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A Report by the  
Prisons and  
Probation  
Ombudsman  
Nigel Newcomen CBE

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**Investigation into the death of a man in  
December 2013 at HMP Elmley**

## ***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 20 December 2013. 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 Elmley cooperated fully with the investigation.

The man had been in prison custody since 2007 serving an indeterminate sentence, but had spent many years in a secure hospital before that. He had been at Elmley since 2008. The man had a number of mental health problems and was unable to cope on a standard prison wing. He therefore lived in the prison's healthcare centre throughout his time at Elmley.

The man suffered from high levels of anxiety and reacted badly to suggested change. As a result, he found it difficult to engage with sentence planning and was frustrated by his consequent lack of progress. Special hospitals would not accept him as the man had not previously responded well in a therapeutic environment. He was due to be assessed for suitability for a specialist unit for prisoners with severe personality disorders. He also said he was considering asking for a transfer to a prison in Scotland, to be nearer to his mother, but had not made a formal application. He had arranged to meet his solicitor on 23 December 2013 to discuss this and other matters.

On 19 December, he told a member of the mental health team that he had some concerns about the way the healthcare centre was run, but he did not seem angry or distressed. That night, he spoke to the night patrol officer several times, but did not seem particularly upset about anything. In the early hours, a member of healthcare staff noticed him pacing around his cell. He said that he had a couple of things on his mind but did not say what they were. The member of staff talked to him to try to calm and reassure him. Neither member of staff believed that he was distressed or at risk of harming himself. Shortly before 5.30am, the night patrol officer found the man hanged in his cell. Prison staff and paramedics were unable to resuscitate him and he was pronounced dead.

I am satisfied that the man received a very good standard of mental health support at Elmley and that his death could not have been foreseen or prevented. It is an obvious concern that the man spent such a long time in the confined environment of the healthcare centre at the prison, but I recognise that his underlying mental health problems made it very difficult for him to progress. While the emergency response was generally swift, an ambulance was not requested immediately as it should have been and it took too long for the prison to inform the man's family of his death.

This version of my report, published on my website, has been amended to remove the name 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. The man had numerous previous convictions and had spent time in prison before. He had been detained in a psychiatric hospital as a teenager after he had taken an overdose and, in 1991, he made a serious suicide attempt at HMP Wormwood Scrubs. He suffered from depression and alcoholism and had been admitted to psychiatric hospitals a number of times.
2. In 1992, the man was admitted to a secure hospital after he had been convicted of attempted murder. He remained hospitalised until February 2007, when he escaped. He was then convicted of having an imitation firearm, destroying property and escaping from lawful custody. Pre-sentence psychiatric reports said that he had made only limited progress in hospital and was unlikely to benefit from further hospital treatment. In October 2007, he was given an indeterminate sentence for public protection with a minimum term to serve of two years and six months. In October 2008, he transferred to Elmley.
3. The man could not cope on an ordinary prison wing because of his high levels of social anxiety and lived in the prison's healthcare centre throughout his time at Elmley. For a month at the end of 2008, he was managed under Prison Service suicide and self-harm prevention procedures, known as ACCT, after saying he had thoughts of suicide, but he was not regarded as a risk at any time after that. In April 2010, the Parole Board recommended that the man should have a psychiatric assessment, comply with a sentence plan, and be transferred to a prison which offered alcohol and victim awareness courses. The man refused to participate in his sentence planning and, at his next review in January 2011, the Parole Board recommended a full psychiatric assessment. In October 2011, a psychiatrist concluded that the man would not benefit from hospital and would be unable to cope with a therapeutic setting.
4. In April 2012, the Parole Board recommended that the man should transfer to a Dangerous and Severe Personality Disorder (DSPD) Unit to see if he could be treated there. In March 2013, a meeting was held to discuss a way forward. The referrals team in the Fens' Unit, a DSPD unit at HMP Whitemoor, was due to consider the man's circumstances in December.
5. On 19 December, the man told his solicitor that he had some issues to discuss at a meeting on 23 December, but did not say what they were. He asked one of the mental health team how he could raise concerns about the way the healthcare unit was run. In the early hours of 20 December, a healthcare assistant saw the man pacing around his cell. He said that he was anxious as he was considering whether to apply for a transfer to a prison in Scotland and was also thinking about a forthcoming meeting. The member of staff had no concerns about his safety.

6. Some time just before 5.30am, a night patrol officer looked through the cell observation panel and saw the man hanging. He summoned assistance and immediately went into the cell. Staff cut the ligature from around the man's neck and tried to resuscitate him. Paramedics arrived and took over the resuscitation attempt. However, at 6.28am, the paramedics confirmed that the man had died.
7. This investigation has found that the man received a good standard of mental healthcare at Elmley and it would have been very difficult to predict or prevent his death. We are concerned that the man lived in the healthcare centre so long without a clear plan to progress him, but we accept that his mental health problems made this exceptionally difficult. Medical records were not as comprehensive as they should have been, an ambulance should have been requested as soon as an emergency code was called and it took too long to inform the man's mother of her son's death. We make three recommendations about these issues.

## THE INVESTIGATION PROCESS

8. The investigator issued notices to staff and prisoners at HMP Elmley informing them of the investigation and inviting anyone with relevant information to contact him. One prisoner responded.
9. The investigator obtained the man's prison and medical records. He visited the prison on 14 January 2014 and spoke to the Governor, other prison staff who had known the man and some prisoners. He visited the healthcare centre where the man had lived.
10. NHS England, Kent & Medway, commissioned a clinical reviewer to review the man's healthcare and treatment at the prison. The investigator liaised with the clinical reviewer and discussed his findings with him.
11. The investigator interviewed four members of prison staff and four prisoners. He also spoke to the man's solicitor. He was unable to interview the nurse who provided emergency medical assistance to the man, as she no longer lived in the UK and could not be contacted. The man's consultant psychiatrist, was also unavailable.
12. We informed HM Coroner for Kent of our investigation and have sent the Coroner a copy of this report.
13. One of our family liaison officers spoke to the man's mother, who did not have any specific questions for the investigation to address. She commented that the chaplaincy at Elmley had been very helpful to her since the man's death. The man's mother received a copy of the draft report. She did not make any further comments.

## **HMP ELMLEY**

14. HMP Elmley is part of the Sheppey group of prisons, which includes HMP Stanford Hill and HMP Swaleside. Elmley serves the courts in Kent and holds up to 1,252 men in six houseblocks, with a mixture of single, double and triple cells. The healthcare centre includes a 29-bed inpatient unit.

## **Her Majesty's Inspectorate of Prisons (HMIP)**

15. HMIP last inspected Elmley in March 2012. Inspectors 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). Overall, offender management was described as reasonably effective.
16. Inspectors found that health care provision was good, but because of staff shortages, there was too much reliance on agency staff. Prisoners' perceptions of healthcare were poor. Prisoners with mental health problems had access to a large mental health team, which largely met their needs, but there were no counselling services at the prison.

## **Independent Monitoring Board**

17. 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 latest annual report, for the year to 31 October 2013, the Elmley IMB noted that the prison continued to house prisoners with serious mental health issues who the IMB considered should be in secure mental health facilities. A new healthcare provider had taken over in February 2013 and, although the standard of health care had improved, many healthcare staff had little prison experience. The IMB was concerned about that too few officers worked in the healthcare unit and that prisoners there spent too much time in their cells. The IMB noted that there had been three different psychiatrists attached to the prison, which did not help continuity of care for prisoners.

## **Previous deaths at Elmley**

18. The man was the fifth apparent suicide at Elmley since the beginning of 2012 and there has been another one since. We have previously made recommendations about calling ambulances in an emergency and informing a prisoner's next of kin as soon as possible after a death.

## **Assessment Care in Custody and Teamwork**

19. Assessment, Care in Custody and Teamwork (ACCT) is the Prison Service process for supporting and monitoring prisoners at risk of

harming themselves. The purpose of the 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 not be at predictable intervals to prevent the prisoner anticipating when they will occur. Part of the ACCT process involves assessing immediate needs and drawing up a caremap to identify the prisoner's most urgent issues and how they will be met. Regular multi-disciplinary reviews should be held. The ACCT plan should not be closed until all the actions of the caremap have been completed.

## KEY EVENTS

20. The man had a long history of suffering from depression. When he was 15, he took a drug overdose and was admitted to a psychiatric hospital for the first time. He was subsequently admitted to psychiatric hospitals a number of times. His other mental health difficulties were complicated by depression and exacerbated by alcohol use. Records indicate that the man had taken several overdoses in 1991. After being charged with attempted murder that year, he cut his throat while in HMP Wormwood Scrubs and needed a blood transfusion.
21. The man had 13 previous convictions for 33 offences. Many were for theft but some were for offences against the person, and some involved weapons. In 1992, the man was admitted to Rampton secure hospital under Section 37/41 of the Mental Health Act (a court imposed hospital order rather than a sentence of imprisonment). He remained there for 12 years, but reports show that he made little progress. On one occasion in hospital, he took a hostage during a dispute. In 2006, he was assessed for a place at Broadmoor Hospital but was judged unsuitable because he had not successfully addressed his alcohol misuse or personality problems.
22. The man moved to a medium secure hospital in 2006 from where he escaped in February 2007 and took a hostage. He threatened police with an imitation firearm. He later said this was an attempt to get the police to shoot him, as suicide was against his beliefs. He was remanded to HMP Belmarsh. His medical record shows that he was referred to Broadmoor again but was regarded as unsuitable. He said that he had a history of back pain, with associated numbness in his legs. The man was allocated a single cell on a standard residential wing at Belmarsh but was unable to cope with life on an ordinary prison wing and was moved to the healthcare centre shortly after arriving. He moved back to an ordinary prison wing in November, but was again unable to cope and went back to the healthcare centre after two weeks.
23. In October 2007, the man was convicted and given an indeterminate sentence for public protection with a minimum term to serve of two years and six months before he could be considered for release. He was also still subject to a hospital order from which he would need to be discharged before he could be released. Pre-sentence psychiatric reports said that he had made very limited progress in hospital and was unlikely to benefit from further hospital treatment.
24. On 22 October 2008, the man transferred from Belmarsh to Elmley. Because of his general and social anxiety he was assessed as needing a low stimulus and highly protected environment. He was allocated a cell in the prison's healthcare centre. It was noted that he displayed low-grade symptoms of depression and anxiety, together with obsessive ruminations (prolonged, undirected thinking), dysphoria (emotional discomfort) and at times dissociation (a feeling detachment

from one's surroundings). On 1 November, he said he had thoughts of suicide, and was managed under ACCT suicide and self-harm prevention procedures until 17 December.

25. In early 2009, reports about the man were positive and described him as having a good attitude towards others. He attended an art group and worked in the garden and was said to be polite and compliant with prison rules. His mood and behaviour were described as settled.
26. On 3 June 2010, the man was found guilty of a disciplinary offence after he refused to attend a drug test. Later that month, he assaulted another prisoner. In November, a security report shows that he threatened a doctor who he thought was responsible for blocking a move to a medium security hospital. He was assessed as suitable to undertake the Thinking Skills programme but never did it.
27. In January 2011, a Parole Board review concluded that as he had not participated in his sentence planning the Board was unable to say whether his risk of offending had reduced. The Parole Board was concerned at the apparent deterioration in his mental health, and recommended a full psychiatric assessment. In February, the man fought with another prisoner and was found with fermenting liquid in his cell.
28. In October 2011, the consultant psychiatrist with responsibility for the man's day-to-day care, wrote a report for a mental health tribunal. The consultant psychiatrist noted that the man suffered from a mixed personality disorder. He was prone to avoidance, dependence, depression, and obsessive compulsive disorder. This caused reduced interest, poor concentration, and little energy, along with excessive anxiety and difficulty being with groups of people. He also suffered significant dissociation at times, which caused delusions. As a result, he felt unable to leave the healthcare centre and was unwilling to engage in offending behaviour group work. The doctor concluded that there appeared to be little prospect of the man gaining any benefit from further hospital treatment, and that he would be unable to cope with a therapeutic setting, even in prison.
29. In April 2012, the Parole Board recommended that the man should transfer to a Dangerous and Severe Personality Disorder (DSPD) Unit for assessment and for the DSPD unit to make a recommendation about future treatment. Later that month, staff found a bottle of fermenting liquid in the man's cell.
30. On 30 May, the man's offender supervisor in the prison, told the man that he was being allocated a new offender manager (probation officer) as his current one was moving. He was upset by this, as he thought that he had established a good rapport with his offender manager, something he usually found difficult.

31. On 18 June, the man was downgraded to the basic level of the incentives and earned privileges scheme after he refused to return to his cell. On June 29, the man said he was going to refuse food but subsequently took his lunch as he needed to eat with his medication.
32. A note on the man's healthcare record shows that a mental health tribunal was to be heard on 26 July. There is nothing further on his prison medical record about this.
33. On 27 February 2013, the man declined permission for the prison's mental health inreach team to share information about him with other services, but he allowed them to speak to his solicitor. On 6 March, the man's solicitor spoke to a member of Elmley's mental health inreach team and they discussed how the man had become stuck in the system. They agreed that a Care Programme Approach meeting would be arranged, which member of the mental health in reach team would attend, to decide how the man's care could be progressed. (The Care Programme Approach –CPA- is a particular way the NHS has of assessing, planning and reviewing someone's mental health care needs if they have a severe mental health disorder or a range of other vulnerabilities such as having been detained under the Mental Health Act or having a history of violence or self-harm. Someone who needs CPA support should have a formal written plan that outlines any risks and a CPA care coordinator to organise and review the plan.)
34. The meeting was held on 2 May. The man attended with the consultant psychiatrist, his consultant psychiatrist and a doctor from Chase Farm Hospital a STaR (support, time and recovery) worker from the mental health team, a nurse a member of staff from the mental health in reach team, the healthcare centre manager, and a member of staff from Elmley's safer custody team. The man accepted that he was not likely to be released in the immediate future, but was concerned about his slow progress and said he had not seen his offender supervisor for nine months. The GP said that the man needed to address his drug and alcohol issues and that he would contact the John Howard Centre, which specialises in personality disorders, to see if they would take him or provide advice on future treatment. He told the man that if they were unable to accommodate him, he would need to co-operate with the offender management unit for his future sentence progression.
35. On 17 June, the man was found to have a number of tablets that had not been prescribed to him. He was downgraded to the basic level of the IEP scheme and remained on basic for ten days, when he returned to the standard level. On 22 July, he refused to attend a mandatory drug test and was given a disciplinary warning.
36. The man's offender supervisor at Elmley was now Senior Officer (SO). In August, he arranged a meeting between the man and his new offender manager. However, when the offender manager arrived at the

prison, the man became anxious and refused to leave the healthcare centre. He said that he had not been informed of the meeting and would not attend.

37. The consultant psychiatrist had referred the man to the John Howard Centre, but they did not accept him. In September a consultant forensic psychiatrist from the Fens Unit, the DSPD unit in HMP Whitemoor, and a consultant psychiatrist from North East London Forensic Personality Disorder Service discussed the man's future treatment. The psychiatrist noted that they took a new group of prisoners for assessment twice a year, and it was likely that the man could be considered for admission in the first half of 2014. Elmley were asked to provide some further information and it was agreed that the man would be considered at the meeting of the referrals team in December. Another CPA meeting was arranged for 28 January.
38. On 14 October, the SO met the man to prepare for his next parole review in March 2014. The man said that he would attend a meeting with the offender manager if he was given enough notice so he had time to prepare. The SO said that he would arrange the meeting. (The man died before a meeting had been arranged.)
39. On 28 October, when the SO took the man a copy of his parole dossier, the man told him that he did not like reading things that had been written about him as it made him anxious. He would not accept the dossier and said that he would wait until he had a meeting with his solicitor when he could discuss the contents with him.
40. On 5 December, the man met his solicitor. He said that he needed some money to buy telephone credit, but his mother was unwell and unable to provide it. The man's solicitor said he would arrange for £50 to be sent to him. The man said that he wanted to talk to someone about an incident when he had been the person who had found a prisoner who had killed himself in the healthcare centre at Elmley in January 2013. (We investigated that death and found that the person who discovered the dead prisoner was a nurse, not the man. Two other prisoners had initially helped the nurse, neither of whom was the man.) He said he felt that the suicide could have been prevented, but nobody had spoken to him about it, either to ask for his views or to offer support. He said that on one occasion he rung his cell call bell and waited twenty minutes for staff to respond. When someone came, all they did was switch off the bell outside his cell.
41. In the afternoon of 19 December, the man telephoned his solicitor. He said that the money had been credited to his account. He told the solicitor that he had been assaulted by a member of staff, but did not give any other details. The man's solicitor was due to see the man on 23 December, and told the investigator that he suspected that the man might have expanded on this then. The post-mortem report did not indicate any signs of assault.

42. A member of the mental health team, had worked with the man since March 2013 and was in the healthcare centre in the early evening of 19 December, when the man spoke to her. She said he was agitated and told her that he was annoyed about a number of matters relating to the running of the healthcare centre. He said that he was due to speak to his solicitor and would keep quiet until then. The member of staff from the mental health team told the investigator that the man had not been upset and she did not consider that there was anything in his manner to suggest that he was at risk of suicide or self-harm.
43. The investigator spoke to the prisoners in the cells next to and opposite the man's. They said that they did not notice anything out of the ordinary about him during the afternoon or evening of 19 December. They said that he had seemed happy enough and had been joking with them. They saw nothing to indicate that he was in any distress that evening.
44. An operational support grade (OSG) was on duty in the healthcare centre after prisoners had been locked into their cells for the night. He conducted a roll check at approximately 8.30pm, and remembered the man saying hello to him when he checked him. During the course of the night, the OSG said that the man had pressed his cell call bell on three or four occasions, and he had responded. He said that the man had not seemed particularly distressed, but just wanted to talk to someone. He told the OSG that he was looking forward to moving to a prison in Scotland to be near his mother (although he had not made a formal application for this). He said that he was anxious about having to leave the healthcare centre to attend a meeting with his solicitor the next day. The OSG said that he had talked to the man as much as he could, but was unable to have a long conversation with him as he had other work to attend to. The OSG told the investigator that the man had not seemed distressed or upset at any point and he did not think that he might be a risk to himself.
45. At approximately 4.10am on 20 December, healthcare assistant was in the corridor of the healthcare centre and saw the man walking around his cell. The healthcare assistant said he had asked the man what was wrong and the man had told him that he did not know what was happening about his application to transfer to a prison in Scotland, and he was anxious about a meeting scheduled for January, although he did not say what the meeting was. He was also concerned about his mother's health. The healthcare assistant talked to him and tried to calm him down.
46. The Night Orderly Officer, in charge of the prison that night, was one of the prison managers. During the course of the night he went to the healthcare centre several times to see a prisoner who was being managed under ACCT procedures. The prison manager told the investigator that at no point during the night was he made aware that

there were any specific problems with the man or any concerns about his safety.

47. The OSG began the morning roll check at approximately 5.25am and he estimated that he would have arrived at the man's cell about three minutes later. When he looked through the observation panel, he saw the man hanging from the window bars. He immediately radioed an emergency code blue, to indicate a prisoners is unconscious, not breathing or is having breathing difficulties. Night patrol staff carry a cell key in a sealed pouch for use in an emergency and The OSG broke the seal on his pouch and opened the cell door. As he did, an officer arrived in response to the emergency call. As they went in, a nurse also arrived and helped the OSG support the man's body, while the officer used an anti-ligature knife to cut the twisted bed sheet that the man had used as a ligature. They laid him on the cell floor, and the nurse began cardiopulmonary resuscitation.
48. Other staff arrived in response to the emergency call, and the OSG went to the office and telephoned the communications room to tell them to call an ambulance, which had not yet been done. (The investigator was told that they did not call an ambulance automatically when a code blue was called.) The ambulance service relayed the emergency call at 5.37am. The healthcare assistant went to the healthcare office to get a defibrillator and oxygen. The prison manager and four other officers then arrived at the man's cell. The prison manager estimated that they arrived there less than a minute after the emergency call. The healthcare assistant had not been able to find the defibrillator in the healthcare office so the prison manager sent an officer to the orderly office to bring one from there. The healthcare assistant returned to the cell with oxygen and other emergency equipment.
49. A nurse attached the defibrillator and oxygen to the man while the officer took over cardiopulmonary resuscitation. The defibrillator did not detect any heart output, so the staff continued cardiopulmonary resuscitation. The prison manager arranged for staff to be ready to escort paramedics through the gate when they arrived. A first response vehicle arrived at 5.45am and paramedics then took over attempts to revive the man. At 5.58am a second ambulance arrived and the crew joined their colleagues. The resuscitation attempts were unsuccessful and, at 6.28am, the paramedics agreed that the man had died.

## **Debrief**

50. A hot debrief was held that morning for the staff involved in the emergency response. No specific issues were raised and the staff care team was present to provide support.

## **Informing staff and prisoners**

51. Notices from the Governor informed staff and prisoners of the man's death. All prisoners who were on open ACCTs had their circumstances reviewed in case they had been adversely affected by the news of the man's death. Wellbeing checks were made on the other prisoners in the healthcare centre.

## **Contacting next of kin**

52. The prison chaplain, was appointed as family liaison officer. He was informed by email of the man's death, but he was not on duty, and did not learn of it until Sunday 22 December. No one else had attempted to contact the man's family in the meantime. The man had not listed a next of kin, but the prison chaplain was aware that his mother was living in Scotland. He asked permission from the Coroner to go into the man's cell to look for the address in the man's correspondence but this was denied. (When there is a death in a prison the cell is sealed until initial police and Coroner's enquiries have been completed.) On 23 December, the chaplain found the man's mother's address from a different source, and because of the distance involved and the time that had already elapsed, he contacted the Scottish Prison Service to ask if a family liaison officer from a prison near her home could break the news to her. The Prison Service contacted the police service for confirmation of the address, but the police insisted that it was their policy to pass on such messages. The prison chaplain asked the police to pass on his contact details to the man's mother. Police visited her home and informed her of her son's death and at 4.00pm on 23 December, the man's mother telephoned the chaplain, who explained further what had happened and offered sympathy and support.

## **Funeral**

53. The man's funeral was held on 28 January and the prison chaplain conducted the service. Elmley contributed to the funeral costs in line with Prison Service guidance. A memorial service was held in the prison on 23 December in the healthcare centre to allow staff and prisoners to pay their respects.

## **Post-mortem**

54. The post-mortem recorded the cause of death as hanging.

## ISSUES

### The man's healthcare

55. Because of his mental health problems, the man had lived in healthcare institutions for a long time and had spent all of his time since he had arrived at Elmley in 2008, living in the healthcare centre. The clinical reviewer found that the man had very good medical and psychiatric care while he was at the prison, exceeding that which he could have been expected to receive in the community. As a part of his mental health care plan, his mental health key worker, saw the man at least once a week. There was nothing to indicate to staff that the man was at increased risk of suicide and self-harm on 19 December and we do not consider that staff at the prison could reasonably have foreseen or prevented his actions.
56. There were some gaps in the man's healthcare records. The Parole Board recommended a full psychiatric assessment in April 2010 but there is nothing on his file to show whether this was completed. A note on the man's healthcare record shows that a mental health tribunal was to be heard on 26 July 2013 but there is no further reference to this. Notes of his Care Programme Approach meeting in May 2013 were not included in the man's medical record, and not all the correspondence about his transfer to a DSPD unit was uploaded onto his electronic medical record. It is important for the continuity of care that a prisoner's medical records are accurate and contain all relevant information. We make the following recommendation:

**The Head of Healthcare should ensure that medical records include all relevant information**

### The man's sentence management

57. The man was serving an indeterminate sentence with a minimum term of serve of two years and six months. He was also still subject to a hospital order and needed to demonstrate that was no longer a risk to the public before he could be released. However, his mental health problems meant that he lived in the healthcare centre continuously. He was reluctant to leave the unit and this made it very difficult for him to attend courses and progress through his sentence. He was assessed for a place at Broadmoor Hospital in 2007 and again in 2013, but was found to be unsuitable. In October 2011, the man's consultant psychiatrist, had noted that there was little prospect that the man would benefit from further hospital treatment, and that he would not cope with a therapeutic setting, even in prison. The Parole Board recommended in April 2012 that the man should transfer to a DSPD unit for treatment, but that process had not been completed when he died in December 2013. At his CPA meeting in May 2013, the consultant psychiatrist agreed to refer him to the John Howard Centre for people with personality disorders but they declined to accept him.

58. It was not easy for staff to help the man progress in his sentence. He suffered a high level of anxiety over any changes to his routine, found it hard to leave the healthcare centre and was unwilling to attend any groups, which made it difficult for him to participate in offending behaviour courses. The Parole Board noted in 2011 that he had not complied with his sentence plan. In his assessment in October 2011, the consultant psychiatrist noted that the man was unwilling to engage in any offending behaviour course work which would help reduce his risk. The man refused to attend a meeting with his offender manager in August 2013. His mental health worker told the investigator that the man often placed obstacles in the way of anything that was done to help make progress, such as insisting on last minute changes to the arrangements for his CPA meeting in May 2013.
59. The man's behaviour deteriorated whenever it seemed that there might be a change in his circumstances. In April 2010, the Parole Board recommended that he should transfer to a prison offering certain offending behaviour courses. In June, he refused to attend a drug test, and assaulted another prisoner. In January 2011, the Parole Board recommended a full psychiatric assessment. The following month, the man was involved in a fight with another prisoner, and was also found to be fermenting liquid in his cell. In April 2012, the Parole Board recommended that he should transfer to a DSPD unit, and that month he was again found with a bottle of fermenting liquid. In May, he was told that he would be allocated a new offender manager. In June, he refused to return to normal location and was subject to disciplinary action. In May 2013, his CPA meeting recommended that he be considered for a move to a DSPD unit, but in June he was found to be in possession of unauthorised medication.
60. We note that contact between the man's offender supervisor and his offender manager happened only when an issue arose, rather than a part of a regular plan to discuss strategies to encourage the man to him to comply with sentence plan goals. The SO said that offender supervisors were expected to speak to high risk offenders on their caseloads every month but workloads often meant this was not possible. While we would have preferred to have seen more active sentence management to help the man progress, we accept that that this was very difficult to achieve, if not impossible, until his underlying mental health problems had been addressed. Sadly this meant that the man spent over five years living in the healthcare centre at Elmley without making any progress.

### **Emergency response**

61. When he found the man hanging, the OSG appropriately radioed a code blue emergency immediately. Although he was on his own at the time, commendably, he used his emergency cell key to go into the cell without delay. As the man lived in the healthcare centre, a nurse was

with him very quickly and able to begin to try to resuscitate him without delay. Other staff responded, and the prison manager made arrangements for the ambulance to be met at the gate and escorted directly to his cell. .

62. However, we were concerned that the staff were unable to find a defibrillator in the healthcare centre, and the prison manager had to send a member of staff to the orderly office to obtain one from there. This is particularly concerning as most staff would expect to be able to obtain such equipment from the healthcare centre in an emergency.
63. When the OSG called a code blue emergency, the control room did not request an ambulance automatically and one was not called until the OSG requested one, almost ten minutes after he found the man hanging. The investigator was told that ambulances are not routinely requested when a code blue is called. Prison Service Instruction (PSI) 03/2013 *Medical Emergency Response Codes*, issued in February 2013, 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 explicitly states that all prison staff must be made aware of and understand this instruction and their responsibilities during medical emergencies and that an ambulance should be requested automatically and immediately as soon as an emergency code is called. Elmley has a local protocol based on the PSI that says that an ambulance should be requested when a medical emergency is called but this did not happen and it does not appear that the staff were aware of the instruction. 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, including the location of emergency equipment and that there are no delays in calling, an ambulance.**

### **Contacting next of kin**

64. The prison chaplain, was appointed as family liaison officer but he was informed of the man's death in an email which he did not see until 22 December, two days after the man's death. This was inappropriate and resulted in unnecessary delay. The prison chaplain then had difficulty establishing the man's next of kin details and arranging for an appropriate person in Scotland to inform her. As a result, the man's mother was not contacted until three days after his death.
65. PSI 64/2011 gives instruction to prisons about informing families when there is a death in custody. The instruction states that time is of the essence for this contact to be made. The duty governor had a responsibility to ensure that the prison chaplain's mother was informed as soon as possible. We have made a previous recommendation to

Elmley after there were delays in contacting a prisoner's family after their death. The response said that the Governor was committed to ensuring that next of kin are notified as soon as possible after a death. We do not consider three days to be acceptable. We repeat the recommendation:

**The Governor should ensure that, in line with PSI 64/2011, the next of kin are informed as soon possible after a prisoner's death.**

## **RECOMMENDATIONS**

1. The Head of Healthcare should ensure that medical records include all relevant information
2. The Governor should ensure that all prison staff are made aware of and understand PSI 03/2013 and their responsibilities during medical emergencies, including the location of emergency equipment and that there are no delays in calling, an ambulance.
3. The Governor should ensure that, in line with PSI 64/2011, the next of kin are informed as soon possible after a prisoner's death.

ACTION PLAN

No	Recommendation	Accepted/Not accepted	Response	Target date for completion	Progress (to be updated after 6 months)
1	The Head of Healthcare should ensure that medical records include all relevant information	Accepted	The Head of Healthcare will meet with all the health care providers to ensure data is accurately recorded and shared within the prisoner's record. This recommendation will be included in the Strategic improvement plan for the prison and reviewed via the patient safety work stream to ensure compliance.	30th September 2014	
2	The Governor should ensure that all prison staff are made aware of and understand PSI 03/2013 and their responsibilities during medical emergencies, including the location of emergency equipment and that there are no delays in calling, an ambulance.	Accepted	<ul style="list-style-type: none"> <li>• A new policy document has been published that contains hyperlinks to PSI 03/2013.</li> <li>• A review has been completed of the emergency response equipment available. A full response kit is carried by the healthcare emergency responder for all medical emergencies.</li> <li>• All staff carry fish knives to assist in the removal of ligatures.</li> <li>• Local instructions have been</li> </ul>	Completed	

			amended to ensure that the requirement for the control room to contact the emergency services when a medical emergency code is called is clear, and that on their arrival they should be immediately escorted to the location of the medical emergency.		
3	The Governor should ensure that, in line with PSI 64/2011, the next of kin are informed as soon possible after a prisoner's death.	Accepted	<ul style="list-style-type: none"> <li>• The Next of Kin of all prisoners is requested on reception.</li> <li>• The Safer Custody department complete a weekly check of all prisoners to identify those prisoners who have no next of kin recorded, in order that this can be rectified.</li> <li>• Chaplaincy also request Next of Kin for all prisoners that they come into contact with.</li> <li>• The contingency plans have been revised to remind staff that a Family Liaison Officer is appointed as soon as practicable and that the Next of Kin is informed at the earliest time</li> </ul>	Completed	

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