anyone with information to contact her. No one came forward.

14. The investigator visited Elmley on 18 January and met the Deputy Governor. She visited the inpatient unit of the healthcare centre where the man died, and spoke informally to two prisoners and a mental health team manager. She also spoke to the residential manager who was duty governor on the day the man died. She collected copies of his prison record and other relevant paperwork.

15. The local Primary Care Trust (PCT) appointed a clinical reviewer to carry out a clinical review. The investigator and clinical reviewer interviewed seven members of staff and one prisoner. The investigator spoke to another member of staff by telephone. She gave written and verbal feedback to the prison liaison officer and the Governor during the investigation.

16. One of our family liaison officers informed the man's nominated next of kin about the investigation. His family have been sent a copy of this report.

HMP ELMLEY

17. HMP Elmley is part of the Sheppey group of prisons, which includes HMP Standford Hill and HMP Swaleside. Elmley serves the courts in Kent and holds both remanded and sentenced adult men, as well as unsentenced young adult men between 18 and 21. It can hold more than 1,200 prisoners in five wings, with a mixture of single, double and triple cells.

18. At the time of the man's death, the local PCT commissioned healthcare services at Elmley. The healthcare centre includes a 29-bed inpatient unit. Oxleas NHS Foundation Trust provided mental health care, in partnership with KCA Services, a private provider that delivers primary mental health care at the prison.

19. The inpatient unit is managed by a ward manager (a band seven mental health nurse) and two deputy ward managers (both band six nurses) and staffed by a team of two mental health nurses, two healthcare assistants and a registered general nurse. A separate mental health in-reach team consisting of five mental health nurses works with prisoners with mental health needs on standard wings. A consultant forensic psychiatrist works with both teams and decides who is to be discharged from the inpatient unit. There are two 'gated cells' with minimal furniture designed for prisoners needing constant supervision. The usual cell door is replaced by an open barred gate covered with perspex to aid observation. A further three cells are designated as safer cells.

Her Majesty's Inspectorate of Prisons (HMIP)

20. HMIP last inspected Elmley in March 2012. The Inspectorate found that incidents of self-harm were lower than in many local prisons and those in crisis received good levels of care, particularly from Listeners (prisoners trained by the Samaritans to support other prisoners).

21. The Inspectorate found that health care provision was good, but there was too much reliance on agency staff to address staff shortages. Prisoner perception of healthcare was poor. Prisoners with mental health problems had access to a large mental health team. The mental health team largely met the needs of prisoners, but there were no counselling services at the prison.

Independent Monitoring Board

22. Each prison in England and Wales has an Independent Monitoring Board of unpaid volunteers from the local community who monitor day-to-day life in the prison to help ensure that proper standards of care and decency are maintained. The 2012 Elmley IMB report noted that staff shortages in the healthcare team, including mental health practitioners, had affected morale. It reported a decrease in self-harm at the prison, and considered that the standard of suicide prevention documentation had improved over the previous year.

Previous deaths at HMP Elmley

23. The man's death was the third of three apparently self-inflicted deaths at HMP Elmley since October 2012. In one of these cases, we judged that the prisoner did not receive the mental health care he required and there were concerns about the dose of medication received without review. As in his case, we were concerned that an ACCT was not opened in the inpatient unit despite the prisoner being held in a safer cell because of his risk.

ACCT (Assessment Care in Custody and Teamwork)

24. 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. Levels of observations and interactions are flexible and can be set according to the perceived risk of harm. If staff perceive the risk of harm to be very high, the prisoner may be constantly observed. Other checks should be irregular to prevent the prisoner anticipating when they will occur.

25. Part of the ACCT process involves drawing up a caremap to identify the prisoner's most urgent and pressing issues, set achievable goals to help resolve the issues and identify who is responsible for achieving each goal. 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

26. The man was born in London in 1986. He had a history of drug misuse and at various times used heroin, crack cocaine and cannabis. In December 2007 while on remand at HMP Brixton, he told staff that he wanted to kill himself because he felt depressed and lonely. He was sentenced to 30 months imprisonment in March 2008. On 31 May 2008, he was transferred from Brixton to hospital after self-harming and complaining of hearing voices. He was diagnosed as malingering in order to try and avoid prison and reportedly told a nurse that his symptoms and threats were “all fake”. He was released from prison in February 2009.

27. On 12 May 2011, the man was re-admitted to hospital and treated with anti-psychotic medication. He was discharged on 6 June after being diagnosed as malingering and his medication was discontinued. He returned to hospital on 14, 20 and 21 June but was discharged the same day each time as he was regarded as malingering. On 23 June, he was admitted under section 2 of the Mental Health Act after concerns he had taken an overdose (section two provides for compulsory admission to hospital for up to 28 days for assessment). He was released on 28 June, again with a diagnosis of malingering. He had another short admission between 3 and 5 July.

28. On 15 July 2011, the man was convicted of possessing class A and class B drugs with intent to supply and resisting arrest. On 23 July, he was admitted to hospital for an eighth time, this time from prison. During his admission, he was transferred on several occasions to the psychiatric intensive care unit at Oxleas House (an acute ward for adults) after behaving aggressively and needing restraint. He was diagnosed variously with schizoaffective disorder, psychosis, anti-social personality disorder and malingering. A probation assessment to measure risk and needs (OASys) in August 2011 said his risk of harm to others was low but indicated concerns about his risk of suicide, self-harm, coping in custody and that he would be vulnerable in prison. He was discharged to the community from hospital in December 2011.

29. After his release from prison, he was supervised by a community mental health support team but was discharged from their caseload on 29 March 2012 with a diagnosis of malingering and a note that he feigned mental illness when he was facing possible custodial sentences.

30. On 17 June 2012, the man was admitted to hospital again under section two of the Mental Health Act after being assessed by a psychiatrist at a police station. He remained there for a short period of observation after his girlfriend and his mother raised concerns about his behaviour. His behaviour was diagnosed as a maladaptive behavioural response to stressful life events and not mental illness. He was offered help with his coping skills but declined and was discharged on 26 June.

31. On 27 July 2012, the man was charged with two counts of damaging property and two counts of battery. He was granted bail to appear on 16 August at Magistrates Court. On 15 August, he was arrested and charged with assault

occasioning actual bodily harm (ABH). He spent the night in a police station and the next day, on 16 August, he appeared at Magistrates Court. The person escort form (PER - a form listing risk indicators that travels with a person every time they move between police custody, the courts and prison) showed risk indicators for; suicide/self-harm in relation to an incident in 2009, violence, in relation to his offences, and drugs/alcohol also in relation to previous offences. The box for mental health risks was completed "paranoid schizophrenia/personality disorder?"

32. The man was remanded to custody at HMP Elmley. A Senior Custody Officer (SCO) became concerned about his behaviour in the court cells. She completed a suicide self-harm warning form indicating that he was showing signs of "bizarre behaviour or other signs of mental disorder". (This form also travels with the PER.) She wrote that he was quiet and appeared withdrawn. She listed the risk indicators on his PER and noted he had not made any statements of intended self-harm in custody that day. She put him on intermittent observations, telephoned Elmley reception and told an officer of her concerns.

33. The man arrived at Elmley at 2.50pm and completed the reception process with an officer in the First Night Centre. A mental health nurse completed his first reception health screen. The nurse said he appeared subdued and avoided eye contact. He told the nurse that he suffered from depression, personality disorder and anxiety. The nurse questioned him about his suicide and self-harm warning form. He said he had no current suicidal thoughts and asked for a shower and a rest. The nurse advised him how to access support services in Elmley if he found it difficult to cope. The nurse said his speech was "bizarre" and difficult to follow at times. He appeared paranoid and suspicious and angry with the police. The nurse referred him to the inpatient unit for a mental health assessment. He said he showed overt psychotic symptoms but had no suicidal thoughts or ideation. He spent the night in the first night centre

34. On 16 August at 4.30pm, a mental health nurse and one of two deputy inpatient unit managers completed a psychiatric assessment using a standard assessment tool. The man's scores indicated mild depression, very mild anxiety, very mild suicidality, mild hallucinations and moderate/severe suspiciousness. The nurse admitted him to the inpatient unit and created a primary mental health care plan. He was allocated a named nurse to monitor his mood, behaviour, sleep, appetite and motivational levels. The named nurse was also to have daily one-to-one sessions with him to talk about his feelings. The nurse noted his previous history of drug misuse and self-harm and said that he should be monitored closely for evidence of deliberate self-harm and vulnerability. The nurse did not think he presented a current risk of self-harm.

35. A doctor saw the man on the morning of 17 August and said he appeared to have paranoid psychosis and repeated the same suspicions many times. She referred him for an urgent assessment by the mental health in-reach team (MHIRT) for medication for relief of his psychotic symptoms. A mental health

nurse and the consultant forensic psychiatrist saw him an hour later. The psychiatrist wrote that he was hostile and suspicious and spoke in a thought-disordered way. He did not think he was at risk of harming himself or others. He was difficult to interview because of his poor concentration, drowsiness and "ruminative autistic thinking". The psychiatrist thought that some of his replies to his questions were in response to auditory hallucinations. He offered him oral medication, at which point he became hostile and aggressive. The psychiatrist diagnosed acute psychosis and prescribed olanzapine (an anti-psychotic). He wrote on his record:

> "PLEASE NOTE THAT DUE TO HIS DEGREE OF THOUGHT DISORDER HE DOES NOT HAVE CAPACITY at this point and that if his level of distress and aggression remain at this level and he refuses oral medication that he may be administered the anti-psychotic medication under whatever level of restraint is needed to allow this to be administered safely (within the terms of the mental capacity act)."

36. A nurse attempted to give the man his medication that afternoon but he became verbally aggressive. The nurse therefore organised a planned intervention with prison officers. However, although he was described as passively resistant and non-cooperative he accepted his medication without force being used. The same evening a nurse updated his core care plan. Under the new plan he was put in a cell with minimal items (safer cell) and was to be visited every day and have a total time of 30 minutes one-to-one contact, including a one-to-one visit on every duty. His named nurse was to monitor his mental health, physical health and hygiene daily. (Under the named nurse system at Elmley a nurse is given responsibility every morning for ensuring a specific care plan is adhered to. The named nurse might be different depending on who is on duty.) It is not clear from the records provided when he moved from the safer cell.

37. The psychiatrist saw the man again on 21 August. He said he appeared calmer and clearer and was taking his medication. On 23 August, he was scheduled to appear at Magistrates Court but he was assessed as unfit due to his mental state. Later the same day, a nurse described him as elated and unpredictable. A forensic psychiatrist saw him on a ward round and described him as thought disordered and still without capacity to make decisions about his medication. He said he was not depressed and had denied suicidal thoughts.

38. The man remained in the safer cell and continued to behave in a thought disordered and paranoid way. On 29 August, the psychiatrist said his delusional system had become more complex. He said he had microchips in his body and his cell was bugged. He thought the psychiatrist was working for the government and talked about the Queen, the Illuminati and the Rothschilds. He said voices of demons talked to him at night. The psychiatrist said he was calmer but unkempt. He said he remained psychotic and without capacity but thought he was improving as a result of the medication.

39. At about 6.30pm on 1 September, the man told a nurse that he had had thoughts of deliberate self-harm since being in prison. He said he felt unable to cope with hearing voices and felt like stabbing himself with a plastic knife or hanging himself. He said he had self-harmed in the past and had tried to hang himself two days previously. The nurse then opened an ACCT. He was to be observed at least once an hour until an assessment. He was offered the opportunity to speak to a Listener (a prisoner trained by the Samaritans to offer confidential support) and to use the Samaritans phone (a cordless telephone with a direct line to the Samaritans).

40. A Senior Officer (SO) (a trained ACCT assessor) assessed the man at 2.40pm the next day, 2 September. He said he had nothing to live for. He said he had financial concerns he was unable to solve and had nowhere to live when he was released. He had no relationship with his mother or father. He said he wanted to cut his wrists or hang himself. He then told the SO that he was okay while he was in prison. He said he had thought of suicide since arriving at Elmley but had only now told staff because he was worried he would be transferred to a "mental hospital". He said he had attempted suicide previously both in and out of prison but would not elaborate on when. He said he had a plan and did not care anymore or have any interest in anything.

41. The man said he was distressed about his grandmother's stroke. (He had been brought up by his grandmother and had lately acted as her carer.) The SO noted that she appeared to be a positive part of his life but that he still wanted to kill himself. The SO summarised his concerns as: financial issues, housing, grandmother's stroke, and possible mental health transfer. He said he could not think of any ways in which his situation could be improved.

42. The first case review after the assessment took place at 3.30pm. The then inpatient unit manager, the SO, a nurse and the man all attended. The man reiterated his desire to kill himself and said he had made nooses but had disposed of them. He asked for a pin number for the telephone system in order to be able to call family and friends. The review decided he should remain on hourly observations and have a psychiatric review. A caremap was drawn up with a single action point for him to apply for a replacement pin number.

43. The same evening, a nurse completed another mental health assessment. The man said that he did not remember much of his childhood because of his distorted thinking. He said he could not live with his mother because she suffered from bi-polar disorder. He said he was homeless and could not communicate with his family, which caused him stress. The nurse said throughout the assessment he responded to unseen stimuli. He said he was a Muslim and asked to talk to the Imam. The nurse used the standard prison psychiatric assessment tool. He rated moderately severe for anxiety and depression and moderate for suicidality, hallucinations, unusual thought content and bizarre behaviour.

44. On 3 September, a health care assistant (HCA) saw the man for his daily one-to-one session. He told the HCA he had cut up bed sheets to make nooses. His cell was searched but no nooses were found.

45. A psychiatrist saw the man on 4 September after staff became concerned that he was talking about killing himself in response to his voices. The psychiatrist described him as hostile and preoccupied and diagnosed worsening acute psychosis. He prescribed clopixol (another anti-psychotic) in addition to olanzapine.

46. A mental health nurse, a chaplain and the man attended an ACCT case review on 5 September. He was reported to have engaged well. He was aware of his mental health issues but blamed them on the devil. He said he wanted to remain independent and did not want any staff input. He wanted to "move forward" and transfer to a house block with a TV so he could use this as a coping strategy for his auditory hallucinations. The caremap was updated to show that the goal of getting a new pin number as completed. A new goal of finding a means to help him distract himself from hearing voices was entered. This was to be discussed by the multi-disciplinary team and the inpatient unit managers. Later the same evening, staff reported he was very distressed and shouting that he had had enough of the voices. He was given Kalms and Nytol (herbal sleep remedies) to help him sleep.

47. The next morning on 6 September, the man presented as drowsy. He remained in his cell but came out to collect his meals. At 6.30pm, a nurse discovered him trying to put a torn sheet between the plastic and metal of his strip light. The prison orderly officer (the member of staff responsible for the day to day running of the prison) supervised the removal of his bedding, clothing and shoelaces. He then tore his mattress and made threats to kill himself. The orderly officer decided to put him on constant observation in the gated cell. Once in the gated cell, he was observed sitting on his bed talking to himself. He then tried to rip his T-shirt and blanket. He told the orderly officer that he was going to kill himself no matter what because God had told him to. The blanket was then removed from the gated cell.

48. The man talked continuously throughout the evening about being killed or people trying to kill him. At 9.00pm, he tried to rip his mattress and said he wanted to hang himself as he had just seen the devil. He remained restless and responding to voices until about midnight when he went to sleep. He spent most of the next day, 7 September, asleep. At 4.20pm, a member of the Independent Monitoring Board managed to get him to sit up and talk to her. They discussed travelling time from London for his friends to visit. He also told her he liked artwork and computer games.

49. The duty governor checked the man's ACCT that evening. He noted that the caremap had not been signed and that there was no photograph on the cover.

50. On 8 September, an operational manager and a nurse held an ACCT review. The man said he would kill himself by any means possible given the opportunity. He said he was hearing voices telling him to kill himself. He said

he would not be motivated to change his mind until he had been to court. He remained constantly supervised. He asked for and was given a sheet and pillowcase. After the review he told a mental health nurse that he still wanted to kill himself but would not share any plans he had to do so. He said he had no future when he was released because his family did not want any contact with him after an incident in which the police had kicked a door down. He said he had apologised but had been asked to leave the family home. He then talked about the Queen controlling people's lives and the devil telling him to kill himself because he was sick. He said he heard voices and people were talking about him. Later in the afternoon and evening he was observed verbally responding to voices and making constant hand gestures.

51. The next day, 9 September, an operational manager, the inpatient manager and the man attended another review. He said he still wanted to kill himself but did not know how he would do it. He talked about "strange things" such as the Illuminati and the Queen inhabiting people's bodies. He asked for a TV but was told he could not have one in a constant watch cell. It was decided he should remain constantly supervised. Throughout the day he was seen responding to voices. At one point he was reported shouting and screaming at them to go away. He asked again for a TV and it was explained that he could not have one while he was being constantly supervised. He was offered a book instead but declined.

52. On 10 September, the man appeared via the prison's video link at a hearing in Magistrates Court. He had a quieter day but said that he heard a voice telling him he was sick. During the late afternoon a member of staff who identified himself on the record, who we understand was an agency nurse, saw him try to tear his T-shirt to make a noose. He then squeezed his wrist against the bed and was seen to have pieces of glass under his pillow. Officers entered the cell and removed these. The agency nurse heard him telling the voices that his problems were too many, that he had had a disagreement with his family and that he could not wait for another month before his next court appearance. The agency nurse said he spoke to him and tried to encourage and persuade him that killing himself was not a solution. He sat near the door of the cell to talk to the agency nurse and cried. He told him that he was fed up of life and wanted to kill himself because he could not continue "like this".

53. On 11 September, the man attended another ACCT review with the inpatient manager, a chaplain and the duty principal officer. He said he no longer had suicidal thoughts but also that his situation had not changed. There was discussion about allowing him a TV and transferring him to a standard wing. He gave assurances about his safety but the inpatient manager noted that his mental state remained questionable. He was taken off constant supervision and moved to a standard cell where he could have a TV. He was observed hourly.

54. Another review took place the next day on 12 September attended by the man, a nurse and the Muslim chaplain. His mood was described as "euthymic" (neither depressed nor highly elevated). Again he said that he had no thoughts of suicide but also that his situation had not changed. He asked

the chaplain about attending Friday prayers and appeared more interested in his future. His observations were reduced further to once each duty during the day and hourly during the night. The ACCT on-going record shows that in practice further observations were recorded throughout the next two days and entries appear every two hours or more. Thereafter entries were made during the morning duty, during lunchtime patrol state (when prisoners are locked in their cells), during the afternoon duty, during the evening duty and hourly during the night duty.

55. The man was described as much calmer on 13 and 14 September but, during the evening of 15 September, he became suspicious about his medication and spent the evening "in bed, wailing and howling". He was heard shouting, "stop hurting me" but told staff nothing was wrong when they spoke to him.

56. The man appeared to be more settled on 16, 17 and 18 September. He attended another ACCT review on 19 September with two nurses and a chaplain. He was again described as euthymic but told the review that he heard distressing voices. He said that he did not feel suicidal but felt like self-harming. Observations remained at the same level.

57. On 21 September, it was noted in an ACCT management check that the man had still not signed his caremap, there was still no photograph on the ACCT and no check sheet for recording management checks. The same day at midday he asked for a razor to shave with. He returned it to the healthcare assistant (HCA), minus the blade, and the HCA noticed that he had made cuts to the back of his right calf. He said that voices had told him to cut himself. A psychiatrist saw him later the same afternoon. He talked about previous occasions on which he had been put in hospital under the provisions of the Mental Health Act 1983. He also talked about the Queen inhabiting other bodies. The psychiatrist thought he appeared to believe what he was saying and recommended that he be considered for referral to a hospital.

58. On 23 September, the man told a nurse that he wanted to cut himself with a sharp knife. She reminded him of the various coping strategies he had learned. He continued to have daily one-to-one sessions with mental health staff as part of his careplan. Over the next few days he appeared to become more settled, interacting well with staff and other prisoners. He told an ACCT case review on 27 September with a nurse and a chaplain that his voices continued to tell him to self-harm. The nurse said he could not see any signs of distress or indications of psychosis in him. Observations were reduced to daily. No changes were made to the caremap.

59. A psychiatrist assessed him the same day and found no abnormal movements or behaviours. His speech was normal but his train of thought was hard to follow. He said he was having difficulty sleeping and the psychiatrist noted staff reports that he shouted loudly at night about things interfering with him. The psychiatrist concluded that his delusions and perceptual abnormalities were consistent with those he had described for several weeks despite treatment with anti-psychotic medication. He decided to refer him for assessment by the hospital, with a view to a transfer there.

The psychiatrist continued his prescription for olanzapine and clopixol and started him on promethazine (an anti-histamine with sedative properties prescribed for insomnia).

60. On 29 September, the man told a mental health nurse that he had picked an old self-harm wound and cut it after voices told him to. He said he felt much better and didn't intend to do it again. The nurse discussed distraction techniques such as reading and writing or drawing. He was given an alcohol disinfectant wipe and a plaster for his cut. His medical record shows that he slept a lot and appeared to have low motivation.

61. A nurse, a manager and the man attended an ACCT review on 3 October. The man said he continued to hear voices commanding him to end his life. The nurse said his mental state remained the same and he said he did not have any thoughts of suicide. No changes were made to the caremap or to the level of observations. His medical record described him as calm and relaxed.

62. On 5 October, a psychiatrist wrote to the referrals co-ordinator at a NHS Foundation Trust. He said that he was extremely concerned about the man's mental state. He presented with psychotic symptoms including fixed delusional systems involving the Queen, auditory hallucinations and thought interference. Nurses had observed that he was very distressed at night. The psychiatrist noted the previous opinion at the hospital that he was malingering but asked that they review him, with a view to transfer for assessment and treatment.

63. The man's behaviour remained settled. On 12 October, he attended another ACCT review with a nurse and staff. The man said there was no change in his mental state and felt that there was nothing else staff could do to help him. He said he would always self-harm but did not wish to kill himself. He said he should be released from prison by 8 November. No changes were made to the level of observations or to the caremap.

64. Also on 12 October, the medical secretary was told that the man's referral to the NHS Foundation Trust had been discussed and passed to the High Support Team (a separate part of the same Trust) for discussion on 15 October.

65. The man continued to appear more relaxed and settled and, although he spent some time in his cell, he was polite and talkative with staff. He was often seen talking with other prisoners. On 16 October, the High Support Team telephoned to say that he had been referred to a psychiatrist, who would contact the prison with a date for his assessment.

66. On 17 October, a nurse, an officer and the man attended an ACCT review. The man said that he continued to hear voices telling him to harm himself and would like to have his medication reviewed with the psychiatrist. He said that no one believed him when he told them how he felt but that he was due to be released in November and would discuss this with the mental health team.

The nurse amended the caremap to include the goal of the psychiatrist reviewing his medication. The level of observations remained the same: once during morning duty, lunchtime patrol state (when prisoners are locked in their cells), afternoon duty and evening duty and hourly during the night.

67. The man continued to appear calm and relaxed and was not seen displaying any psychotic symptoms. A nurse, a healthcare assistant and the man attended an ACCT review on 24 October. He talked about the negative voices he heard. He agreed to try to get up in the mornings and have a shower. The nurse told him to speak to staff if he felt that "it all became too much". No changes were made to the caremap or level of observations. The same day, the medical secretary followed up his referral and was told that a psychiatrist had just returned from annual leave and the prison would be given an assessment date as soon as possible.

68. On 29 October, a nurse, a healthcare assistant and the man attended an ACCT review. The man talked about the voices he continued to hear. The nurse discussed his progress in not acting on them and he agreed that he did not currently feel suicidal or like harming himself. He said he understood how to contact the Listeners and how to access the Samaritans phone. He also agreed to continue to work with the mental health team. The nurse closed the ACCT with his agreement. A post-closure review was scheduled for 5 November.

69. The next day on 30 October, an offender supervisor went to see the man at noon and discovered him standing on his bed attempting to attach the other end of a noose tied tightly around his neck to his light fitting. He encouraged him to step off the bed and cut the noose from around his neck. After a brief discussion, he told him he had nothing to live for and thought of dying quite often. The offender supervisor opened an ACCT. The immediate action plan was completed and he was observed every hour until he could be assessed. He told a nurse that he did not know why he had made a noose.

70. A chaplain completed the man's ACCT assessment the same afternoon at 3.30pm. He said he felt down. He said voices were telling him, "meet me in hell", "end it all" and "you are an idiot". He said he wanted to die because of the voices and because he had nothing to live for. He said he was in prison, he had no job and his grandmother was very ill. He said he was very close to his grandmother.

71. The next morning, 31 October, the man attended his first ACCT case review with a nurse and a chaplain. He talked about becoming involved in charity work in the community on release. He was encouraged to think about what activities he could do in prison to prepare for this. He said he missed his grandmother and had thoughts of deliberately harming himself. A nurse completed the caremap with a single goal for him to find activities to keep himself occupied and improve his prospects for employment. In order to do this, he was to complete wing applications and think about his future and going to college or working. The level of observations was set at one per hour.

72. At 1.40pm, the man was seen asleep in his cell. At 4.40pm the same afternoon, an officer went to lock him in is cell and found him with a noose around his neck attempting to put the other end around his light. At 7.25pm, he was reported to be asleep. A nurse wrote in his medical record that he had engaged in a therapeutic session with a nurse (not named) after he was found with the noose and would be seen for his one-to-one session the next day. There is no other record of this incident. At interview, a number of staff from the unit told the investigator that he tied nooses whenever it was suggested that he would go to a standard houseblock. On 2 November, a nurse saw him and reported that he had kept a low profile but was eating well.

73. On 6 November, the man attended an ACCT review with a nurse. He said he wanted to kill himself because he was distressed about his voices. He was taking medication to help reduce the impact of these. He told the nurse that he was going to court later that week and was expecting to be released. The level of observations remained the same and no change was made to the caremap. A psychiatrist saw him the same day. He noted that he stayed in his cell either sleeping or watching TV. He did not take part in activities. Every time staff spoke about moving him to a standard wing he devised a noose "without planning or concealment". The psychiatrist said the medication appeared to have reduced his distress.

74. On 9 November, the man attended Crown Court. His ACCT shows that he said he was happy with proceedings when he returned to his cell in the court custody area. When he returned to Elmley at 4.00pm, he told an officer in reception that he felt suicidal but had no current plans to kill himself. The next entry on the on-going record is at 8.00pm when he was reported to be asleep. There is no reference to his comments in reception in the medical record or wing observation book. He was reported to be stable with no concerns over the next two days. He ate well, mixed with his peers and used the telephone.

75. On 12 November, a consultant forensic psychiatrist from forensic pathways assessed the man together with the prison psychiatrist. He appeared subdued and was not very talkative. The psychiatrist concluded that his delusional systems were being resolved by his medication. He thought that his voices and visions were a result of anxious overlay and this had led to the previous diagnosis of malingering. He did not currently fit the criteria for transfer to hospital. The psychiatrist thought that he was a low risk of harming others but was at high risk of low severity self-harm (for example by mild cutting). He suggested "watchful waiting" and asked to be informed if his situation changed.

76. On 13 November, the man attended an ACCT review with a nurse, one of the Muslim chaplains and an officer. He said he still had thoughts of self-harm and did not want to engage in any activities, preferring to remain in his cell. He said he received support from his girlfriend and was happy that he had been referred to hospital. No changes were made to either the level of observations or the caremap.

77. According to the ACCT on-going record, at 11.48am on 16 November at lunchtime lock up a prison officer found the man with a noose. He was moved to the gated cell. There is no reference to this incident on the medical record or in the wing observation book but it appears that he returned to his own cell in the afternoon and did not spend any time on constant supervision.

78. An entry in the wing observation book at 9.00am on 17 November (signature illegible), reminded staff that the man had been due for an ACCT case review on 16 November and this had not taken place. He attended an ACCT review with a healthcare assistant and a nurse at 4.50pm that afternoon. There was no reference to the incident with the noose the previous day. He said he had thoughts of self-harm but was currently able to manage them. He asked to remain in the inpatient unit until his court appearance on 7 December. No change was made to the level of observations or caremap. The HCA wrote on his medical record that he appeared settled in mood and spent most of his time in his cell with minimal engagement with others.

79. On 21 November, the man attended an ACCT review with a nurse and staff. He said he would try to hang himself if he was moved from the inpatient unit as other prisoners had done this in the past and not been moved. The nurse said he planned to discuss with the psychiatrist and the Head of Healthcare how best to support him if he moved to a standard wing. He said the normal wings were too noisy. The nurse told him he could remain as a day patient and sleep on a wing but he did not want to. No change was made to the level of observations or caremap.

80. On 22 November, an operational manager wrote on the senior management team ACCT check sheet that no case manager had been named, there were no dates on the caremap and the first case review had been completed a day late.

81. At 10.20am on 28 November, the man attended an ACCT review with a nurse and a chaplain, prompted by the death of another prisoner in the inpatient unit. He said the death had not increased his desire to harm himself. At 5.15pm, he set fire to some paper in his cell. Staff put it out and removed his lighter. A comment on the ACCT on-going record says that he did not appear to know what he had done. The next day he attended a scheduled ACCT review with a nurse and staff. He said he would harm himself and make nooses if he was moved to a standard wing, which were too noisy. His observations were set at once during the day and once at night.

82. The man's behaviour was settled over the next couple of weeks with normal speech, no sign of auditory hallucinations or paranoid ideas. He told an ACCT review with a nurse and a chaplain on 13 December that he continued to want to self-harm because he wanted to be released from prison. He said he had split up from his partner and did not want any input from the mental health team. He wanted to remain in the inpatient unit and not transfer to a standard wing. He confirmed that he knew how to contact a Listener and access the Samaritans phone.

83. On 17 December, the man went to Crown Court. His medical record shows he slept well the night before and that there were no concerns before or after attending court. He was remanded back to Elmley pending a court appearance on 8 January.

84. At 8.15pm on 20 December, the man complained of feeling hungry and said he had traded his breakfast pack that afternoon. He then set fire to something in his cell in front of staff. Officers put it out and removed his lighter. He was reported to be quiet over the next week. He slept a lot but ate well and interacted appropriately with staff.

85. On 28 December, the man told a nurse and a chaplain at an ACCT review that he was finding it difficult to get up in the mornings, have a shower and clean his cell. He still thought about harming himself but had no active plans to do so. He was looking forward to his next court appearance to see if he was released. The caremap was reviewed and it was discussed that he was finding it difficult to get up early, have a shower and clean his cell. Staff were to prompt him to do this. He declined the offer of joining in with activities.

86. Two days later on 30 December, staff held another ACCT review with the man. The review agreed that he presented a low risk of self-harm and was to be re-assessed as part of the discharge process from the inpatient unit. It was written on the caremap that he was better at getting up in the mornings and the goal was ticked as completed. The ACCT was closed. The on-going record notes that he was "fairly settled in mood and behaviour" though he still presented with poor mental health. He denied being actively suicidal.

87. On 5 January 2013, a manager interviewed the man for his ACCT post-closure review. The manager said his self-harm and suicide attempts related to his desire to be discharged from prison and his anxiety at being moved to a standard prison wing. He said he would talk to the mental health team if he wanted support. He did not sign the post-closure interview form.

88. On 8 January, the man attended Crown Court. At 7.50pm that evening, he rang his cell bell and told a nurse that he had cut his wrist with a small metal clip. She described the cut as superficial and only one or two centimetres in length. He said he was feeling low after his court appearance and just wanted to talk. He told her that his girlfriend had unexpectedly given evidence in court against him and he might be facing a four year sentence. He said his girlfriend had been using his credit cards. She advised him to discuss his options with his solicitor and officers. She said he did not show any signs of suicidal intent and talked to her about the future, including his court case and the long term future of his relationship with his girlfriend. He told her he did not want to commit suicide he just did not want to be in prison. She gave him Nytol and Kalms to help him sleep. She did not open an ACCT but increased the frequency of observations by the nursing team.

89. The man attended court again the next morning on 9 January. A nurse saw him in reception before he left and described him as calm and relaxed. He said he was feeling okay. At court he was convicted of threats to kill, ABH,

two counts of battery and damaging property. When he got back to the prison he told a nurse that he had pleaded guilty and was due to be sentenced in about a month's time. He said he expected to be sentenced to four years imprisonment. The nurse said he appeared calm and relaxed and his speech was normal in tone. He responded and engaged well and maintained good eye contact. He said he had felt low the previous day and had made cuts to his wrists. He said he did not feel suicidal or have any intention to self-harm. He said he was not experiencing abnormal thoughts but admitted that he had been quite "mentally ill" in the past. He said he had good family support but they had not been able to visit him due to distance. The nurse told another nurse about the conviction. He was noted to be unsettled until about midnight, talking to himself and trying to get the attention of the prisoner in the adjoining cell.

Day of the incident

90. At 10.00am a doctor saw the man who told her that he did not feel very well "mentally" and was hearing voices. The doctor wrote in his record that he was physically well but was in the inpatient unit under the care of the mental health team.

91. At 2.40pm, Nurse A unlocked the man's cell after the lunchtime break and discovered him hanging from a noose made from a bed sheet tied to the main light fitting. The nurse pressed the general alarm bell. At the same time, two prisoners came into the cell. Nurse B also arrived in response to the alarm bell. The two prisoners and Nurse A held him up while Nurse B cut the noose with his cut down tool. He was laid on the floor. He did not appear to be breathing and Nurse A could not find a pulse. Nurse A began chest compressions at a rate of 30 compressions to two breaths.

92. A nurse brought the emergency response bag from the treatment room and attached a defibrillator to the man's chest. The nurse also inserted an airway into his mouth and used an ambu-bag to give him oxygen. The defibrillator instructed staff to continue with cardio pulmonary resuscitation (this means that it was unable to detect a heart rhythm). Two nurses took over chest compressions and oxygen and then a number of staff continued in rotation.

93. An ambulance was called at 2.41pm. A nurse inserted a canula into the man's arm at about 2.55pm and, at about 3.05pm, a prison GP administered adrenaline and glucose solution via an intravenous line. The first ambulance crew arrived at the prison at 3.01pm and at the cell at 3.06pm. A second crew arrived at the prison at 3.06pm. At 3.20pm, the helicopter emergency medical service (HEMS – the air ambulance) arrived. They were escorted to the cell and took over from the paramedics. The HEMS doctor pronounced him dead at 3.42pm.

94. The duty governor and two POs managed the incident and completed the death in custody contingency plans. All the prisoners were locked in their cells. A log was kept of all staff in attendance.

95. A hot debrief took place at 5.30pm. All the staff involved in managing the incident and in attempting to resuscitate the man were present. He had last been seen alive at the lunchtime roll check, but the prisoner who occupied the cell next to him told staff he had spoken to him about 15 minutes before the general alarm was pressed.

96. A prison chaplain attended the inpatient unit at about 3.00pm and also one of the prison's staff care team. The staff involved told the investigator that they were satisfied with the level of support offered to them. One member of staff was still waiting for an appointment with the staff care team and this was fed back to the liaison officer.

97. A memorial service was held for the man on the inpatient unit later that afternoon. Five Listeners came to the wing and the prisoners were unlocked so that they could visit each cell and offer support. The inpatient unit orderly (a trusted prisoner) said that he had spoken to the Listeners and also been offered counselling.

98. Three letters written by the man the day before his death were retrieved from the prison post. The letters were written to his mother and his mother's previous long-term partner and asked them to send him postal orders for £20 by recorded delivery.

Family liaison

99. A prison chaplain acted as the prison's family liaison officer (FLO). The man had given his uncle's name and address as his next of kin. The police advised the chaplain that they should be present when prison staff went to the house. At 6.30pm, the FLO, a chaplain and the Deputy Governor drove to the address, arriving at 7.45pm, and told the police they were there. No one appeared to be at home. The police arrived at about 8.50pm. They found correspondence at the house addressed to a different person. The prison staff decided to return to the prison to make further enquiries but, on the way back, the police told them that they had gone back to the house and the lights were now on. The prison staff went back to the house where they found the man's uncle and broke the news of his nephew's death.

100. The man's uncle told them where his nephew's mother lived. They offered to go and see her and break the news, but he said he would do this. The FLO subsequently spoke to the man's mother. His family were offered the opportunity to visit the prison and see where he had lived. The prison offered financial assistance with the funeral in line with Prison Service guidance.

Post-mortem examination

101. A post-mortem examination gave the cause of death as suspension. The pathologist did not give an estimated time of death, but commented that in cases of suspension, unconsciousness can develop almost immediately with a suggested average time of some 10-15 seconds. Following the loss of

consciousness the heart will stop in a time period from almost immediately to approximately one to two minutes.

ISSUES

The man's mental health care at Elmley

102. The man was judged to have overtly psychotic symptoms during his first reception health screen and was referred for a mental health assessment. This took place the next day and he was admitted to the inpatient unit as a result. The day after that, he was referred urgently to a GP, who saw him within an hour. He remained an inpatient throughout his time in Elmley. He was treated with anti-psychotic medication that appeared after some weeks to control his acute symptoms. In September, he was referred for assessment for transfer for hospital treatment but his symptoms had improved by the time this took place in November and he was not admitted.

103. The man was managed on a care plan involving daily one-to-one contact with mental health nurses. In addition, he was regularly assessed and his care plan reviewed after significant events. Despite a history of admission to hospital and a diagnosis of malingering, all of the mental health staff interviewed believed him to have been very ill during his first few months at Elmley. The psychiatrist was concerned that his previous diagnosis of malingering would affect his future treatment and, after discussion with another psychiatrist, an alternative diagnosis of "anxious overlay" was given.

104. In his clinical review, the reviewer concludes that the man's management was appropriate and his medication was in keeping with the diagnosis. He said the interactions recorded in the notes suggest a very careful and well applied management plan for a vulnerable man. He notes that his assessment by a psychiatrist was obtained more quickly than it would have been in the community. He concluded that his mental state was variable and this made him difficult to assess. There was evidence in the last two months of his life that he had been feeling more mentally well and that much of his low mood related to his possible sentence and a potential discharge from the inpatient unit.

Management of the man's risk of self-harm in custody

Use of safer cells

105. On 17 August, the man was put into a safer cell with minimal items, in the inpatient unit. At the time, a psychiatrist had judged him to be acutely psychotic and not to have mental capacity. It is not clear from the records provided how long he spent in the safer cell but there is nothing to suggest that he was moved from the safer cell until his move to a gated cell on 6 September. However long he was in the safer cell, he was clearly, and we think properly, regarded as a risk to himself. Prison Service Instruction PSI 64/2011 – Safer Custody, points out that safer cells cannot resolve the problems underlying a prisoner's self-harming or suicidal behaviour and cannot replace the individualised and multi-disciplinary care plan for prisoners at risk of self-harm. We understand that he was being cared for by the mental health team, but consider, as we indicated in a previous investigation report

about a death at Elmley, that when a safer cell is used to manage a prisoner's risk, an ACCT should always be opened.

The Governor and Head of Healthcare should ensure that an ACCT is opened whenever it is considered that a prisoner's risk needs to be managed by location in a safer cell.

Use of ACCT in the healthcare inpatient unit

106. Examination of the two ACCT documents opened on the man shows that both were opened appropriately. However, we are concerned, that there was a disjunction and some confusion between healthcare procedures in the inpatient unit and the ACCT procedures, indicated by the use of the safer cell referred to above and some of the decisions about risk. At times, healthcare staff appeared to regard the ACCT system as a prison process, separate from and unrelated to their care plans. PSI 64/2011 specifically says that ACCT plans for prisoners in healthcare units must be managed in line with the same procedures as prisoners on normal wings. We acknowledge that he was managed on a care plan to help address his mental health problems and that he received significant input from the mental health team. However, the ACCT process serves a different purpose – to reduce the person's risk of suicide and self-harm by identifying issues and working towards resolving them through a caremap in a multi-disciplinary way. One process does not obviate the need for the other. It is important that prisoners at risk of self-harm are managed effectively under the ACCT process, no matter where they are in the prison and no matter what other interventions they are receiving, to ensure they are kept as safe as possible. We make the following recommendation:

The Governor and Head of Healthcare should ensure that the ACCT process is managed and conducted effectively for prisoners in the healthcare inpatient unit who are at risk of suicide or self-harm.

107. The man was placed on constant supervision between 6 and 11 September. The guidance contained in PSI 64/2011 is that constant supervision should be used only during acute crisis and for the shortest time possible. Both psychiatrists had both diagnosed him with acute psychosis and he appeared to be very distressed during this period. Although five days is longer than we would like to see someone on constant supervision, we are satisfied that this was a crisis period for him. However, prisoners on constant supervision should have daily multi-disciplinary case management reviews for the first 72 hours. We have seen no evidence that a review took place on 7 September.

108. Although several staff attended more than one ACCT review, there was no named case manager and no one who consistently chaired reviews. This was pointed out on management checks but no action appears to have been taken to remedy the situation. Six different staff chaired the 13 case reviews on the first ACCT. Three different staff chaired the ten reviews on the second ACCT. There does not appear to have been a case review on 16 November despite

the man tying a noose that lunchtime. When a review took place the following day, there was no mention on the record of the noose.

109. We are concerned that the number of different staff involved in the ACCT review process meant that there was a lack of continuity of care, which might in turn have affected the effectiveness of the process. We are also concerned that a review that should have taken place while the man was on constant supervision appears not to have been done. Such reviews are a fundamental part of the process in keeping prisoners safe. We make the following recommendation:

The Governor and Head of Healthcare should ensure that prisoners subject to ACCT procedures in the inpatient unit have a named case manager who ensures that ACCT reviews are held as required and, where possible, chairs each case review to ensure continuity of care.

ACCT Caremaps

110. The caremaps on both ACCTs were inadequate. The caremap should reflect the reasons for the prisoner's needs, level of risk and triggers for distress and deal with the issues identified by the ACCT assessment. In the man's case, these were his grandmother's health, housing, his financial problems and the possibility of a mental health transfer. None of these appeared on the first caremap. The only issue identified by the first case review and put on the caremap was for him to apply for a new pin number for the prison phone system. If this was the only issue that actually needed to be addressed, we would question why an ACCT was necessary. The issues noted as causing him distress were not addressed in the caremap and therefore there was therefore no effective plan to manage his risk. The issues and actions required on both caremaps often had no target date for completion. The first two actions required on the first ACCT were marked as completed the day after the ACCT was opened. No new action was added until 17 October. That meant that for five weeks, there was no plan for reducing his risk.

111. The caremap is the vital tool in the ACCT process to ensure that the factors that mean that a prisoner is at risk of suicide or self-harm are appropriately addressed. In the man's case, the review team do not appear to have understood the reasons he was at risk, and therefore did not put a suitable plan in place to help him address these issues. We make the following recommendation:

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 the ACCT on 30 December 2012

112. We have a number of concerns that the ACCT was closed on 30 December. Christmas and New Year is known to be a period of heightened risk in prison and, as the man had been on an ACCT for four months by this time, it seems to us that it would have been prudent to have left the ACCT open until after this period. Perhaps more importantly, he was due in court the next week. Court appearances are known to be another trigger which increases risk of self-harm and the run-up to them can also be very unsettling for prisoners, as the outcome of the appearance might result in a change of status or transfer to another prison.

113. The ACCT review of 30 December noted that the man was due to be reassessed as part of the discharge process from the inpatient unit. PSI 64/2011 gives specific instruction about moving prisoners on ACCT from healthcare. The PSI states "If a move to normal location is likely within a foreseeable timescale, the ACCT must remain open until the move has taken place and the prisoner has settled in their new accommodation". In this circumstance, we do not believe that the ACCT should have been closed while a change in location was evidently being considered, particularly as this was a clear and known trigger for him to self-harm.

114. The man had many of the risk factors outlined in PSI 64/2011. On 28 November, he had set a fire in his cell and said that he would tie nooses if moved to a wing. On13 December, he said he had split up with his partner. He had set a cell fire on 20 December and on 28 December he said he still felt like harming himself. It is hard to see how these risks had been sufficiently mitigated to justify closing the ACCT on 30 December, or how he had demonstrated that he could remain stable for an extended period of time. A caremap objective discussed, at a review on 28 December, for him to get up early, have a shower and clean his cell and was marked as achieved only two days later. Again we do not consider this to be sufficient evidence of an improved pattern of behaviour to suggest his risk had reduced significantly. We make the following recommendation:

The Governor should ensure that ACCTs are closed only with the full agreement of a multidisciplinary case review panel, who have fully taken into account all risk factors and are satisfied that these have been addressed.

Assessment of risk in January

115. The man harmed himself after returning from court on 8 January. Although this appears to have been a superficial cut, a nurse was sufficiently concerned to have asked her colleagues to check on him overnight. While in itself this might have been a reasonable response, we believe that in the circumstances it would have been appropriate to open an ACCT. He had harmed himself after returning from court (a known trigger for self-harm), where he said his girlfriend had unexpectedly given evidence against him. When he returned from court the next day, where he was sentenced (which is another known

trigger) he reported making cuts to his wrists the day before, although he was described as engaged and in a relatively good mood. That night, he was observed talking to himself in his cell and, the next morning, he told a doctor that he was hearing voices.

116. We believe that there was sufficient evidence of risk in this period to suggest that staff should have opened another ACCT. For a prisoner with the man's history of mental health problems, a court appearance and sentencing was always likely to prove difficult for him. Any episode of self-harm should have prompted the opening of an ACCT, especially as the staff involved in his care at this time knew him well and should have been fully aware of his history. However, it seems that they relied more on his presentation and not on the two episodes of self-harm, observation of him talking to himself and hearing of voices, which would suggest that he was in need of structured support. We make the following recommendation:

The Governor and Head of Healthcare should ensure that all staff are aware of their responsibility to open an ACCT if there is any indication that a prisoner has thoughts of suicide or self-harm and take account of all known risk factors.

Emergency response

117. Prison officers help with locking and unlocking cells on the inpatient unit. For safety reasons, the prisoners are not unlocked until a certain number of staff are present. On the day the man was discovered, a psychiatrist placed another prisoner on constant supervision, which resulted in some nurses taking a later lunch break than usual. A combination of this and a delay waiting for officers meant that the prisoners were unlocked about an hour later than they might usually expect, although Elmley is a busy local prison and lunchtime unlock is not at a set time each day.

118. It was therefore 2.40 pm, an hour later than the routine, when the man's cell was unlocked and he was found hanging. It is not possible to say whether he thought he might be discovered by staff when he was still alive, as he had been on previous occasions when he tied a noose. He was not on an ACCT and therefore there was no requirement to check him that lunchtime.

119. A nurse promptly summoned assistance by pressing the emergency bell outside the man's cell. Two prisoners were immediately on scene as they were already unlocked. The prisoners helped release him from his noose by which time other nurses were on the scene with emergency equipment. CPR was started at the correct ratio of breaths to compressions. A defibrillator was attached and the instructions were followed. He was also given adrenaline. As he was in the inpatient unit it is difficult to see how the response to finding him could have been more prompt. All the equipment was in working order and the staff worked effectively as a team to try to save his life. We are satisfied that there was an appropriate emergency response.

RECOMMENDATIONS

1. The Governor and Head of Healthcare should ensure that an ACCT is opened whenever it is considered that a prisoner's risk needs to be managed by location in a safer cell.

   The prison accepted this recommendation and responded:

   "A Notice to Staff will be issued (that will include all Healthcare providers) re-enforcing that an ACCT must be opened whenever it is considered that a prisoner's risk needs to be managed by location in a safer cell. The case manager will document the location reasons on the caremap plan and discuss at the ACCT review."

2. The Governor and Head of Healthcare should ensure that the ACCT process is managed and conducted effectively for prisoners in the healthcare inpatient unit who are at risk of suicide or self-harm.

   The prison accepted this recommendation and responded:

   "All providers of Healthcare have been reminded that the ACCT process must be managed and conducted effectively for all prisoners located in IPD.

   "All healthcare staff (directly employed and agency) have to complete ACCT awareness training before being allowed to commencing employment. All ACCTs have a daily management check by the manager or supervisor of the area the prisoner is held within, plus there are weekly management checks completed by a member of the SMT."

3. The Governor and Head of Healthcare should ensure that prisoners subject to ACCT procedures in the inpatient unit have a named case manager who ensures that ACCT reviews are held as required and. Where possible, chairs each review to ensure continuity of care.

   The prison accepted this recommendation and responded:

   "All IPD Managers have been informed that they will take responsibility as named Case Managers ensuring that the ACCT process is robustly followed and provide quality assurance.

   "There are 3 designated IPD managers of which 1 will be allocated as the primary case manager for each patient subject to ACCT whilst located in IPD. At the start of each day during briefings a key worker is allocated to prisoners who are on ACCT documents by the IPD manager. If the primary case manger is on duty they will conduct the ACCT reviews for their prisoner. All ACCTs have a daily management check by the manager or supervisor of the area the prisoner is held within, plus there are weekly management checks completed by a member of the SMT."

4. 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.

   The prison accepted this recommendation and responded:

   "A Notice to Staff will be issued (that will include all Healthcare providers) re-enforcing that caremap plans are completed with realistic goals set and discussed as part of the ACCT review process which is documented with an up-date on the caremap plan and review document.

   "Care Maps are reviewed & discussed with the prisoner at each ACCT review and this will be recorded in the text as agreed suitable by both the prisoner & multi-disciplinary review panel. All ACCTs have a daily management check by the manager or supervisor of the area the prisoner is held within, plus there are weekly management checks completed by a member of the SMT."

5. The Governor should ensure that ACCTs are closed only with the full agreement of a multidisciplinary case review panel, who have fully taken into account all risk factors and are satisfied that these have been addressed.

   The prison accepted this recommendation and responded:

   "A Notice to Staff will be issued (that will include all Healthcare providers) re-enforcing that ACCTs are closed with the full agreement of a multi-disciplinary team with all risk factors being discussed and the panel are satisfied that these have been addressed.

   "It is to be recorded in the review that all of the multi-disciplinary team conducting the review are in agreement that a document can be closed. Safer Custody team to review all closed documents after post closure. Safer Custody department to be included in clinical governance meetings to discuss all action plans relating to DICs and update until all actions are complete.

   "All ACCTs have a daily management check by the manager or supervisor of the area the prisoner is held within, plus there are weekly management checks completed by a member of the SMT."

6. The Governor and Head of Healthcare should ensure that all staff are aware of their responsibility to open an ACCT if there is any indication that a prisoner has thoughts of suicide or self-harm and take account of all known risk factors.

   The prison accepted this recommendation and responded:

   "A Notice to Staff will be issued (that will include all Healthcare providers) re-enforcing staff's responsibility as directed in the PSI 64/2011 that all known risk factors are considered when an ACCT is opened.

“All healthcare staff (directly employed and agency) have to complete ACCT awareness training before being allowed to commence employment. All ACCTs have a daily management check by the manager or supervisor of the area the prisoner is held within, plus there are weekly management checks completed by a member of the SMT. Training in Introduction To Safer Custody/Refresher training is currently ongoing with courses being planned on a monthly basis. Level of risk is discussed and reviewed at each ACCT review by the multi-disciplinary team.”