A Report by the Prisons and Probation Ombudsman Nigel Newcomen CBE

Investigation into the death of a man at HMP Elmley on 27 November 2014

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, who was found hanged in his cell at HMP Elmley on 27 November 2014. The man was 52 years old. I offer my condolences to his family and friends.

The investigator was appointed. A clinical reviewer reviewed the man's clinical care at Elmley. Staff at Elmley co-operated fully with the investigation.

The man had been in prison a number of times before and in May 2011, received an indeterminate prison sentence. He had been at Elmley since October 2013. In May 2014, prison staff began suicide and self-harm prevention procedures when the man said he had taken an overdose of medication because other prisoners were bullying him. He would not name the prisoners, but little was done to investigate the allegation. Staff moved him to another houseblock, which appeared to resolve his problems. However, in September, staff moved him back to his previous houseblock, without any apparent consideration of the implications.

On 22 November, the man was taken to hospital when he complained of chest pains and was admitted overnight for observations. He was discharged the next day with no sign of any cardiac event. While he was at hospital, another prisoner told the unit manager that the man had taken an overdose to get off the houseblock as he was in debt to other prisoners. No one began suicide and self-harm prevention procedures, and there is no evidence that anyone spoke to the man about this. Three days later, the man took 20 paracetamol tablets and was taken to hospital again. Staff treated this as an isolated incident, related to tooth pain, rather than as a pattern of self-harming behaviour and did not identify him as at risk of suicide and self-harm. When he returned from hospital on 26 November, a nurse refused the man's request to be admitted to the prison's healthcare unit, as he was not acutely unwell. The next morning, an officer found the man hanged in his cell.

I am concerned that prison staff did not identify the man as a risk of suicide or self-harm in the week before his death, particularly as he had a history of harming, or threatening to harm himself, when he felt that he was under threat from other prisoners. It is also worrying that no one appears to have spoken to the man about the allegation that he took an overdose on 22 November or began suicide and self-harm prevention procedures when he said he had taken an overdose on 24 November. I am also concerned that violence reduction measures at Elmley appear to have been ineffective and staff did not consider the possible link between bullying and the risk of suicide and self-harm.

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 **July 2015**

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SUMMARY

1. The man arrived at HMP Elmley in October 2013. He had been to prison a number of times before and had previously been managed under Prison Service suicide and self-harm prevention procedures (known as ACCT) for short periods.

2. In May 2014, the man told prison staff that other prisoners on Houseblock 4, where he lived, had assaulted him and stolen some of his property. Later that month, he took an overdose of medication and an officer began ACCT procedures. The man refused to name the men who he said had bullied him and staff moved him to a different houseblock. He said that the bullying stopped after his move. Staff ended the ACCT procedures in June.

3. The man moved back to Houseblock 4 in September. It is not clear why he returned to the houseblock or whether staff considered the implications. We do not know if the prisoners who had allegedly bullied him were still there.

4. On 22 November, the man was taken to hospital when he complained of chest pains and was admitted for observations. The next day, a prisoner told a manager that the man had taken a substantial amount of illicitly obtained medication because he wanted to get off the houseblock as he was in debt. No one began ACCT procedures and there is no evidence that anyone discussed the situation with the man. The hospital found no significant problems and discharged the man on 23 November. His friend told us that the man had told other prisoners that he had swallowed a packet of drugs in hospital and would pay off his debts when the drugs passed through his system. The man's friend believed this was a ruse to delay paying his debts for drugs he had been obtaining from other prisoners.

5. The man went to hospital again on 24 November, after he said he had taken 20 paracetamol tablets and other medication, because of pain caused by a loose tooth. No one considered this in the light of the previous information or begin ACCT procedures. When the man came back to the prison on the evening of 26 November, he asked to be admitted to the prison's healthcare inpatient unit, but a reception nurse decided that there was no clinical reason.

6. The next morning a prison officer found the man hanged in his cell. There were differing accounts of whether the officer used the appropriate emergency code, and no one called an ambulance until the first healthcare asked for one. Staff began cardiopulmonary resuscitation, but after further emergency treatment, paramedics confirmed that he had died.

7. We found that prison staff should have identified that the man was at risk of suicide and self-harm and begun ACCT procedures when they received information that he might have taken an overdose. Violence reduction procedures were ineffective and no one considered the possible link between the risk of suicide and self-harm. Poor emergency procedures meant that the prison did not call an ambulance immediately, but we understand that the prison has now taken action to address this. We make two recommendations.

THE INVESTIGATION PROCESS

8. The investigator issued notices to staff and prisoners at HMP Elmley informing them of the investigation and inviting anyone who had relevant information to contact him. No one responded.

9. The investigator went to Elmley on 2 December 2014, visited the houseblock where the man had lived and spoke to one of the man's friends. He met the prison's family liaison officer and a member of the prison's Independent Monitoring Board. He obtained a copy of the man's prison records.

10. The investigator interviewed nine members of staff at Elmley in January and February 2015.

11. NHS England commissioned a clinical reviewer to review the man's clinical care in prison.

12. We informed HM Coroner Mid-Kent and Medway of the investigation, who provided the results of the post-mortem examination. We have sent the coroner a copy of this report.

13. One of the Ombudsman's family liaison officers contacted the man's sister, his nominated next of kin, to explain the investigation. His sister was concerned that:

    - The man had written to an ex-girlfriend a few months before his death and said he was depressed and was going to take his life. The man's ex-girlfriend did not report this to the prison as she did not think he was serious. His sister later discovered that the man had been managed under suicide and self-harm prevention arrangements and asked us to explain why.
    - In a letter left in his cell, the man said his request to move to the prison's healthcare inpatient unit when he got back from hospital on 26 November had been refused. The man's sister thought that he should have been checked overnight as he had recently been to hospital with chest pains. The man's sister also asked us to clarify the dates and reasons for his recent hospital admissions.
    - The man's sister was aware that there had been a number of self-inflicted deaths at Elmley recently and was concerned that there might be wider failings that had contributed to the man's death.

14. The man's sister received a copy of the draft report. She did not make any comments.

HMP ELMLEY

15. 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 can hold up to 1,200 remanded and sentenced men, in five houseblocks, with a mixture of single, double and triple cells.

HM Inspectorate of Prisons

16. HM Inspectorate of Prisons last inspected Elmley in July 2014. Inspectors found an increasing number of fights and assaults and prisoners and staff told them that bullying was common. Many prisoners inspectors surveyed said that they had felt unsafe at some time and almost twice as many prisoners said they had been victimised compared to other similar prisons and the previous inspection in 2012. Inspectors found that violence reduction measures were unsophisticated and failed to address underlying causes. There had been a substantial increase in the number of incidents of self-harm and inspectors found that ACCT assessments were not always completed on time and care plans were often completed using standard objectives not tailored to individuals. Too little had been done to implement previous recommendations from the Prisons and Probation Ombudsman.

17. Inspectors found that there was too little purposeful activity and 15% of prisoners spent 23 hours each day locked in their cells. Offender management was poor and prisoners serving indeterminate sentences were not identified or supported and found it difficult to progress.

Independent Monitoring Board

18. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help ensure that all prisoners are treated fairly and decently. In its latest published annual report, for the year ending October 2014, the IMB reported on a rise in violent incidents during the year. They found that the violence reduction team had addressed this by being more proactive at targeting and challenging violent behaviour. The IMB also reported a significant increase in prisoners harming themselves over the period and subsequent increase in the number of prisoners being managed under ACCT procedures.

Previous deaths at HMP Elmley

19. The man was the eighth prisoner to die at Elmley in 2014 and the third apparently to have taken his own life. Another prisoner hanged himself the week after the man's death. Our investigation into the death of a man who died in March 2014 found that prison staff had missed opportunities to identify his risk of suicide and self-harm. We have made a number of recommendations about the need for prison staff to use the nationally required emergency code procedures and call an ambulance immediately in a life-threatening situation.

ACCT - Assessment, Care in Custody and Teamwork

20. Assessment, Care in Custody and Teamwork (ACCT) is the care planning system the Prison Service uses to support prisoners at risk of suicide or self-harm. 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 care map 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 care map have been completed. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011.

KEY EVENTS

21. In July 2010, the man was remanded to prison for charges of burglary. He had been in prison several times before. The man was dependent on drugs and began an opiate reduction programme. The man suffered from angina, which was sometime treated in hospital. Prison doctors prescribed him medication for depression. Staff assessed the man as at high risk for sharing a cell, because there was information that some of his previous offences had been racially aggravated. He therefore spent most of his time in prison in a single cell and refused to share a cell with anyone.

22. Prison staff supported the man under ACCT procedures several times, usually for around a week at a time. Staff began ACCT procedures twice in 2011, including in May 2011, when the man received an indeterminate sentence for public protection, with a minimum period to serve of five and a half years before he could be considered for release. In 2012, prison staff managed the man under ACCT procedures when he said he had taken an overdose because he was in debt to other prisoners who were threatening him. Security information suggested he might have invented the overdose to get moved from his wing. In 2013, prison staff opened another ACCT as the man was in a very low mood and said that other prisoners had stolen some of his clothes and he was scared of being attacked by them. He told prison staff that he had tried to hang himself in 1991, after the deaths of his father and brother.

23. On 28 October 2013, the man moved to Elmley from HMP Swaleside. On 23 March 2014, officers saw the man take a package from a visitor. He spent the night in the prison's segregation unit. On 27 March, someone put a note under the staff office door on Houseblock 4, where the man lived, which said that the man had taken the package because he was under threat from other prisoners. There is no record of the action taken as a result.

24. On 17 May, two unidentified prisoners assaulted the man in his cell. The man said that he knew who the prisoners were but did not want to name them. He said that the two prisoners had also stolen his trainers a week before and had come back for his stereo. The man said that he tried to fight them off and this led to the assault. An officer completed a security information report and on 19 May, the prison's violence reduction team asked a residential manager, to investigate the incident. There is no evidence that the residential manager undertook any investigation.

25. On 24 May, the man took an overdose of medication and said that other prisoners were bullying him and had taken some of his possessions. A Supervising Officer (SO) began ACCT procedures and noted that the man would benefit from a move to another houseblock. The next day, an officer assessed the man, who told him that prisoners were bullying him for no reason. He said he had owed someone a packet of tobacco, which he had paid back, but they had taken his stereo anyway. The man also said that he had lost contact with his children and was not making any progress in his sentence.

26. The SO chaired the first ACCT case review on the afternoon of 25 May, with the officer. There was no member of healthcare staff present. The officer recorded that the man appeared very nervous and did not say much during the review. They discussed the man's issues on Houseblock 4 and agreed to arrange a move to another houseblock when a space became available.

27. On 29 May, a prison nurse, reviewed the man's risk assessment for keeping prescribed medication in his possession. Although he incorrectly noted that the man had not taken an overdose while he had been in prison, the nurse concluded that the man should now collect his medication each day and take it in front of a nurse.

28. On 31 May, the man moved to Houseblock 2. On 4 June, the SO and a prison chaplain, held another ACCT review. The man said he was no longer being bullied since he had moved houseblock. The SO noted that he was more positive and settled since the move and the ACCT was closed.

29. On 16 June, an officer from the prison's safer custody team spoke to the man about the bullying he said he had experienced on Houseblock 4. The officer told us that he went to see the man as the residential manager had not responded to the request to investigate the assault on 17 May. The man told the officer that he did not want to name the prisoners who had taken his things but said he had experienced no problems since he had moved to Houseblock 2.

30. On 19 September, the man climbed onto the safety netting that separates landings on Houseblock 2. A friend of the man told us that he did this in protest about being locked in his cell for much of the time. Officers talked the man down from the netting and took him to the segregation unit. The man spent a week in the segregation unit. He told an officer that he wanted to take part in the offending behaviour courses he needed to do as part of his sentence plan and that he did not feel that anyone was listening to him.

31. On 26 September, the man moved from the segregation unit to Houseblock 4. He was allocated a cell on A Spur, where he had lived before his move to Houseblock 2 in May. It is not clear why he returned to Houseblock 4 or whether staff considered the circumstances of his earlier move. As he had not identified them, we do not know whether the prisoners who had allegedly bullied the man in May were still there.

32. Officers on Houseblock 4, who knew the man, said that he got on well when he came back and did not raise any issues with them. The Supervising Officer (SO) said that the man's only concern was that he wanted to move to a prison in the north to be nearer his family.

33. The prisoner who was friends with the man also moved to Houseblock 4, and lived on the same spur. He told us that the man began to smoke spice (a synthetic cannabis or new psychoactive substance that can be considerably stronger than cannabis) around once a week. However, in the week or so

before his death, the prisoner said that the man had seemed very down and had smoked spice every day.

34. The prisoner said that the man appeared very low when he saw him collecting his medication on 22 November. Later that morning, the man complained of chest pain, which he said was not relieved when he used his glyceryl trinitrate spray (GTN, a spray used to ease angina pain). Prison nurses called an emergency ambulance, which took the man to the Medway Maritime Hospital in Gillingham.

35. On 23 November, the prisoner told the SO that the man had taken “loads of pills” because he wanted to get off the houseblock as he was in debt. The SO recorded in a security information report that the prisoner told her that the man hoped that he would get a family visit in hospital to pay off his debts and had said for some time that he would do anything to get out of Elmley. (Although the man had little contact with his family.) The prisoner told us that he had also told the SO that the man had said that he was thinking about hanging himself. The SO said she did not recall this. The SO submitted a security information report and reported the conversation to the duty manager. She told us that she did not begin ACCT procedures as the man was in hospital, but would have done had he been in the prison. The duty manager told us that he contacted the escort officers so they could alert hospital staff about the possible overdose.

36. Hospital doctors found no evidence that the man had experienced a cardiac event. They prescribed a course of isosorbide mononitrate (medication to prevent angina attacks) and paracetamol, and planned for him to return for an outpatient scan. The man returned to Elmley on the afternoon of 23 November. The prisoner said that, after the man got back, he told other prisoners that he had swallowed a packet of drugs in hospital and would pay off his debts when this came out. The prisoner believed that this was a ruse by the man to delay paying his debts. No one began ACCT procedures when the man got back to Elmley.

37. On the morning of 24 November, a prison doctor prescribed isosorbide mononitrate and paracetamol, as the hospital had advised. In line with his risk assessment, the man had to collect these medications each day from the houseblock treatment hatch. That afternoon, the man told prison staff that he had a very loose tooth. He saw the nurse and said that he had taken 20 paracetamol tablets and four other unknown tablets for the pain, which he had obtained from another prisoner. The nurse sent the man to hospital for assessment and observation. The prisoner told us that the man’s tooth had not been loose beforehand and he thought the man might have loosened it himself in order to get off the houseblock.

38. The duty manager noted that there was security information suggesting that the man might pick up drugs while he was in hospital, to pay off a debt. He asked the ambulance crew whether the man could go to Maidstone Hospital rather than Medway Maritime Hospital but they were not able to divert to

another hospital. The manager told us that he agreed to him going as he did not want to delay the man's treatment.

39. Also on 24 November, the violence reduction team began an investigation into the issues highlighted in the SO's security information report. The officer told us that the form they used to initiate the investigation was one used for 'prominent nominals' - prisoners who themselves have been involved in bullying or violence in the past. He wrote "refused to name" next to an entry relating to the security information report on the duty manager's daily briefing sheet. The officer could not remember clearly, but said it was likely he had telephoned Houseblock 4 to see whether anyone had spoken to the man about this and was told that he did not want to name anyone involved. There is no record of anyone talking to the man about this.

40. The man returned to Elmley on the evening of 26 November and asked the reception nurse if he could go to the prison's healthcare inpatient unit for "respite". The nurse told us that the man was not in pain and appeared very well. She said that she could not admit him to the inpatient unit, as he was not acutely unwell and there were no clinical reasons for her to do so. The nurse said that the man walked away muttering to himself when she explained this.

41. The officer remembered speaking to the man when he arrived back on Houseblock 4 that evening. The man had said that he was all right, and the officer then locked him in his cell. The officer said he only spoke to the man briefly, but he had no concerns about him at the time.

42. At around 5.30am on 27 November, the night patrol officer conducted a morning check of all the prisoners in the houseblock. The night patrol officer told us that the man had appeared to be asleep when he checked his cell.

43. Two officers unlocked prisoners on A Spur for work and treatments later that morning. One officer arrived at the man's cell shortly before 8.30am. He looked through the observation hatch and saw that the man was hanging from a ligature made from a piece of bedsheet, tied to his bed frame which he had turned to stand on its end. The officer shouted to the other officer that he had found a prisoner hanging and told us that he radioed a code blue medical emergency. The SO said that she heard the officer shout and call a code blue. She pressed the general alarm before going to assist. The communications room officer told us that he only heard a general alarm and not an emergency code. He recorded the general alarm at 8.29am and said that no one asked for an emergency ambulance at the time.

44. The officer opened the cell and cut the sheet from around the man's neck, while the other officer supported his weight. They placed the man on the floor and the officer began cardiopulmonary resuscitation, assisted by another officer who arrived shortly afterwards. Two members of gym staff arrived around a minute later and took over.

45. A healthcare assistant, responded to the general alarm (he also said that he did not hear an emergency code) and assisted the gym staff when he arrived. He asked someone to call an emergency ambulance and the communications room called one at 8.31am.

46. Other healthcare staff arrived with emergency equipment. They attached a defibrillator, which advised no shock. The first paramedic arrived at Elmley at 8.48am and reached the man's cell at 8.52am, followed shortly afterwards by three colleagues. At 9.34am, after emergency treatment, the paramedics confirmed that the man had died.

47. Prison staff found a note in the man's cell in which he said he was very unwell and criticised the nurse for not admitting him to the inpatient unit when he had come back from hospital the previous evening. The man wrote that he hoped that his death would help others in a similar situation in future.

48. The man had not been in contact with his family for some time and had listed his next of kin as an offender manager at HMP Wealstun (where he had last been in 2009). The prison chaplain acted as the family liaison officer and telephoned Wealstun and arranged for a member of staff there to speak to the offender manager. The chaplain found an address for the man's sister in his old prison records and asked a family liaison officer at HMP Liverpool to visit. The family liaison officer visited the address at around 12.15pm, but found no one home. He returned at around 5.00pm and a neighbour told him that the man's sister no longer lived there, but the man's nephew lived on the same road. HMP Liverpool's family liaison officer went to see him and told him that the man had died. HMP Liverpool's family liaison officer and the man's nephew then visited the man's sister and informed her of her brother's death.

49. The Chaplain telephoned the man's sister at around 7.00pm to offer condolences and spoke to her several times over the following days. The man's funeral took place on 30 November and the prison contributed to the costs in line with national guidance.

50. An officer went to see the prisoner individually in his cell to let him know what had happened and to offer support. Staff reviewed prisoners being monitored under ACCT arrangements in case they had been adversely affected by the news of the man's death. The head of safer custody debriefed the staff involved in the emergency response and offered them the support of the prison's staff care and welfare team.

51. A post-mortem examination established that the cause of death was hanging.

ISSUES

Identification of risk of suicide and self-harm

52. The man had a history of self-harm, both at Elmley and in previous prisons. There was information that he was in debt to other prisoners and therefore potentially at risk of violence. Significantly, the man's previous self-harm had often been linked to violence or threats from other prisoners, related to debt.

53. The man's friend told the SO on 23 November that the man had taken an overdose because he was in debt. The SO passed the information to the duty manager, but told us that she did not open an ACCT document because the man was in hospital and not on the houseblock. Although the information about the man's apparent overdose was widely shared, there is no evidence that anyone else considered opening an ACCT document. Staff took no further action when the man returned from hospital and there is no record that anyone even spoke to the man about the possibility that he had taken an overdose.

54. The next day, 24 November, the man reportedly took 20 paracetamol tablets plus four other tablets. He said at the time that he took the tablets because of the pain of a loose tooth. Although the duty manager considered the previous day's information from a security perspective, no one considered whether this might also have been a deliberate overdose, possibly the second in 48 hours, and whether it would be appropriate to begin ACCT procedures.

55. We consider that prison staff should have been more alert to the signs that the man was at risk of suicide and self-harm. PSI 64/2011 has a mandatory instruction that "any member of staff who receives information … which may indicate a risk of suicide/self-harm must open an ACCT". We consider that the SO should have realised that the information she received on 23 November, indicated a risk of suicide or self-harm and should have opened an ACCT document in line with national instructions. It is also a concern that the duty manager did not recognise this when the SO passed the information to him. Opening an ACCT would have led to prison staff monitoring the man more closely over the following days and allowed them to identify and address his issues. We also consider that prison staff missed a further opportunity to open ACCT procedures on 24 November, when they received information that the man had taken another overdose. While we cannot say that this would have led to a different outcome, it would have given prison staff more chance of preventing his death. We make the following recommendation:

    The Governor should ensure that all prison staff are aware of their responsibilities to manage prisoners at risk of suicide or self-harm in line with national guidelines and open an ACCT whenever they have information suggesting a prisoner is at risk of suicide or self-harm.

Bullying

56. Elmley has a local violence reduction policy which says that "appropriate sanctions for perpetrators will be applied robustly … victims will be supported and protected". The policy highlights the process for raising and investigating any form of unacceptable, violent or anti-social behaviour. First, any member of staff who witnesses, or has reported to them, such an act should complete an 'incident alert form' and pass this to the wing manager for investigation. The wing manager should then complete an investigation report and decide what action to take against any proven perpetrator. The policy requires victims to be supported and reviewed through a support plan.

57. In March 2014, prison staff received information that the man had been threatened to smuggle a package into the prison. The man was also apparently a victim of bullying in May 2014. No one completed an incident alert form, but the violence reduction team picked this up through the security intelligence reporting system. A wing manager was asked to investigate, but the officer from the violence reduction team went to speak to the man instead, as the manager had taken no action. The officer told us that this is a common problem and he and another safer custody officer have to investigate the majority of reports themselves. The man moved to Houseblock 2 and told the officer that he was happy and had no problems after the move. He did not want to name the perpetrators. There was therefore no further investigation.

58. The man returned to A Spur on Houseblock 4 in September, after spending a week in the segregation unit. It is not clear whether anyone considered whether it was appropriate to move him back to the same houseblock and spur, where he had previously been a victim of bullying. This is concerning as the prisoners who had apparently targeted him had not been identified and might still have been there. The man had no support plan for the move back and there is no evidence that anyone considered the risks that might be involved, or that anyone spoke to the man about the move and the potential implications for him.

59. In November, a prisoner told the SO that the man had taken an overdose so he could get off the houseblock because he was in fear of other prisoners who he was in debt to. The SO did not complete an incident alert form, but the violence reduction team noted the allegation through the duty manager's daily report. They completed an incident form used for 'prominent nominals', which suggested that the man might be involved in bullying himself. We are not aware of any corroborative evidence that the man had bullied other prisoners in the past and the staff who knew him described a man who did not present them with any difficulties. While the man had presented challenges during his time in prison - he refused to share a cell and had in the past told prison staff that he would assault anyone he was made to share with – he said that he had been a victim of violence and bullying several times in the past, including on Houseblock 4.

60. Again, the violence reduction team initiated an investigation rather than a wing manager. However, this seemed to involve only a telephone call to

Houseblock 4, when an unknown member of staff told them that the man had refused to name the men he was in debt to. There is no record of who had this conversation with the man and when or where it took place. The only record of the investigation is the words ‘refused to name’ hand-written on a printed copy of the duty manager’s daily report. No one spoke to the prisoner as part of the investigation. No victim support plan was initiated and, as we have previously noted, no one considered whether the man might be at raised risk of harming himself.

61. On several occasions staff at Elmley did not investigate potential bullying in line with their local policy. We do not know the impact that the alleged bullying had on the man, and he did not mention it in the letter he left in his cell. However, bullying is a factor associated with raised risk of suicide and self-harm. In June 2011, a Prisons and Probation Ombudsman’s report found that evidence of bullying and intimidation featured in 20 per cent of self-inflicted deaths we considered. In a follow up report issued in October 2011, on violence reduction, bullying and safety, we identified the importance of implementing local violence reduction strategies, investigating all allegations of bullying and recognising that prisoners who have been victims of bullying are potentially at greater risk of suicide and self-harm.

62. While it is not usually possible to draw a direct link between bullying and prisoners who take their own lives, the evidence of increasing levels of bullying and intimidation at Elmley, identified in the 2014 inspection report, and the recent rise in the number of self-inflicted deaths at the prison, suggests an urgent need for the prison to take proper measures to protect prisoners at risk of bullying and investigate any allegations effectively. This did not happen in the man’s case. We make the following recommendation:

The Governor should ensure that all information about bullying and intimidation is fully coordinated and investigated in line with the local policy and that apparent victims are effectively supported and protected with meaningful solutions which address their individual situation, including through ACCT procedures where appropriate.

The man’s request for inpatient admission on 26 November

63. The man left a note in which he strongly criticised a nurse for not admitting him to the healthcare inpatient unit when he returned from hospital on 26 November. He wrote that he was very unwell and wanted admission for respite.

64. The nurse told us that the man said to her he wanted inpatient admission for respite. However, she said that he was not in pain and appeared well. The nurse found no clinical reason to admit the man to the inpatient unit. We and the clinical reviewer agree that the nurse’s decision was correct. There was nothing to indicate that the man met the criteria for inpatient admission and it appears he may have had other reasons than medical ones for wanting to avoid returning to his houseblock.

65. The man's sister asked whether the man should have been checked overnight because of his recent hospital admission. We note that he had been discharged by the hospital and was not considered acutely unwell. As in the community, there would be no reason to monitor him more closely on health grounds and the man was able to alert staff using an emergency cell bell if he had any health problems at night. As previously noted, we consider that an ACCT document should have been opened, which would have led to some additional monitoring overnight. However, we cannot know whether this would have altered the outcome for the man and there was little to indicate that his level of risk was such that he needed very frequent monitoring.

Emergency response

66. PSI 03/2013 *Medical Emergency Response Codes,* issued in February 2013, sets out the actions staff should take in a medical emergency. It contains mandatory instructions for governors to have a protocol to provide guidance on efficiently communicating the nature of a medical emergency, ensuring staff take the relevant equipment to the incident and that there are no delays in calling an ambulance. It stipulates that if an emergency code is called over the radio, an ambulance must be called immediately. Staff should ensure there are no delays in calling an ambulance and that it should not be a requirement for a member of the healthcare team or a manager to attend the scene before an ambulance is called. Elmley uses the emergency codes 'blue' and 'red' to meet the requirements of PSI 03/2013.

67. The officer told us that he radioed a code blue emergency when he found the man and the SO said that she heard the officer make this call. The communications room operator, the other officer said that he heard only a general alarm and not an emergency code. The first healthcare responder, the healthcare assistant, also said that he responded to a general alarm and did not hear a code. We cannot be certain whether the officer used an emergency code, but this message was not received by the communications room or healthcare responders. A code blue should have led to the communications room calling an ambulance immediately and this did not happen.

We have made recommendations about poor emergency response procedures in seven previous investigations at Elmley since 2012 and there appeared to have been an unwillingness to comply with the national instruction. In our investigation report into a death at Elmley in August 2014, we directed our recommendation to the Deputy Director of Custody for Kent and Sussex. We are now satisfied that action has been taken and therefore do not make another formal recommendation about this matter.

RECOMMENDATIONS

1. The Governor should ensure that all prison staff are aware of their responsibilities to manage prisoners at risk of suicide or self-harm in line with national guidelines and open an ACCT whenever they have information suggesting a prisoner is at risk of suicide or self-harm.

2. The Governor should ensure that all information about bullying and intimidation is fully coordinated and investigated in line with the local policy and that apparent victims are effectively supported and protected with meaningful solutions which address their individual situation, including through ACCT procedures where appropriate.

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 all prison staff are aware of their responsibilities to manage prisoners at risk of suicide or self-harm in line with national guidelines and open an ACCT whenever they have information suggesting a prisoner is at risk of suicide or self-harm.	Accepted	Staff training is completed in accordance to Prison Service Instruction 64/2011. This will include all staff working with offenders. Information sharing protocols exist between partner agencies and PSP, with P NOMIS used as the platform for information sharing across departments. Where there is a risk of suicide and/or self harm, an ACCT document is opened and national guidelines complied with. As part of the ongoing local ACCT training, staff will be reminded of their ability to open ACCTs when prisoners are located at external hospital; to record information received on the risk of self-harm and to open an ACCT following an incident of self-harm.	Completed Head of Safer Custody.	
2	The Governor should ensure that all information about bullying and intimidation is fully coordinated and investigated in line with the local policy and that apparent victims are effectively supported and protected with meaningful solutions which address their individual situation, including through ACCT procedures	Accepted	A violence reduction/stability meeting is held once a week to discuss the issue of bullying within the establishment and those who are identified as perpetrators are investigated and dealt with within the Prison Rules and the local violence reduction strategy. Staff have been reminded of the procedures and victims are encouraged to disclose information regarding perpetrators but where this information is not	Completed Head of Safer Custody	

Action Plan					
No	**Recommendation**	**Accepted/Not Accepted**	**Response**	**Target date for completion and function responsible**	**Progress (to be updated after 6 months)**
	where appropriate.		forthcoming, staff will do their utmost to support victims. Where they are deemed to be at risk of suicide and/or self-harm an ACCT will be opened. Relevant risk information will be shared between departments and with partner agencies as appropriate. The Governor is confident that systems are in place to keep prisoners safe, reinforced by the outcome of the recent unannounced safer custody audit.		