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 November 2013 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 investigation report into the death of a man at HMP Isle of Wight in November 2013. The man died from loss of blood as a result of cutting his neck. He was 52 years old. I offer my condolences to the man's family and friends.

The investigation was carried out by an investigator. A clinical reviewer reviewed the man's clinical care in custody. HMP Isle of Wight cooperated fully with the investigation.

The man had been at HMP Isle of Wight since July 2013. About three weeks after he arrived, he reported concerns about his safety and said he had heard other prisoners, who he was unable to identify, mentioning his name and threatening violence. It does not appear that any formal investigation was carried out or that the man was offered any additional support at that stage. The man continued to be anxious about his safety and, in October, he made a written complaint that he had heard other prisoners having aggressive and threatening conversations about him which was affecting his mental wellbeing. Officers could find no evidence of threats being made and began to consider that his anxieties were the result of mental stress.

On Saturday 2 November, officers referred the man to the mental health team because of their concerns, but the team did not receive the referral until Monday 4 November, after his death. The officers had discussed the risk of suicide and self-harm with the man, who assured them he had no such intentions. On 3 November, the man's cell mate told staff that he no longer wanted to share a cell with him as he was finding it difficult to continue supporting the man with his anxieties. The man was moved to a single cell on another wing later that day. The next morning, he was found in his cell with severe cuts to his neck. The emergency response was swift but, sadly, the man had died.

It would have been difficult to predict the man's actions on 4 November, but the investigation identified some missed opportunities to support him. In particular, it is a concern that staff did not make an earlier mental health referral when it became apparent that the man was very anxious. Prison staff cannot be expected to diagnose mental health problems, but need to be trained to recognise signs of illnesses that require professional intervention. I am also concerned that, on 2 November, officers discussed with the man whether he intended to harm himself but no record was kept of this and there was no further assessment of his risk when he was moved to a single cell on a different wing the night before he died, when his increased vulnerability should have been recognised.

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 2014**

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SUMMARY

1. On 17 August 2012, the man was sentenced to 14 years imprisonment for sexual offences. On 31 July 2013, he transferred to HMP Isle of Wight.

2. The man was reported to be a quiet man who spent most of his free time reading in his cell and did not mix much with other prisoners. On 20 August 2013, the man put in writing to his wing officers his concerns about his safety. He said that he had heard other prisoners, whose identity he did not know, mentioning his name and threatening violence. The man's personal officer told him that they needed more information about the other prisoners before anything could be done. A security information report was completed to document the man's concerns, but it appears that there was no further investigation or action taken at that stage.

3. On 21 October 2013, the man made a formal complaint that he was not being protected from other prisoners' aggressive and threatening conversations about him and that this was affecting his mental wellbeing. As part of the response, a supervising officer (SO) and a wing officer discussed his concerns with him, but were unable to find any evidence of threats being made. In a written response, outlining what they had agreed they could do to help him, the SO indicated that a mental health referral might help the man with his anxieties, but the SO did not make a referral at that point.

4. On Saturday 2 November, the man spoke to the SO and another wing officer about the written response he had received to his complaint. During the conversation, the officers decided that a mental health referral was necessary and made one that day. They considered whether the man might be suicidal, but the man said he had no thoughts of killing himself.

5. The man's cell mate told the investigator that the man had seemed frightened and paranoid for some weeks, but he had seen no evidence that other prisoners were threatening him. He reported that, on 2 November, the man appeared to be very anxious, was awake a lot at night and paced up and down the cell. He said that he did not want to eat anything, even when his cell mate brought his meals to the cell. On Sunday 3 November, the man's cell mate told staff that he felt that he could no longer support the man and did not want to share a cell with him any longer. Staff believed that, in addition to the man's anxious behaviour, he had disclosed the details of his offence to his cell mate, but his cell mate said this was not the case.

6. The man moved to a single cell on another wing on the afternoon of 3 November. Staff on his new wing were unaware of the reasons for the man's move. No further consideration was given to whether he was at risk of suicide and self-harm and needed additional support and monitoring.

7. On Monday 4 November, at a routine early morning roll check, the man was found in his cell with a severe cut to his throat. Although there were signs that he had already died, prison staff tried to resuscitate the man, until paramedics arrived and pronounced his death.

8. The investigation found that some opportunities to support the man were missed. An earlier referral to the mental health team might have been

appropriate. We are concerned that, although prison staff were aware of the man's fears and his cell mate had reported his extreme anxiety on 3 November, they did not brief staff on his new wing about the background to his move that day. We consider that his risk of suicide and self-harm should have been assessed again when he was moved to a single cell on another wing. We make recommendations about these issues and about the need to adhere to the local policy to reduce violence. While it would not have affected the outcome for the man, we consider there is need to ensure that staff use appropriate emergency medical codes in a life threatening situation and to clarify emergency procedures at night.

THE INVESTIGATION PROCESS

1. Notices announcing the investigation were issued to staff and prisoners at HMP Isle of Wight, inviting anyone with relevant information to contact the investigator. The investigator interviewed two prisoners who responded.

9. The investigator visited HMP Isle of Wight on 11 November 2013 and obtained copies of the man's prison records. She met staff who knew the man and visited the wing where he died. The investigator interviewed staff and prisoners on 23 and 24 January 2014 and gave preliminary written feedback to the governor during the investigation.

10. NHS England commissioned a clinical reviewer to review the man's clinical care at HMP Isle of Wight. The clinical reviewer was present during all interviews.

11. The investigator informed HM Coroner for the Isle of Wight of the investigation who provided a copy of the post-mortem report. We have sent this investigation report to the Coroner.

12. One of the Ombudsman's family liaison officers contacted the man's mother and her niece to explain our investigation. The investigator and family liaison officer visited the man's family on 29 January 2014 who had the following questions and concerns for the investigation to consider:

    - His family found it difficult to visit him and believed that this would have affected his mood. They wanted to know why he had been transferred so far away and why he had not been moved closer to home when he had requested it.
    - His family were concerned that the man was not identified as being in need of extra support on the afternoon of Sunday 3 November when his behaviour was worrying enough for him to be moved to a different wing. They believed extra checks should have been made.
    - The man had coped well at his previous prison and his family wanted to know what happened at the Isle of Wight to cause such a decline in his mood and why staff had not noticed this and given him extra support.
    - His family wanted to know how the man had the means to kill himself and what the policy was for checking prisoners during the night.
    - His family considered that the written response to the man's complaint was inadequate and wanted to know why was there a delay between his complaint and a referral to the mental health team.

13. The man's family had sight of a draft of this report and made no comments n response to it. NOMS provided a response to our recommendations and these appear at the end of this report.

HMP ISLE OF WIGHT

13. HMP Isle of Wight is an amalgamation of two prisons, Parkhurst and Albany. The prison mostly holds sex offenders. The man lived on the Parkhurst site.

HM Inspectorate of Prisons

14. The last inspection of HMP Isle of Wight was in June 2012. It found 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 (IMB)

15. Each prison in England and Wales has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community, who help ensure that prisoners are treated fairly and decently. In its most recent annual report for 2012 the IMB commented that after a mental health service review in 2012, referrals to the mental health team had doubled, with about 220 referrals a each quarter. Restraints on services often meant only short term support could be offered for immediate crises and the use of self-help material was promoted. The IMB was satisfied with Assessment, Care in Custody and Teamwork (ACCT) procedures and said that the prison adopted a multidisciplinary approach to dealing with prisoners at risk of suicide and self-harm. The IMB reported that there were violence reduction officers on each wing and that there was through monitoring with careful recording of the progress of both victims and perpetrators.

Previous deaths at HMP Isle of Wight

16. We have investigated a number of previous deaths at HMP Isle of Wight, most of which were a result of natural causes. The last self-inflicted death was in December 2012 and there are no similarities with the circumstances of the man's death.

Assessment, Care in Custody and Teamwork (ACCT)

17. Assessment, Care in Custody and Teamwork (ACCT) is the Prison Service process for supporting and monitoring prisoners at risk of harming themselves. Once a prisoner has been identified as being at risk, 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

18. The man had a criminal record for theft, burglary, violence and firearms offences. He was given his first custodial sentence when he was 16 years old and served several short sentences in young offender institutions and adult prisons. On 17 August 2012, the man was sentenced to 14 years imprisonment for sexual offences.

HMP Altcourse and HMP Parc

19. The man was sentenced in August 2012 and initially taken to HMP Altcourse. Due to the nature of his offences, he was identified as a vulnerable prisoner to be kept separate from the general prison population. On 18 August 2012, a member of the mental health team assessed the man because of the length of sentence he had been given. He said that he had no previous mental health problems and no thoughts of suicide or self-harm.

20. On 27 September 2012, the man transferred to HMP Parc. At his induction assessment, the man told staff that he did not feel depressed and had no thoughts of harming himself.

21. On 3 December 2012, at a monthly personal officer interview, the man said that he was low in spirits because of his long sentence. He had a job in a workshop at Parc, but spent a lot of his spare time in his cell reading and did not mix with other prisoners. The man said that he was a long way from his home in the North West of England and he did not receive many visits.

HMP Isle of Wight

22. On 31 July 2013, the man transferred to HMP Isle of Wight and was sent to the Albany site. The reception assessment completed by a nurse on 1 August 2013 described the man as calm and lucid. On 18 August 2013, the man moved to the Parkhurst site where he and another prisoner asked to share a cell together as they knew each other from HMP Parc.

23. On 20 August 2013, the man submitted a wing application form in which he reported that he feared for his safety. His personal officer spoke to him to find out more and the man said that he had heard other prisoners mentioning his name and threatening violence, but said he did not know who they were. An officer suggested a move to another wing, but the man said that this would not help as he felt that the problem would follow him. The officer told the man that he needed more information about the identity of the alleged perpetrators before he would be able to take action.

24. The officer completed a security information report about what the man had told him. He also completed a report to the prison's safer custody team who use them to manage incidents of violence or threats by prisoners. The safer custody team did not complete the second half of the report or carry out any further investigation. The man was not offered any support from the safer custody team.

25. On 30 August, the officer noted in the man's prison record that he had not raised any further concerns with staff about his safety. In September 2013, the officer made two further personal officer entries in the man's prison record. Both entries noted that the man was very quiet and spent a lot of time in his cell. The officer told the investigator that it was not unusual for prisoners to choose to do this.

October 2013

26. On 21 October, the man completed a complaint form, which staff received on 23 October. The man said that he was concerned about his safety due to other prisoners' aggressive and threatening conversations about him and that this was affecting his mental wellbeing.

27. On 23 October, a member of staff assessed the man's suitability for the Thinking Skills Programme (an offending behaviour programme). She recorded in the man's prison record that he had talked about concerns about his safety and that he had said that he felt other prisoners were planning to attack him. The staff member discussed the implications of this for him attending the course and afterwards submitted a security information report.

28. On 24 October, a Supervising Officer (SO) and an officer met the man to discuss his complaint. The man said he was unable to identify who was making threats against him, which he said were coming from outside a window.

29. The officers suggested options to help the man including getting out of his cell more, mixing with other prisoners during exercise periods, getting involved in work, speaking to the mental health team and moving to a different wing. They also suggested getting help with some legal issues that the man said were worrying him. The man again said that a wing move would not help his situation. The SO asked the man to start keeping a note of what threats were being made, and at what times, which would enable staff to investigate his allegations. The SO told the investigator that he had not been convinced that the man was being threatened, but he needed to try to establish if there was any evidence before he could be sure of this.

30. The SO told the investigator that after this meeting he had made enquiries about possible threats to the man. He asked night staff to listen for anything and also spoke to the man's cell mate. The SO could find no evidence of threats being made and he wrote a response to the man on 25 October explaining this and detailing the actions that they had agreed to support him. These actions included getting the man a prison job to help him mix with other prisoners and that 'it may be best to refer you to the mental health in-reach team to help you with your anxieties'. However, no mental health referral was made at this time.

31. The man attended one individual session and two group sessions of the Thinking Skills Programme on the week commencing Monday 28 October 2013. A programme facilitator on the course told the investigator that the man voluntarily contributed during the group sessions and she had no concerns about his wellbeing on the course.

Saturday 2 November 2013

32. On Saturday 2 November, an officer and SO had a long discussion with the man. The officer told the investigator that the man had wanted to discuss the SO's written response to his complaint with her.

33. The man said that he still felt that he was being threatened. The officer told the investigator that they had discussed a possible wing move. The officers suggested a move to Phoenix wing as it was 'self-contained' and prisoners mainly stayed on the wing to work and had their own exercise yard. The man said that he did not want to move wings and that his preference would be transferred to a prison closer to his home. The SO told the investigator that they had explained to the man that it was not possible to arrange a transfer immediately as he was due to be assessed for a sex offender treatment course. The SO said that this information did not seem to "sink in" and that the man continued to be preoccupied with needing to move to another prison.

34. Both officers told the investigator that the man appeared not to understand that the prison was a mainly sex offender population and that he was fixated on the idea that other prisoners knew what his offence was. (The age of the victim of the man's offence might have made him more vulnerable to threats and intimidation if other prisoners became aware of it.) The man told the officers that prisoners had got information about him and his offence from his paperwork. When the officer asked how others would have got this he told her "I put it down the toilet and they got it out".

35. The man handed the officers a sheet of notes setting out his thoughts about the threats being made against him. The notes did not provide any evidence of specific threats, but suggested that the man was feeling increasingly anxious. Both officers thought that a mental health referral should be made. The SO said that it appeared that the man might have been hearing voices.

36. The SO told the investigator he had hoped they could "fast track" his referral to the mental health team. The man thought that he already had an appointment booked with the mental health team for some time during November so the officer telephoned the healthcare team to check this. There was no record of the man having an appointment so the officer was advised to complete a routine mental health referral, which she did. The mental health team received this referral on Monday 4 November, after the man had died.

37. The officer told the investigator that she and the SO had openly discussed suicide and self-harm with the man, the officer said that they did not open an ACCT because he did not appear to be at any heightened risk. The SO told the investigator that he explicitly asked the man whether he thought he would take his own life and the man said he would not. Neither of the officers made an entry about this in the man's prison record. The SO told the investigator that he believed that the prison's anti-bullying procedures, Challenging Anti-Social Thinking, were not appropriate to use with the man because there was no actual evidence of threats.

38. The officer said that she had encouraged the man to go outside during exercise periods to try and "involve him in the wing". After their discussion,

the man went outside for an exercise period and his cell mate walked around with him.

39. The man's cell mate told the investigator that, about one month before the man died, he had started to seem frightened and paranoid. The man's cell mate said that he had asked other prisoners if any threats were being made against the man and did not find any evidence of this. The man's cell mate said that in the weeks before the man's death, he was awake a lot at night and pacing in the cell. He said on 2 November the man wanted the cell door to be closed and he would not go out to get his meals. He had brought food to the cell for the man, but he would not eat it.

Sunday 3 November 2013

40. On Sunday 3 November, the man's cell mate asked the SO if the man could be moved. He said that the man had been pacing the cell all night and going to the window. The man's cell mate told the investigator that he felt that he was not the right person to help and that he could not cope with the man any more.

41. The SO said that the man's cell mate had told him that the man had disclosed the details of his offence to him. The SO told the investigator that this information had led him to decide to move the man. He explained that they moved the man rather than the man's cell mate to see if this would stop the man from hearing voices. The man's cell mate said that he was disappointed that he did not feel able to share with the man anymore as they had known each other for some time.

42. The officer also told the investigator that she believed that the man's cell mate had said that he had become aware of the man's offence. The man's cell mate disagreed with the officers' accounts and told the investigator that he did not know what the man's offence was and that they had not discussed it.

43. The SO examined the options for moving the man. He told the investigator that a single cell was necessary because his pacing and anxiety could have put him at risk from another prisoner in a shared cell. There is no inpatient healthcare unit at the Parkhurst site and at the time there was no cell available on Phoenix wing, which the SO felt would be most appropriate as many of the older prisoners lived there.

44. The SO identified an available cell on C wing and explained to the man that he would be moving to a single cell. He agreed to this and moved to C wing at around 4.15pm that afternoon. There was no further discussion with the man about how he felt or any evidence that consideration was given to whether his risk of suicide or self-harm had increased. No entries were made in his prison record or in the C wing observation book about the background and reasons for the move. C wing night staff told the investigator that they were not aware of the reasons why the man had been moved.

Monday 4 November 2013

45. An officer was on night duty on 3/4 November. He told the investigator that he was not aware that the man had moved onto C wing that afternoon. At approximately 5.35am on Monday 4 November, the officer began a morning check to ensure that all prisoners were present in their cells. When he arrived at the man's door he opened the observation flap and turned the night light on to check he was in the cell. He noticed at first that the man's mattress was half on the bed and half on the floor and then that the man's legs were on the floor pointing away from the door. The officer thought that he could see blood in the cell. He kicked the door to try and get a response, but there was none.

46. An officer was also working a night shift on C wing, supervising a prisoner who needed a constant watch as he was at high risk of suicide. The officer alerted another officer that something was wrong in the man's cell. The officer told the investigator that, as the prisoner he was supervising was asleep, he went to assist the officer. Both officers agreed that they needed to go into the cell. One of the officers radioed for the custodial manager in charge of the prison to attend. The officer did not use an emergency medical code and told the investigator that asking the custodial manager to attend at night would make it obvious that something was wrong.

47. As the man was lying behind the door, the officers decided it would be best to open the door outwards and so went to the wing office to obtain an anti-barricade key which would allow them to do this. The officer telephoned the control room to request an ambulance. The officer told the investigator that while he was in the office he also collected several pairs of gloves as he thought he had seen blood in the cell.

48. The officers had already begun to unscrew the bolts on the door when the custodial manager arrived and they went into the cell. All three members of staff told the investigator that the man appeared lifeless, his body was stiff and he had deep cuts to his shoulder and neck. The custodial manager, who was first aid trained, immediately began chest compressions. The officer brought a defibrillator (a life-saving device that gives the heart an electric shock in some cases of cardiac arrest) that was kept on the wing.

49. The defibrillator was applied twice, but detected no shockable heart rhythm so the custodial manager continued with chest compressions until paramedics arrived at 5.45am. The paramedics asked the custodial manager to continue with chest compressions while they analysed the man's condition. Shortly after, at 5.52am, they pronounced the man dead.

50. The paramedics found a small pencil sharpener blade, which was next to the man's head on the floor, which appeared to have been used to cause his injuries. The cause of the man's death was recorded as exsanguination (blood loss) and an incised wound to the neck.

Support for prisoners

51. Prisoners on the wing where the man had died, and on the wing where he had transferred from, were informed of his death by an operational manager when they were unlocked in the morning. A room with Listeners (prisoners who are

trained by the Samaritans to offer emotional support) and refreshments was made available on both wings. All prisoners subject to suicide and self-harm monitoring procedures were reviewed in case they had been adversely affected by the man's death.

Support for Staff

52. Shortly after the man was declared dead, the operational manager held a debrief meeting to support the prison staff involved in the emergency response. This allowed the night staff to go home without significant delay. The majority of officers who spoke to the investigator reported that there was good support available after the man's death. One member of staff told the investigator that he had been treated in an insensitive way by others and his comments about his experience were passed to the Governor.

Family liaison

53. The prison appointed a family liaison officer. The man's nominated next of kin was his mother, whose home was a long way from the prison so the prison arranged for family liaison officers from HMP Risley, to break the news of the man's death. This was done early that afternoon.

54. The family liaison officer spoke to the man's mother by telephone to help organise funeral arrangements and offered financial assistance in line with national guidance. The family liaison officer and an officer attended the man's funeral and visited his mother at her home that day.

ISSUES

Clinical care

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

Mental health

56. The man moved to the Parkhurst site of the Isle of Wight on 18 August. Just two days later he reported to prison staff that he feared for his safety. Staff attempted to establish more details about the threats that the man believed were being made against him. They were unable to obtain hard evidence of any actual threats or intimidation and, when he raised his concerns again in October, the SO and officer who spoke to him began to wonder whether the man's fear and anxieties were the result of mental health problems.

57. The man's cell mate and an officer both told the investigator that the man thought that a mental health referral had been made for him. When the officer checked on 2 November, this had not happened. A routine mental health referral was not made until Saturday 2 November 2013 and not received by the mental health team until after the man had died.

58. The clinical reviewer found evidence from interviewing staff and prisoners that would suggest that the man had clinical depression. The clinical reviewer reports that, while the man did not himself report low mood, opportunities were missed at an earlier stage to identify that he was in need of support and potentially at risk of harming himself. We consider that there was enough evidence on 24 October, when the SO and an officer met the man, to have referred him to the mental health team. By that stage, they thought that his fears about threats were unfounded and he had told them that the threats were coming from outside his window. However, this was less than ten days before his death and we cannot know whether a routine referral at that point would have led to effective mental health intervention to alleviate the man's anxieties in such a short time.

59. It might have been reasonable to make an urgent referral for the man on Saturday 2 November, given his increasingly anxious behaviour and his belief that he could hear people talking about him. However, there are no mental health staff in the prison over the weekend and so, in any event, no one from the mental health team would have been able to see him until the beginning of the following week.

60. It is unfortunate that the input of mental health professionals who might have been able to identify ways to support the man and establish the cause of his anxieties at an earlier stage was not sought. The clinical reviewer makes a recommendation about staff training in mental health awareness and we agree this would be helpful to assist staff in identifying behaviour which might prompt a referral to the mental health team. This reflects a finding of HM Inspectorate of Prisons in 2012, that too few operational staff had had mental health awareness training. We make the following recommendation:

The Governor should ensure that staff working with prisoners receive adequate awareness training to understand when to refer prisoners to the mental health team.

The man's location

61. The man's family, who live in the North West of England, were concerned that his move to the Isle of Wight made it difficult to visit him and that this affected his mood. The investigator was unable to find any written reason in the man's records for his allocation to the Isle of Wight or who made the decision. The prison explained that the man, like all offenders, would initially be placed in a local prison after his conviction to be assessed and then moved to an appropriate establishment to meet his offending behaviour needs. They considered that the man was appropriately allocated to HMP Isle of Wight, as he was convicted of serious sex offences. As part of his sentence plan, he would need to participate in the sex offender treatment programme that the prison provides in order to reduce his risk of reoffending. The prison is geographically isolated, but it is a specialist prison for sex offenders which allows them to be treated in a safer environment than would be possible in most category B prisons. The prison said that, as almost all prisoners at the Isle of Wight are sex offenders, violence towards them as a result of their offences is rare.

62. Where possible prisoners should be held near to their homes to facilitate visits from family members, not least because supportive contact with families can be a protective factor against suicide and self-harm. We have been unable to establish whether any other prisons nearer to the man's home were considered, but we recognise that there are relatively few category B prisons which run the sex offender treatment programme. Allocating prisoners to appropriate prisons to meet their offending behaviour needs will usually take priority and it is not possible to conclude that the Isle of Wight was an inappropriate allocation for the man.

63. At HMP Isle of Wight, the man shared a cell with a prisoner who he knew from HMP Parc. They shared a cell for a number of months and the man's cell mate appears to have been a source of support for him. Staff suggested a transfer to a different wing on various occasions when the man raised concerns about his safety, but he was adamant that he did not want this.

64. On Sunday 3 November, the man was moved to a single cell on C wing after the man's cell mate felt that he could no longer help him and was himself disturbed by his behaviour. The SO told the investigator that the man's cell mate had also become aware of the details of the man's offence, although the man's cell mate denies any knowledge of this.

65. It has not been possible to establish for certain whether the man's offence had become known. The SO believed this to be the case and said this was a key factor in his decision to move the man to C Wing. Although the SO had been involved in a referral to the mental health team the previous day, he did not consider that any additional monitoring or support were necessary when the man transferred to C Wing. He told the investigator that he contacted C wing and asked staff to look at the case notes in the man's prison record which explained the background to why he was being moved. We have not been

able to establish who the SO spoke to on C wing and no entries were made in the man's record on the day of his move to explain the reasons.

66. The staff working on C wing that night said that they were not told anything about the man's move in their handover and therefore had no interaction with him. Prisoners are not routinely checked during the night unless there is a specific reason, such as those who have been identified as needing to be monitored as at risk of suicide or self-harm.

67. We consider that the man was particularly vulnerable that evening. He had been moved from a cell, where he had the support of a prisoner whom he knew well, to a single cell on a different and unfamiliar wing with staff he did not know. He had said on a number of occasions that he did not want to move wings, but was moved due to his increasingly paranoid and unusual behaviour and the possibility that he had disclosed the details of his offence. While we agree it was reasonable to find an alternative location for the man, particularly as his cell mate was becoming stressed by the situation, we are concerned that he was moved, without staff on his new wing being briefed about the circumstances. Even though he had not been identified as at risk of suicide and self-harm, a move in such circumstances would be likely to have added to his stress and anxieties. Full briefing might have led to extra checks that evening and night to help ensure his wellbeing on the new wing. We make the following recommendation:

The Governor should ensure that relevant wing staff are appropriately briefed about the circumstances of any non-routine moves and that the reasons are entered in the prisoner's case notes and in wing observation books.

The man's risk of suicide and self-harm

68. The man reported concerns about his safety a number of times between August and November. With hindsight after his death, it appears that his anxiety had increased significantly in the previous weeks and that he was in need of more formal support than the friendship of his cell mate. It is not clear what prompted the decline in the man's mood. There is no evidence that he was genuinely at risk from other prisoners and, unless he hoped to get a move to another prison, the escalation in his fears for his safety seems to have been a sign of a decline in his mental health and his ability to cope.

69. The officer and SO both told the investigator that, on 2 November, the man explicitly rejected their suggestions that he might have any thoughts of harming himself. However, they did not record this anywhere. It does not appear that the issue of his risk of suicide and self-harm was revisited with the man on 3 November, when he was told that he would be moving to another wing and away from the support of his cell mate, whom he had previously relied on. Given the background to the man's behaviour and his concerns, it is apparent that this move would have significantly increased his anxiety and therefore his potential risk of suicide and self-harm.

70. While we recognise that there was no clear evidence that the man was at risk of suicide and self-harm, we are concerned that none of the staff involved appear to have considered the potential increase in risk when the man was

moved and that no one explored this with him, either before or after the move, even though this appears to have been considered the day before (although not documented.) Nor did the staff alert any managers that the man might be at increased risk. This is a particular concern as the man was moving away from the protective environment of a shared cell with a prisoner he appeared to trust and it is likely that his risk was heightened. We make the following recommendation:

The Governor should ensure that all staff are alert to the circumstances which might increase a prisoner's risk to themselves, communicate any concerns to managers, consider opening an ACCT plan and record decisions in the appropriate documents, including the prisoner's record and wing observation books.

Items available to the man

68. The man's family were concerned that he had access to the means to injure himself. Prisoners have access to a wide range of items in their daily lives which they can use to harm themselves and it would not be possible to remove all such items. When prisoners have been identified as at particular risk of suicide and self-harm there should be consideration of whether items they could use to harm themselves should be removed. Even then, removal of possessions is usually kept to the minimum necessary for safety, otherwise there is the risk of undermining further a vulnerable prisoner's feeling of self-worth. As the man had not been identified as at risk of suicide or self-harm there was no reason to consider removing any of his possessions from him, including the pencil sharpener that he used to cut himself with.

Procedures to protect prisoners at risk of harm from others

72. In line with national instructions, HMP Isle of Wight has its own policy for managing and preventing violence and bullying in the prison. The challenging anti-social thinking (C.A.S.T) policy sets out procedures for how to deal with anti-social behaviour and support victims. When the man first reported that he was being threatened to his personal officer filled out the appropriate form to notify the safer custody team. However, in the records made available to the investigator only half of the form was completed. It was not possible to see from the documents what support was offered to the man as a possible victim or whether this incident was investigated any further. Several of the staff who the investigator interviewed were unclear on how use the C.A.S.T policy to support prisoners such as the man. We make the following recommendation:

The Governor should ensure that staff are appropriately trained to use challenging anti-social thinking procedures and that all allegations of threats and violence are thoroughly investigated and recorded.

Emergency response

71. There was no significant delay in the emergency response when the man was discovered, and officers began to attempt cardio-pulmonary resuscitation (CPR) quickly. Paramedics arrived quickly. However, the evidence indicates there were signs of rigor mortis present at the time the man was found and

resuscitation would not have been possible. Because of this, the clinical reviewer suggests that staff are given guidance about when it is acceptable not to perform CPR, to minimise the distress for all involved.

72. While the emergency response was quick, and in any event it would not have been possible to save the man, we are concerned that a medical emergency response code was not used. This would alert all those involved to the nature of the incident and prompt control room staff to call an ambulance automatically rather than waiting for a separate request, as happened here. In this case, there was a defibrillator on the wing, but we were told these were not provided on every wing at Parkhurst and officers were concerned that one would not always be available. Healthcare staff at the Isle of Wight are based at the Albany site at night and it is not clear from the prison's local emergency procedures whether they are expected to respond to medical emergencies at night and, in their absence, who is excepted to bring emergency equipment.

73. Prison Service Instruction (PSI) 03/2013, issued at the beginning of February 2013, required prisons to use standard medical emergency response codes in life threatening incidents and this is reflected in the prison's local procedures. The fact that a code was not used, suggests that the system is not yet embedded at the Isle of Wight. The officer who called for the custodial manager in charge of the prison to attend said it would have been obvious that 'there was a problem'. However, the nature of the problem would not have been apparent: the purpose of emergency codes is to prompt specific actions in response to the type of incident identified. To avoid potential delays in future, we also consider there is a need to clarify responsibilities for attending emergencies and bringing appropriate emergency equipment. If there are no healthcare staff on duty, there needs to be an identified first aid trained responder. We make the following recommendation:

The Governor should ensure that all prison staff are made aware of and understand PSI 03/2013 and their responsibilities during medical emergencies and that HMP Isle of Wight has a Medical Emergency Response Code protocol which:

- **Provides guidance to staff on efficiently communicating the nature of a medical emergency;**
- **Specifies who should attend and that staff called to the scene bring the relevant equipment; and**
- **Ensures there are no delays in calling, directing or discharging ambulances**

RECOMMENDATIONS

1. The Governor should ensure that staff working with prisoners receive adequate awareness training to understand when to refer prisoners to the mental health team.

2. The Governor should ensure that relevant wing staff are appropriately briefed about the circumstances of any non-routine moves and that the reasons are entered in the prisoner's case notes and in wing observation books.

3. The Governor should ensure that all staff are alert to the circumstances which might increase a prisoner's risk to themselves, communicate any concerns to managers, consider opening an ACCT plan and record decisions in the appropriate documents, including the prisoner's record and wing observation books.

4. The Governor should ensure that staff are appropriately trained to use challenging anti-social thinking procedures and that all allegations of threats and violence are thoroughly investigated and recorded.

5. The Governor should ensure that all prison staff are made aware of and understand PSI 03/2013 and their responsibilities during medical emergencies and that HMP Isle of Wight has a Medical Emergency Response Code protocol which:

    - Provides guidance to staff on efficiently communicating the nature of a medical emergency;
    - Specifies who should attend and that staff called to the scene bring the relevant equipment; and
    - Ensures there are no delays in calling, directing or discharging ambulances

PRISONS AND PROBATION OMBUDSMAN for England and Wales
Independent Investigations

ACTION PLAN

No	Recommendation	Accepted/Not accepted	Response	Target date for completion and function responsible	Progress (to be updated after 6 months)
1	The Governor should ensure that staff working with prisoners receive adequate awareness training to understand when to refer prisoners to the mental health team.	Accepted	Operational staff undertake mental Health awareness training as part of the ongoing local training plan. Currently 168 operational staff have received this training as part of then ongoing process to train all operational staff. Our training department run 1 course a month with 12 attendees, thus delivering a constant source of information for new staff or refresher training as necessary.	Head of Corporate Services/Head of Healthcare Target date is ongoing as either initial or refresher course for all operational staff.	
2	The Governor should ensure that relevant wing staff are	Accepted	All staff have been reminded that 'Every Contact Matters' and that they should be recording on NOMIS	Head of Residence Services	

	appropriately briefed about the circumstances of any non-routine moves and that the reasons are entered in the prisoner's case notes and in wing observation books.		all key events and decisions that effect prisoners. A notice to staff (NTS 295-13) reminding them of this requirement has been issued.	(Completed)	
3	The Governor should ensure that all staff are alert to the circumstances which might increase a prisoner's risk to themselves, communicate any concerns to managers, consider opening an ACCT plan and record decisions in the appropriate documents, including the prisoner's record		Currently 88.8% of all staff in post are trained in either the original ACCT foundation training or the new introduction to safer custody course. This course covers the issues raised by the PPO. The Head of Safer Custody issued notices to staff relating to being vigilant about potential circumstances which may increase a prisoners risk of self harm, and additional risks over the holiday period (published 9 December, 2013), which included further advice	Head of Corporate Services Ongoing as training is delivered to all staff.	

	and wing observation books.		in response to changes from lessons learnt from DIC and PPO investigations (issued locally 8 May, 2014).		
4	The Governor should ensure that staff are appropriately trained to use challenging anti-social thinking procedures and that all allegations of threats and violence are thoroughly investigated and recorded.	Accepted	Since the man's death, the prison has reviewed the Safer Prisons reports (which are completed by staff when they witness a violent act or believe someone is being bullied, and are then passed to the safer custody and security departments for further investigation) to ensure procedures have been correctly followed, and reviewed the Challenging Anti Social Thinking (CAST) policy. The Governor has issued Operational instruction 6 – 2014 to remind staff that all allegations of threats and violence are both investigated and recorded. Associated training will be delivered to staff via monthly functional briefings and at full staff meetings.	Head of Safer Prisons and Equalities 16 July, 2015	

			This is also an objective in staff SPDR which is open to constant review.		
5	The Governor should ensure that all prison staff are made aware of and understand PSI 03/2013 and their responsibilities during medical emergencies and that HMP Isle of Wight has a Medical Emergency Response Code protocol which: a)Provides guidance to staff on efficiently communicating the nature of a medical emergency; b)Specifies who should attend and that staff called to the scene bring the	Accepted	An operational instruction has been reissued in order to ensure that all staff are aware of the need to communicate effectively with the control room and medical services during an emergency incident, who should attend the scene, and the process for calling and discharging ambulances. This was issued in March 2014. An updated version including identifying equipment that staff attending a scene should bring will be published.	Head of Safer Prisons and Equalities 16 July, 2014	

	relevant equipment; and c)Ensures there are no delays in calling, directing or discharging ambulances				