Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of a man, a prisoner at HMP Elmley, in November 2014

A report by the Prisons and Probation Ombudsman
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Our Vision

To carry out independent investigations to make custody and community supervision safer and fairer.

Our Values

We are:

Impartial: *we do not take sides*
Respectful: *we are considerate and courteous*
Inclusive: *we value diversity*
Dedicated: *we are determined and focused*
Fair: *we are honest and act with integrity*

The Prisons and Probation Ombudsman aims to make a significant contribution to safer, fairer custody and community supervision. One of the most important ways in which we work towards that aim is by carrying out **independent** investigations into deaths, due to any cause, of prisoners, young people in detention, residents of approved premises and detainees in immigration centres.

My office carries out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

The man was found hanged in his cell at HMP Elmley in November 2014. He was 41 years old. I offer my condolences to his family and friends.

The man told prison staff a number of times that he was under threat from other prisoners from a rival Traveller family. His family and his solicitors contacted the prison about this, but I am concerned that there is no evidence that anyone investigated matters or ensured that he was appropriately protected. He appears to have resorted to attempting to assault staff and set fires in order to be sent to the segregation unit and remain there. On 11 November, he threatened to kill himself if he was moved back to his houseblock. He was appropriately placed on suicide and self-harm prevention procedures.

The investigation identified weaknesses in suicide and self-harm arrangements at Elmley, including a failure to record the exceptional reasons for segregating the man and to complete the required hourly checks at the time he hanged himself. I am also concerned that, despite it having been a very difficult night in the segregation unit, the unit was staffed by a single officer who was not trained in suicide and self-harm prevention procedures. This officer evidently felt unable to cope and appeared to have been inadequately supported.

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 **April 2016**

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Summary

Events

1. On 15 May 2014, the man was remanded to HMP Elmley. He said he had a history of heart disease and angina. He had substance misuse problems and completed a drug detoxification programme. On 25 September, he was sentenced to 12 months in prison.

2. On 22 October, the man was taken to hospital after complaining of chest pains. There is no record of the results of the hospital tests. When he got back to Elmley on the morning or 23 October, he told a custodial manager that he was under threat from other prisoners in his houseblock and feared for his safety. That afternoon, he complained of chest pains again. There was no sign of a cardiac cause and healthcare staff, who knew he was concerned about his safety, considered this could have been caused by anxiety. That evening, he complained of pain again, and demanded to move from the houseblock. He became aggressive and threw punches at the staff. Officers took him to the segregation unit to await a disciplinary hearing. The next day, he was found guilty of the charges and received a punishment of seven days cellular confinement in the segregation unit, with a further seven days segregation after that.

3. The man continued to report chest pain and palpitations. He said he was very anxious because other prisoners were shouting threats. His mother and his partner telephoned the prison about this and, on 4 November, his solicitors sent a fax saying that he was in fear of his life because of a feud between his family and another Traveller family. They asked if he could be transferred to another prison, or stay in the segregation unit until he was released in December. No one took any action of investigated this. On 10 November, he asked an officer about moving to another houseblock when he left the segregation unit. The officer could not help him at the time and he became aggressive and pushed him. Officers restrained him and locked him in his cell. The next day, he started a small fire in his cell.

4. That evening, the man complained of chest pains and officers took him to the healthcare centre. He had an ECG test, which was normal. He told the officer that he was worried about going back to his houseblock, the next day, as he was in danger there. He said he would kill himself if he was taken back. The officers began suicide and self-harm prevention procedures, known as ACCT, and told him he would not be moved until he had had discussed his fears with a manager.

5. The night manager decided that staff should check the man at least once an hour as part of ACCT monitoring. That night, another prisoner in the segregation unit was making a lot of noise, which was unsettling for the other prisoners and kept them awake. The segregation unit was staffed by one night patrol officer, an operational support grade, who had also been disturbed by the noise. She said that she has called the night manager to ask for help a number of times, but he had said there was nothing he could do. He did not visit the segregation unit. At 4.30am, he told the night patrol officer that he could not sleep because of the noise. She then went to the unit office because she felt unable to cope. She did

not check him again until approximately 6.45am, when she could not get a response. She called for help from other staff, who went into the cell and found he had hanged himself from the door hinge using a torn bed sheet. Officers and healthcare staff tried to resuscitate him until paramedics arrived and took over emergency treatment. At 7.45am, paramedics recorded that he had died.

Findings

6. We are concerned that no one investigated the man's allegations that he was under threat or ensured he was appropriately supported. There is no record that anyone took any action after his family and his solicitors reported their concerns. He appears to have engineered a move to the segregation unit, specifically to remove himself from the threats. After his initial punishment period, his stay in the segregation unit appears to have been extended for further disciplinary hearings.

7. There is no record that anyone considered whether the segregation unit was an appropriate location for the man, after the ACCT was opened, as should have happened. We are also concerned that the night patrol officer missed ACCT checks, apparently because she felt unable to cope and did not get support from other staff. Although the night officer asked for urgent assistance when she could not get a response from him, there was a short delay in a nurse reaching him because an officer had to collect him from the healthcare centre.

Recommendations

- The Governor should ensure that all information indicating violence, bullying and intimidation is fully coordinated and investigated and that apparent victims are effectively supported and protected.
- The Governor should ensure that prison staff manage prisoners at risk of suicide or self-harm in line with national guidelines, including:
    - Considering and recording all relevant information about the risk of suicide and self-harm in the ACCT record.
    - Completing ACCT checks at the required frequency and recording them as soon as possible after they are made.
    - Training all staff in direct contact with prisoners in ACCT procedures.
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- The Governor should ensure that the segregation unit is appropriately staffed at night and that staff receive additional support when needed.
- The Governor should ensure that healthcare staff are able to reach prisoners as quickly as possible when there is an emergency at night.

The Investigation Process

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

9. The investigator visited Elmley on 14 November 2014. He obtained copies of relevant extracts from Mr Smith's prison and medical records.

10. In line with our protocol with the police, our investigation was suspended for a time while the police made enquiries into the man's death. We regret the consequent delay in issuing our report. The investigator liaised with the police during their investigation and had access to their files and witness statements.

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

12. We informed HM Coroner for Mid Kent and Medway of the investigation, who gave us 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 family to explain the investigation and to ask if they had any matters they wanted the investigation to consider. The man's partner asked whether prison staff had considered transferring him to another prison and whether there was any evidence that he had been involved in an altercation with another prisoner.

14. The man's family received a copy of the initial report. His partner confirmed that she did not wish to make any comments on the report. NOMS received a copy of the initial report, and their action plan is annexed to this final report.

Background Information

HMP Elmley

15. HMP Elmley is a local prison on the Isle of Sheppey, which serves the courts in Kent. It holds more than 1,200 remanded and sentenced men in five wings, with a mixture of single, double and triple cells. The segregation unit consists of 20 standard cells, two special cells (short-term unfurnished cells to prevent violent prisoners harming themselves or others or destroying property) and three cells for prisoners on 'dirty protest'. The prison's healthcare centre includes a 29-bed inpatient unit.

HM Inspectorate of Prisons

16. The most recent inspection of Elmley was in June 2014. Inspectors reported that there had been a substantial increase in the number of incidents of self-harm. ACCT assessments and care plans were too generic and not always completed on time. Inspectors noted that relationships between segregation unit staff and prisoners were reasonably good, but the regime was poor and prisoners had to apply to have showers or make telephone calls. Officers did not always operate the regime fairly. Segregation unit staff made poor written observations and there was little indication that they effectively monitored prisoners' emotional or mental wellbeing. Inspectors reported that most prisoners in the segregation unit were there because they refused to return to their houseblocks, mainly because they believed they would be unsafe. Plans to reintegrate prisoners were not adequately developed.

17. The number of violent incidents had increased. A punitive approach to eliminating violence was not working well, and there was no strategic grasp of trends across the prison. Investigations into reports of violence or bullying were not thorough or consistent. Travellers and Gypsies were under-identified in the prison and there was no specific provision for them. A previous recommendation that the safer custody committee should investigate why Gypsy and Traveller prisoners felt less safe at the prison, and act on the findings, had not been achieved.

Independent Monitoring Board

18. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report, for the year to November 2014, the IMB reported that there had been severe staff shortages in the prison which had led to a restricted regime in the segregation unit. They noted that the segregation unit was a stressful place for staff to work. Incidents of self-harm and the number of prisoners supported using ACCT had increased.

Previous deaths at HMP Elmley

19. The man was the eighth prisoner to die at Elmley in 2014, the third self-inflicted death. Two other prisoners have taken their own lives since. One of them also died in the segregation unit, just three weeks after his death. Our investigation

into the death of a man in March 2014 found that prison staff had missed opportunities to identify his risk of suicide and self-harm.

Assessment, Care in Custody and Teamwork (ACCT)

20. ACCT is the care planning system the Prison Service uses to support prisoners at risk of suicide or self-harm. The purpose of the ACCT is to try to determine the level of risk posed, the steps that staff might take to reduce this and the extent to which staff need to monitor and supervise the prisoner. Checks should be at irregular 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. Staff should hold regular multidisciplinary reviews and should not close the ACCT plan until all the actions of the caremap are completed. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011.

Segregation units

21. Segregation units are used to keep prisoners apart from other prisoners. This can be because they feel vulnerable or under threat from other prisoners or if they behave in a way that prison staff think would put people in danger or cause problems for the rest of the prison. They also hold prisoners serving punishments of cellular confinement after disciplinary hearings. Segregation is authorised by an operational manager at the prison who has to be satisfied that the prisoner is fit for segregation after an assessment by a member of healthcare staff. Segregation unit regimes are usually restricted and prisoners are permitted to leave their cells only to collect meals, shower, make phone calls and have a daily period in the open air. A manager, a member of the chaplaincy team and a member of the healthcare team should visit the segregation unit daily and speak to each segregated prisoner to check their welfare. A doctor should visit at least every three days and a registered nurse on the other days to assess the physical, emotional and mental well being of the prisoner and whether there are any apparent clinical reasons to advise against continuing segregation.

Key Events

22. On 15 May 2014, the man was remanded to Elmley, charged with burglary and theft. He had been in prison before and had been released from a sentence at Elmley in January 2014. He was a Traveller, and this was noted in his prison record.

23. At an initial health screen, the man told a nurse that his doctor had prescribed him painkillers for leg pain, and a glycerol trinitrate (GTN) spray for angina. He said that he had a history of ischaemic heart disease, and suffered from chest pain. He said that he had not received any psychiatric treatment, and had no thoughts of harming himself. He used heroin and the nurse referred him for a detoxification programme. He told a prison GP that he had harmed himself some years previously, but only had psychiatric problems when he used drugs. The doctor represcribed gabapentin (a painkiller) and GTN spray.

24. On 25 September, the man was sentenced to 12 months in prison and was due for release in December 2014. When he got back from court, he told a nurse that he had been expecting a longer sentence and he was pleased with the outcome. The nurse noted that he had no physical or mental health problems, and there were no indications that he had any thoughts of harming himself.

25. On 12 October, the man finished his detoxification programme. A nurse noted in his medical record that he appeared free of drugs. She scheduled a review for 12 November.

26. On 22 October, the man moved from Houseblock Three, which is the induction unit for prisoners undergoing drug detoxification, to Houseblock Five. That morning, he complained of chest pains. He told a prison nurse that he had had a heart attack in the past, and the nurse called an ambulance. His records do not contain the results of the tests he had at hospital. He returned to the prison at approximately 6.10am on 23 October. He told a custodial manager that he was under threat on Houseblock Five and feared for his safety. The manager said he would brief the day shift staff. There is no record that staff took any further action about his allegations.

27. At 2.08pm, the man again complained of chest pains. A nurse went to see him. He was able to walk to another room, sit down, and explain to her what had happened. He said he had had chest pains for 30 minutes, radiating to his shoulder. There were no other symptoms. He had an electrocardiogram test (ECG, testing the electrical activity of the heart) and she faxed it to the hospital. She noted that he had said that he was concerned about his safety and could be suffering from anxiety. At 2.34pm, a GP examined him. He recorded that he looked fit and well and was mobile, with no shortness of breath or sweating (which can be symptoms of a heart attack). He referred him for blood tests and to the prison's chest pain clinic. He said he would review him the following week.

28. That evening, the man reported having chest pain again. A nurse noted that a number of healthcare professionals had already checked him, but had not found any cause for concern. He became aggressive, threw punches at officers and demanded to be moved from the houseblock. The officers restrained him and took him to the segregation unit. The nurse assessed him as fit for segregation.

He did not note any signs or reports of injury following the restraint. He noted that the man seemed happier now he was in the segregation unit, and told him to ask to see a member of healthcare staff, if he felt unwell.

29. On Saturday 25 October, at a disciplinary hearing the man received a punishment of seven days cellular confinement plus a further seven days removal from his living unit, to be spent in the segregation unit. He told officers that he was having palpitations due to stress, and asked them to put him on the list to see the doctor on Monday. In line with Prison Service instructions for prisoners serving punishments of cellular confinement, staff checked him every hour. At 8.41pm he complained of chest pains. A nurse assessed him and did not find any symptoms of anything serious. She talked to him about his recent medical tests, and he said that he understood but he remained anxious about his health and about receiving threats from other prisoners. He went back to his cell, and segregation unit staff began checking him hourly again.

30. An intelligence report dated 26 October, noted that the man had said that he was under threat from members of another Traveller family. He said that prisoners shouted threats at him wherever he went and he would refuse to leave the segregation unit. The report shows that the information had been noted, and that segregation unit and safer custody staff had been informed. There is no record that the allegations were investigated.

31. On 28 October, the man started a fire in his cell. Staff put out the fire and he pushed an officer when staff tried to take his cigarette lighter from him. Officers restrained him and charged him with a disciplinary offence. Afterwards, a nurse assessed him and gave him some painkillers as he said he had pain in his shoulders after being restrained. He said he had no intention of harming himself.

32. On the morning of 30 October, the man started another fire in his cell, which officers put out. During the afternoon, officers warned him for continually ringing his cell bell without a proper reason. His medical record shows that he did not attend a doctor's appointment that day. No reason was recorded.

33. On 2 November, the man's mother telephoned the prison and said that her son had told her he was in danger from other prisoners. This information was passed to segregation unit staff, but there is no record that they took any action.

34. On 4 November, the man's solicitors faxed the prison to alert them that he was in fear of his life because of threats from other prisoners. They said that his family had been involved in a feud with another Traveller family, some of whom were on the same houseblock as him. He said he felt safe in the segregation unit, but was due to move back to his houseblock. His solicitors asked whether he could move to another prison or stay in the segregation unit until he was released in December. Elmley has not given us any evidence that they considered the transfer request and we have seen nothing in the records to show that this was done.

35. An intelligence report dated 4 November noted that the prison had received information that the man said he was under threat from members of another family in the prison, and that threats were shouted at him wherever he went in

the prison. The report noted that he was in the segregation unit, and that the safer custody department were aware of his allegation.

36. On 5 November, the man telephoned his partner and said that another prisoner in the segregation unit had claimed he had been having an affair with her. He was upset, but his partner told him that the story was untrue. He said that if he moved back to the houseblock he would be "cut up". His partner said she had telephoned the prison and passed on the name of a prisoner he said had been threatening him.

37. On 6 November, the man's partner told him that she had telephoned the prison again that morning about his concerns. That day, a hard copy of the fax from his solicitor arrived at the prison and copies were sent to the safer custody department and to the segregation unit manager. The solicitors told the investigator that they did not receive a reply.

38. The next day, 7 November, the man complained to staff that other prisoners were calling him names. A note in his record indicated that staff in the segregation unit were aware of this. That afternoon, he told the duty governor that prisoners near him were threatening him. He would not say which prisoners or what they had said. The duty governor told him to speak to a member of staff when he could be more specific. He reported what the man had said to the safer custody department.

39. At 5.00pm on 10 November, the man asked an officer about whether he would be able to move to Houseblock Three, when he left the segregation unit. The officer said he could not give him an answer to this at that time. He became argumentative and pushed the officer several times before other officers restrained him and locked him in his cell. He covered the observation panel in is cell door and pressed his cell bell a number of times.

40. During the afternoon of 11 November, the man lit a small fire in his cell. Officers confiscated his lighter, and moved him to another cell, until the smoke cleared. He gave no explanation for lighting the fire.

41. Shortly before 9.00pm, the man complained of chest pain. He told a nurse that he had been in pain for about an hour and had used his GTN spray twice. Officers took him to the healthcare centre where a nurse gave him an ECG test and faxed the results to hospital.

42. While waiting in the healthcare centre, the man told two officers who had escorted him that other prisoners on his houseblock had threatened him. He said he had deliberately assaulted two officers so that he would stay in the segregation unit. He was due to go back to the houseblock the next day, and was afraid for his life. One officer told him he would not be sent back to the houseblock if there were genuine concerns about his safety and that he should speak to a manager about this in the morning. E remained very distressed and said he would kill himself if he was sent back to the houseblock.

43. An officer decided to begin ACCT procedures, because of what the man had said. A custodial manager, who was in charge of the prison that night, told him that someone would check him through the night, and that staff would review his

situation the next morning, before deciding whether to move him back to the houseblock.

44. The ECG test results indicated that the man was probably suffering from anxiety, and was not in danger. Healthcare staff agreed that he could go back to the segregation unit. On the way back, the custodial manager said that he had asked the man if he intended to harm himself, and he said he did not. He said in his police statement that he told the man that he would write down his concerns and pass them to a senior manager in the morning. (Although the manager made a note about him in the orderly officer's log, this said only that there had been an emergency call. He did not note that an ACCT had been opened or that he had threatened to kill himself if he was moved. We have not seen any other record that he recorded the man's concerns elsewhere.)

45. The custodial manager had no concerns that the man was at imminent risk of suicide as long as he remained in the segregation unit. He said that, when they arrived back at his cell, the man said he had no intention of harming himself, and thanked the officers for listening to him. He reminded him that he could use the Listener service. (Listeners are prisoners trained by the Samaritans to provide peer support to other prisoners.)

46. The custodial manager told an officer and an operational support grade (OSG), who was the night patrol officer in the segregation unit that night, that the man should be checked at least once an hour and that staff should let him know if he wanted to see a Listener. He did not record the level of checks on the front of the ACCT document, or in the immediate action plan section. Prisoners regarded as at risk of suicide and self-harm should be held in segregation units only in exceptional circumstances, but there is no record that anyone considered whether it was appropriate for the man to remain in the segregation unit after the ACCT was opened.

47. CCTV footage shows the man going back into his cell at 9.02pm. (From other records, we believe the CCTV clock was nine minutes fast, so this actually was at 8.53pm. We have adjusted all subsequent CCTV times.)

48. The OSG checked on the man at 9.36pm, although she recorded this in the ACCT record at 9.50pm. She noted that he was standing by the cell window, talking to another prisoner. The two prisoners in the cells either side of his cell later wrote statements. They said that they had spoken to him through the windows, and he seemed normal. They did not think that he sounded distressed and said nothing about any intention to harm himself.

49. The custodial manager went to the segregation unit at about 11.00pm to supervise staff giving medication to the prisoner in the cell opposite the man. CCTV footage shows that they opened the cell door to deliver the medication. Throughout the evening and night, the prisoner in the cell opposite, constantly shouted and banged on his cell door. Other prisoners complained but he did not stop. The OSG said she contacted the manager a number of times after that and asked if someone could remove the cup that the prisoner was using to hit things and make a noise. She said that the manager told her that as the prison was in night state, he could only open a cell in an emergency. He told the investigator that there was a risk that the prisoner might attack staff if he opened the cell to

remove whatever item he was using to make the noise and that, in any event, the prisoner would probably continue making a noise, using something else.

50. The CCTV shows that, at 9.45pm, the OSG had responded to the man's cell bell but did not record anything in the ACCT document. At 10.44pm, she checked him again and recorded that he was lying on the bed trying to get to sleep, but the noise from the other prisoner was making this difficult. At 12.03, she checked him again and noted that he was asleep. At 12.50am, she recorded that he was asleep, although there is no evidence from CCTV, that she checked him at that time. She checked him again at 1.27am and 1.50am and noted that he was asleep. She checked him again at 3.09am and 3.50am. An entry in the ACCT record at 3.50am appears to cover both checks. She recorded that he had been kept awake by the banging.

51. The OSG told the police that as the night went on she became increasingly stressed by the noise from the other prisoner and contacted the custodial manager several times, asking for help. He told the police that he remembered speaking to her, but could not recall how many times.

52. The OSG said that she had told the operational manager that she was having difficulty coping, but the custodial manager said that he did not get that impression. She said that between 3.00am and 4.00am, she had asked him whether the disruptive prisoner could be removed from the segregation unit, but he had said that this was not possible. He said that he had told her that there was nowhere except the segregation unit to take a disruptive prisoner. He said that she had said she would just have to get on with it.

53. The custodial manager made an entry in the orderly officer log about the prisoner, at some point after 2.00am (the time of the previous entry). He wrote that there "was constant banging all around his cell and keeping all other inmates up". He did not record whether he had considered taking any action or sending another officer to help. He said that it had been a very busy night, with prisoners needing attention in several parts of the prison. However, there were only four entries in the orderly officer log about the man at 9.00pm, and then at 12.20am and 2.00am, before he made the entry about the prisoner making a noise in the segregation unit.

54. At 4.29am, the OSG checked the man again and spoke to him for about a minute. She said that he was upset about the noise from the other prisoner, which was keeping him awake. She told him that there was nothing she could do about that, but asked if he was otherwise okay. He said that he was trying to sleep.

55. At 5.29am, the OSG went to the cells opposite the man. She did not check him but noted in his ACCT record that the other prisoner was still making a noise. At 5.34am, the CCTV footage shows there was some movement in the man's cell, and the light on the left side of the door became blocked out. The movement stopped a minute later and the light remained blocked.

56. At 6.30am, the OSG noted in the ACCT record that the man was still awake because of the banging noise from the other prisoner. CCTV footage showed that she did not check him at the time.

57. At 6.47am, the OSG went to the man's cell. She told the police that he appeared to be standing by the door, but she was unable to get a response from him. She stood at the door for about 40 seconds before leaving the landing. Although she had a radio, she telephoned the night manager, who had taken over from the custodial manager. (The manager told the police that, when he received a handover from the operational manager, he thought like it sounded like a normal night.) He told her to kick the door to try to get a response. She went back to the cell at 6.49am. She could still not get a response and radioed for all emergency response staff to attend immediately.

58. Staff were in the reception area when they heard the call for urgent assistance. They arrived at the segregation unit two minutes later, at 6.51am. Through the observation panel, they could see that the man appeared to have his back to the door. The officers went into the cell and found that he had hanged himself using a ripped bed sheet attached to the door hinge. They cut the sheet from around his neck and lowered him to the floor. They could not detect a pulse and an officer began to perform cardiopulmonary resuscitation. The manager had also arrived at 6.51am and radioed for any available officer to collect the emergency healthcare responder from the healthcare centre, as nurses do not carry keys at night. He then radioed the control room to call an ambulance. The control room log shows that they called an ambulance at 6.54am.

59. An officer took a nurse, the healthcare emergency responder, to the segregation unit. They arrived at 6.54am. An officer was performing cardiopulmonary resuscitation (CPR). He told the nurse that the man had no pulse and was not breathing. The nurse attached a defibrillator to him, which found no shockable heart rhythm. Staff continued to try to resuscitate him until paramedics arrived and took over emergency treatment. The times on the prison and ambulance service logs differ slightly, but the ambulance service log showed that they arrived at the cell eleven minutes after they had been called. CCTV footage showed them arriving at 7.03am. At 7.45am, paramedics recorded that the man had died.

Contact with the man's family

60. A prison chaplain acted as the prison's family liaison officer. He and one of the prison's managers left the prison at 9.20am and went to the address the man had given for his parents, but they had moved. They then went to the new address. The man's parents were not there at the time, but they waited until they came back in the early afternoon. The chaplain and manager then informed them of their son's death and offered their condolences. The chaplain continued to liaise with the family.

61. In line with Prison Service instructions, the prison contributed to the costs of the funeral.

Support for prisoners and staff

62. The manager debriefed the staff involved in the emergency response and offered his support and that of the staff care team.

63. The prison posted notices informing other prisoners of the man's death, and offering support. Staff reviewed all prisoners assessed as at risk of suicide and self-harm, in case they had been adversely affected by his death. Additional Listeners went to the segregation unit in case they were needed.

Post-mortem report

64. The post-mortem report recorded that the man died from hanging. There was no evidence that he had taken drugs. There was a minor abrasion on the edge of his left eyebrow and minor abrasions on both shins.

Findings

The response to the man's vulnerability

65. Elmley has a Violence Reduction Policy, which states that "Everyone has the right to … a safe environment which is free from fear of abuse, harm or oppression. Every verbal or physical act of violence will be challenged … Victims will be supported and protected". The policy says that, when staff receive any information about an act of violence or bullying, they should complete a violence reduction incident alert. This should then be passed to a wing manager to investigate the allegations.

66. The man was a Traveller, and his family had been involved in an ongoing feud with another Traveller family. On 22 October, he moved to Houseblock Five, where members of the other family lived. The next day, he told staff that he was under threat and concerned about his safety on Houseblock Five. On 25 October, he told a nurse that he had been threatened. On 2 November, his mother telephoned the prison and said that he was in danger. On 6 November, his solicitors wrote to the prison saying that he would be in danger if he went back to the houseblock. His partner had also telephoned. On 7 November, he told the duty governor that other prisoners were calling him names and, on 8 November, he told the duty governor that prisoners were passing verbal threats on to him.

67. It is apparent that the man was concerned for his safety and staff were aware of his anxieties. The safer custody team had logged the allegations. A violence reduction report of 10 November noted the letter from his solicitor, his anxiety attack on 11 November and the cell fires of 30 October and 11 November, but did not contain any actions. We have not found any evidence that anything was done to investigate the threats. No one replied to his solicitors and there is no record that anyone considered his solicitors' request to arrange a transfer to another prison to protect him. He resorted to assaulting staff, setting fires and threatening to harm himself in order to ensure that he remained segregated,

68. We do not consider that Elmley appropriately investigated the man's concerns, about his safety, as should have happened under the local policy. This failure meant there was no credible plan to protect him either by ensuring he was safely located in the prison or by considering a transfer elsewhere. We make the following recommendation:

    The Governor should ensure that all information indicating violence, bullying and intimidation is fully coordinated and investigated and that apparent victims are effectively supported and protected.

The man's segregation

69. Prison Service Order (PSO) 1700 sets out mandatory requirements and guidance to ensure the security and safety of those living and working in segregation units. It requires each prison to develop its own segregation policy to reflect its own needs as part of its local safer custody strategy. Elmley does not have its own policy, but healthcare staff assessed the man when he arrived in

the unit, as the PSO requires, and, in his time there, staff checked him in line with guidance for prisoners serving cellular confinement.

70. However, segregation unit staff did not make three quality entries in the man's history sheets each day, as they are required to do. They did not record notable events such as when he pushed an officer or started a fire. The reasons for his segregation were not always clear in his record and the basis for his segregation between 7 and 10 November (after his original punishment had finished and before he pushed an officer) was not recorded. He did not have an allocated personal officer while he was in the segregation unit.

71. In an investigation report into the death of a prisoner at Elmley in December 2014, we found that a number of segregation procedures, were not being competed properly. We made a recommendation that Elmley should introduce a local segregation policy and that each prisoner should have a designated officer responsible for their welfare and duty managers should speak to each segregated prisoner every day and satisfy themselves of their wellbeing. Elmley introduced a new policy in November 2015. We therefore do not repeat the recommendation.

ACCT procedures

72. On 11 November, when the man said that he would kill himself if he went back to his houseblock, an officer rightly began ACCT procedures. The staff did not think that he presented a serious and imminent risk of suicide but said that they thought that opening an ACCT would reassure him that they were taking his concerns seriously and that he would not be sent back to the houseblock the next morning without having the opportunity to discuss his concerns. (There is no record that there was any intention to return him to his houseblock the next day.)

73. The man's concerns allegedly arose from a feud between Traveller families. In January 2015, we published a Learning Lessons Bulletin about deaths of Travellers in prison. The bulletin noted that Travellers are at increased risk of suicide in the community, and when prisons are assessing risk this should be taken into account. There is no record that staff took this into account when considering his immediate risk of suicide and self-harm. However, we recognise that the ACCT had just been opened; there had been no formal ACCT assessment and no first ACCT case review.

74. Guidance on ACCT procedures is contained in PSI 64/2011. The custodial manager should have completed an immediate action plan within an hour of the ACCT being opened but this was left blank and he did not record the frequency of checks on the front of the ACCT document. Elmley's local policy states that within an hour of ACCT procedures beginning, the manager must record this in the wing observation book but this was not done. The manager should also record this in the prisoner's record, summarising the relevant issues. Although these procedures were not followed, we recognise that this did not affect the outcome for the man. The staff were in no doubt why the ACCT had been opened and that they were required to monitor him at least once an hour.

75. PSO 1700 highlights that there is a disproportionately high number of self-inflicted deaths in segregation units, and prisoners under ACCT management should be held there only in exceptional circumstances. The reasons must be clearly documented in the ACCT record and include options that were considered and discounted. PSI 64/2011 reinforces this and says that "prisoners on open ACCT plans must be located or retained in segregation units only in exceptional circumstances".

76. In June 2015, we issued a Learning Lessons Bulletin about self-inflicted deaths in segregation units. One of the learning points was that, too often, prisoners at risk of suicide and self-harm were kept in the segregation unit without sufficient evidence that staff had considered other options or identified exceptional circumstances.

77. The man said that he was distressed at the thought of going back to his houseblock. We can therefore understand why the staff thought that it was reasonable for him to stay in the segregation unit. However, when the ACCT was opened, he was in the healthcare centre and there is no record that anyone considered that location in the healthcare centre might be a better alternative.

78. There is no record that the staff considered the need for any additional support to mitigate the risks of holding the man in the segregation unit until an ACCT assessment and case review could be held the next day. To mitigate the risk, we would have expected some consideration of whether a higher level of checks than one an hour (the standard level of checks in the segregation unit) was needed. No one considered that he was at high risk of suicide in the segregation unit, but it is concerning that the OSG did not complete the required number and frequency of checks. Not all the checks were recorded shortly after they were made.

79. In a report into the investigation of another death at Elmley in December 2014, we recommended that segregation should be regarded as exceptional for prisoners at risk of suicide and self-harm. Elmley has since reminded relevant managers and staff that prisoners assessed as at risk, should not be segregated without considering and exploring all other options and that segregation will be a last resort. We therefore make no further recommendation about this issue. The custodial manager said that the man had explicitly said that he felt safe in the segregation unit and nowhere else. We accept that, in the circumstances, the segregation unit might have been a reasonable location for him, but it is important that the extra risks in segregation units are considered.

80. There were other aspects of the ACCT process, which were not completed correctly, including that failure to check the man as required. We are also concerned that the OSG had not received formal ACCT training. We do not consider that it was appropriate to leave an untrained member of staff alone in the segregation unit, one of the most vulnerable areas of the prison. We make the following recommendation:

The Governor should ensure that prison staff manage prisoners at risk of suicide or self-harm in line with national guidelines, including:

- **Considering and recording all relevant information about the risk of suicide and self-harm in the ACCT record.**
- **Completing ACCT checks at the required frequency and recording them as soon as possible after they are made.**
- **Training all staff in direct contact with prisoners in ACCT procedures.**

Staffing in the segregation unit

81. The OSG told the police that the segregation unit was extremely stressful on the night of the incident, mainly due to the prisoner who was making constant noise. She said that she contacted the custodial manager a number of times to ask for help, but he told her that there was nothing he could do. At 3.00am, she said she told him that things were very difficult. After checks at 4.30am, she said she could not cope any longer and went into the office to try to block out the noise. That meant she missed some required checks, including checking the man.

82. The custodial manager told the police that he had spoken to the OSG during the night, but he did not remember how many times. There is an untimed note in the night orderly officer's log saying that she had contacted him about the noise. He said that, while he could tell that she was frustrated by the situation, he did not think that she was saying she was unable to cope and needed some support.

83. We do not know exactly what discussions took place between them that night but the OSG told the police that she had not been able to cope. This meant she did not carry out her required tasks, including ACCT checks. As the noise continued throughout the night, we consider that the night manager, or one of the officers assisting him, should have visited the segregation unit to assess the situation, speak to the prisoner and offer some support to her. The custodial manager did not go back to the segregation unit after 11.00pm.

84. We accept that there was nowhere the prisoner could have been moved to, but, if necessary, staff could have opened the cell to try to stop him making the noise and disturbing other prisoners and staff. Prison Service Instruction (PSI) 24/2011 (and Elmley's local policy) covering management and security at night does not preclude opening cells at night, provided the night manager agrees and the agreed minimum member of staff are present. We make the following recommendation:

    The Governor should ensure that the segregation unit is appropriately staffed at night and that staff receive additional support when needed.

The man's healthcare

85. The clinical reviewer was satisfied that the standard of healthcare the man received at Elmley, was equivalent to that he could have expected to receive in the community. She noted that staff carried out cardiopulmonary resuscitation correctly

86. The post-mortem report showed that there was a minor abrasion on the edge of the man's left eyebrow and minor abrasions on both shins. His partner asked if he had been involved in an altercation. When healthcare staff were attempting to

revive him they inserted a cannula (a tube to feed drugs into his system) into his shin. This could explain the marks on his shins. Prison and medical records not give any indication of how the minor abrasion to his eyebrow was caused and there is no record of any assault of fight.

Emergency response

87. PSI 03/2013 contains guidance on medical emergencies and requires governors to have a medical emergency response code protocol. It states that all prison staff must be made aware of and understand the protocol and their responsibilities during medical emergencies. The instruction states that when a medical emergency is called, the control room should call an ambulance immediately. Elmley has a protocol in line with PSI, which is reflected in its safer custody policy. The local policy for observing prisoners on ACCT at night states that "if it is not possible to view the prisoner, every effort must be made to get a response. If this is not possible, the [night orderly officer] must be contacted."

88. When the OSG went to the man's cell at 6.47am she believed she saw him standing by the door but could not get a response from him. After telephoning the orderly officer, she went back to his cell but could still not get a response. She then radioed for all response staff to go to the segregation unit but did not use an emergency code. This led to a short delay before an ambulance was called, but Ms Chaney acted in line with the local policy. She was not aware why he was not responding.

89. We are concerned that nurses working in the healthcare centre at night, including the emergency response nurse, do not have keys to let them leave the centre. This led to a delay before the emergency response nurse was able to reach the man's cell. Elmley's emergency response protocol does not contain any instructions or advice about the need for nurses to get to the scene of an emergency at night as soon as possible. There will be an obvious delay if an officer has to collect a nurse and in this case no one did, until another manager specifically asked for an officer to bring the nurse. We make the following recommendation:

The Governor should ensure that healthcare staff are able to reach prisoners as quickly as possible when there is an emergency at night.

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