

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Paul James a prisoner at HMP Elmley on 20 December 2016

**A report by the Prisons and Probation Ombudsman
Nigel Newcomen CBE**

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*



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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.

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

Mr James was found in his cell at HMP Elmley on 20 December 2016. He died from a self-inflicted wound to his abdomen. He was 26 years old. I offer my condolences to Mr James' family and friends.

Mr James' death was truly shocking but, while he had a number of risk factors for suicide and self-harm, there was little to indicate he was at imminent risk of suicide. He received some good clinical care at Elmley, but often did not take his medication and his mood fluctuated. He also had paranoid beliefs, so much so that the prison mental health team suspected illicit drug use, but there was no evidence of this in toxicology results after his death.

Despite the traumatic and tragic outcome, I am satisfied that in the days leading to his death, it would have been difficult for staff at Elmley to have predicted or prevented Mr James' actions as he had not self-harmed or expressed thoughts of doing so in the last five months of his life.

This version of my report, published on my website, has been amended to remove the names of staff and prisoners involved in my investigation.

Nigel Newcomen CBE
Prisons and Probation Ombudsman

September 2017

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Summary

Events

1. On 24 April 2016, Mr Paul James was remanded to HMP Belmarsh. Mr James had been in prison before. On 31 May, he was transferred to HMP Elmley. On 30 June, Mr James was sentenced to 2 years and 2 months in prison.
2. On 5 July, Mr James told staff that he was hearing voices and had mental health problems. Prison staff began suicide and self-harm prevention procedures, known as ACCT. Mr James said he had a history of self-harm and had cut himself two months earlier. Staff referred him to the prison psychiatrist.
3. On 8 July, Mr James severely self-harmed by cutting his arms and legs, and was sent to hospital. He returned to the inpatient unit at Elmley on 13 July, where staff continued ACCT monitoring. Mr James told healthcare staff that he felt anxious and paranoid. The psychiatrist prescribed medication (for his paranoia and poor sleep). Mr James said he had no thoughts of suicide or self-harm.
4. In August, staff noted that Mr James was spending a lot of time in his cell. He said his medication made him feel anxious, have nightmares and disrupted his sleep. The psychiatrist changed his medication and Mr James reported positive effects.
5. On 6 September, healthcare staff discharged Mr James from the inpatient unit and moved him to Houseblock 4. On 12 September, staff held a case review, which no one from the healthcare team attended, and stopped ACCT monitoring because Mr James had settled well, had a job as a cleaner and had a positive outlook.
6. In October, Mr James stopped taking his medication. He said it gave him headaches and had no positive effect. Staff monitored Mr James, which included a period of observations in the inpatient unit. They noted no deterioration in his mental health and that he had no thoughts or suicide or self-harm.
7. Around 12.00am on 20 December, the prisoner in the cell next to Mr James' cell was woken by the loud volume of Mr James' television. Mr James was also making a loud, groaning noise. At 12.15am, a night patrol officer was alerted to the loud volume of a television and went to Mr James' cell. The officer tried to turn on the cell night light but it did not work. He looked through the cell door observation panel and from the light emitted from the television, he said he saw Mr James asleep on his bed. The officer knocked on the cell door several times, but Mr James did not respond. He turned off the electrical power supply to Mr James' cell to stop the loud sound from disturbing others.
8. At 5.05am, the night patrol officer checked on Mr James and believed he was sleeping. At unlock at 9.45am, an officer found Mr James in his bed, with a large cut across his stomach and his intestines protruding. He radioed a medical emergency code and the control room called an ambulance immediately. The prison doctor arrived very quickly and recorded that Mr James had died.

Findings

9. Although Mr James initially had some risk factors for suicide and self-harm, we found there was little to indicate to prison staff that he was at risk in the period before his death.
10. Prison staff and the psychiatrist who assessed Mr James after the July incident suspected that his serious self-harm might have been as a result of NPS use, which he consistently denied. We do not know whether Mr James took drugs, inadvertently or otherwise, in July. We conclude that it is unlikely, in light of the toxicology results, that Mr James had taken any illicit substances, including NPS, before his death.
11. While the mental health team were unable to diagnose Mr James' mental health issues, he received some good care from them, which the clinical reviewer found was equivalent to that he could have expected to receive in the community. The clinical reviewer noted that it was likely that Mr James had had an acute psychotic episode when he cut his abdomen, which was perhaps fuelled by anxiety, impulsivity and a refusal to take his medication. Mr James had never said he wanted to take his own life and we found no evidence of such an intention.
12. When he was managed under ACCT procedures in July and October 2015, there was inconsistency in case managers completing his case reviews and no one from the healthcare team attended them, as was required.
13. On the night of Mr James' death, the night patrol officer did not tell the night manager or anyone else that Mr James' cell night light was not working or complete the night patrol report. He failed to use his torch to assist with his welfare check of Mr James during the night state.
14. A mental health review scheduled for 15 December was cancelled because of staff absence and there was no system in place to cover the absence.

Recommendations

- The Governor and Head of Healthcare should ensure that prison staff assess and manage prisoners at risk of suicide or self-harm in line with national guidelines, including holding multi-disciplinary ACCT reviews with continuity of case management and involving all staff who can contribute to the care of a prisoner at risk.
- The Governor should remind night duty staff of their responsibility to complete the night patrol reports and ensure that they do so.
- The Governor should ensure that staff satisfy themselves of a prisoner's safety at night, and if they cannot see them properly at checks, they use the cell night light and/or torch and tell their manager if they are concerned.
- The Governor should ensure that cell night lights are in good working order at all times.

- The Head of Healthcare should ensure that in the event that mental health staff are unable to attend a prisoner's mental health review, it is covered by a member of the mental health team or rescheduled promptly, and the change is recorded.

The Investigation Process

15. The investigator issued notices to staff and prisoners at HMP Elmley informing them of the investigation and asking anyone with relevant information to contact him. One prisoner did so.
16. The investigator obtained copies of relevant extracts from Mr James' prison and medical records.
17. NHS England commissioned a clinical reviewer to review Mr James' clinical care at the prison.
18. The investigator interviewed 16 members of staff and five prisoners at Elmley in February and March 2017, some jointly with the clinical reviewer.
19. We informed HM Coroner for Kent of the investigation who sent us the results of the post-mortem examination. We have given the coroner a copy of this report.
20. One of the Ombudsman's family liaison officers contacted and visited Mr James' grandmother to explain the investigation. Mr James' grandmother asked us to consider the following issues:
 - How Mr James' mental health was assessed and managed;
 - Whether he was monitored under ACCT procedures;
 - How Mr James was managed when he returned to Elmley after he tried to take his life in July 2016.
 - Why Mr James was discharged from the inpatient unit and whether this was appropriate.
 - What assessments took place after staff discovered that Mr James had stopped taking his medication.
 - Why Mr James lived in a single cell.
21. Mr James' grandmother received a copy of the initial report. She did not highlight any factual inaccuracies within the report and will pursue any remaining questions at inquest.

Background Information

HMP Elmley

22. HMP Elmley is a local prison on the Isle of Sheppey, which serves the courts in Kent. It holds more than 1,200 men in five wings, with a mixture of single, double and triple cells. Integrated Care 24 Ltd provides primary healthcare services, with input from Minster Medical Group. The healthcare centre includes a 29-bed inpatient unit.

HM Inspectorate of Prisons

23. The most recent inspection of Elmley was in November 2015. Inspectors reported that healthcare services had improved since their last inspection in June 2014, and were generally good. The inpatient unit provided good care for prisoners with the most acute needs but general access to healthcare services remained a problem. They said that, contrary to national trends, levels of violence and self-harm had reduced.

Independent Monitoring Board

24. 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 October 2016, the IMB reported that Elmley provided a high level of care and support for those at risk of suicide or self harm.

Previous deaths at HMP Elmley

25. Mr James was the fifth prisoner to take his life at Elmley since January 2014. In our investigation into the death of a prisoner in December 2014, we raised concerns about ACCT procedures.

Assessment, Care in Custody and Teamwork (ACCT)

26. ACCT is the Prison Service care-planning system used to support prisoners at risk of suicide or self-harm. The purpose of ACCT is to try to determine the level of risk, how to reduce the risk and how best to monitor and supervise the prisoner.
27. After an initial assessment of the prisoner's main concerns, levels of supervision and interactions are set according to the perceived risk of harm. Checks should be irregular to prevent the prisoner anticipating when they will occur. There should be regular multidisciplinary review meetings involving the prisoner. As part of the process, a caremap (plan of care, support and intervention) is put in place. The ACCT plan should not be closed until all the actions of the caremap have been completed.
28. All decisions made as part of the ACCT process and any relevant observations about the prisoner should be written in the ACCT booklet, which accompanies the prisoner as they move around the prison. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011.

New Psychoactive Substances (NPS)

29. New psychoactive substances (NPS), previously known as 'legal highs' (although they are now illegal), are an increasing problem across the prison estate. They are difficult to detect and can affect people in a number of ways including increasing heart rate, raising blood pressure, reducing blood supply to the heart and vomiting. Prisoners under the influence of NPS can present with marked levels of disinhibition, heightened energy levels, a high tolerance of pain and a potential for violence. Besides emerging evidence of such dangers to physical health, there is potential for NPS precipitating or exacerbating the deterioration of mental health with links to suicide and self-harm.
30. In July 2015, we published a Learning Lesson Bulletin about the use of NPS and its dangers, including its close association with debt, bullying and violence. The bulletin identified the need for better awareness among staff and prisoners of the dangers of NPS, the need for more effective drug supply reduction strategies, better monitoring by drug treatment services and effective violence reduction strategies.
31. HMPPS now has in place provisions that enable prisoners to be tested for specified non-controlled psychoactive substances as part of established mandatory drugs testing arrangements. Testing has begun, and HMPPS continue to analyse data about drug use in prison to ensure new versions of NPS are included in the testing process.

Key Events

HMP Belmarsh

32. On 27 April, Mr James was remanded to HMP Belmarsh for assault, threatening behaviour and breaching a previously suspended court order. This was not his first time in prison. At his reception screening, Mr James said that he had no thoughts of suicide or self-harm and no substance misuse or mental health problems. He had a deep cut on his left forearm and right hand, for which he had just received hospital treatment after a domestic dispute while under the influence of illicit drugs and alcohol. The reception nurse noted no concerns.

HMP Elmley

33. On 31 May, Mr James was transferred to HMP Elmley. At an initial health screen, a nurse noted no concerns about his physical or mental health. A prison GP saw Mr James and recorded that he had occasionally used cocaine and cannabis in the community. The GP referred him to the psychosocial team for therapeutic support about his drug use. Mr James was not tested for drugs.
34. Mr James was housed on the induction wing. He completed his prison induction over the next few days and was moved on 2 June to another cell on Houseblock 2, which he shared with another prisoner.
35. On 6 June, a nurse from the substance misuse clinical team assessed Mr James in response to the GP's referral. The nurse reported that Mr James was not prescribed medication and had no withdrawal symptoms from illicit substances. Despite this, Mr James reported feeling paranoid and asked to be referred to the mental health team.
36. A mental health nurse subsequently assessed Mr James. He said that he had felt paranoid because he believed staff had told other prisoners on his previous landing personal information about him. He said he felt much better and more relaxed after staff had moved him and his cellmate to another landing.
37. Mr James said that his past substance misuse problem had often led him to criminal activity. He said that a few years earlier, he had misused drugs, and had been detained for 24 hours in a secure mental health hospital. A nurse noted that Mr James interacted well and displayed no evidence of a mental health problem. Mr James was assessed as having a low level of anxiety and depression. He said he had no thoughts of suicide or self-harm and intended to wait for the outcome of his trial before he applied for prison jobs. The nurse discharged Mr James from the mental health team's caseload but encouraged him to apply to attend the mental health workshops.
38. On 30 June, Mr James was convicted of affray, assault, and attempted robbery, and sentenced to 2 years and 2 months in prison. A nurse saw Mr James when he returned from court but noted no concerns and said he appeared calm and relaxed. Mr James said he had no thoughts of suicide or self-harm and intended to get a prison job to keep him occupied.

July 2016

39. From 1 July, Prisoner A shared a cell with Mr James and his cellmate. He said that Mr James was upset with the court's decision, as he had expected a much shorter prison sentence. He said he noticed that Mr James' mood and demeanour slowly deteriorated. He said Mr James had changed from a person who socialised with others to doing "weird" things like rocking from side to side in his cell at night, talking about witchcraft and screaming in his sleep. He had paranoid thoughts about others and believed that people were talking about him. He said he told staff about Mr James' behaviour.
40. On 5 July, an officer began ACCT procedures after Mr James said he was hearing voices, his mood was low and he appeared confused. Staff initially monitored Mr James hourly, and noted he shared a cell and had been referred to the mental health team. A Supervising Officer (SO) assessed Mr James, who told her that he had last heard voices two months earlier when he had tried to kill himself by cutting himself. Mr James said that while he had previous thoughts of suicide and self-harm, he was okay and his partner and family supported him.
41. The SO arranged for the healthcare team to review Mr James urgently, and two nurses examined him. Mr James repeated that he heard voices, felt anxious and sometimes had panic attacks. One nurse recorded that Mr James communicated well and denied taking illicit substances.
42. A nurse noted that Mr James showed no signs of mental ill health but his mood was low. He referred Mr James to the mental health workshop as Mr James had not applied to attend. A prison GP prescribed Mr James promethazine (a sedative and antipsychotic) and they agreed to review him in a week's time.
43. Two SOs completed the first ACCT case review. No member of the healthcare team attended. Mr James said he had thoughts of self-harm but had no intention of acting on them. He wanted to occupy his time and felt anxious. They agreed that Mr James was at low risk of suicide and self-harm and that they would monitor him three times during the day and five times at night. The ACCT caremap noted that staff had referred Mr James to the mental health team and advised him to apply for a job.
44. On 8 July, Prisoner A said Mr James appeared to have a short seizure in their cell. Immediately afterwards, Mr James grabbed a razor blade and started to slash his arms. Prisoner A pressed the emergency cell bell and when staff arrived, Mr James was severely cutting his forearms. Staff removed Mr James' two cellmates from the cell and called for healthcare assistance and an ambulance. Mr James refused to talk to staff or give them the razor blade.
45. While staff prepared to put on personal protective equipment to go into the cell, Mr James' self-harm increased significantly and he made serious cuts to his inner thighs near the femoral artery and his right forearm. Staff immediately went into the cell. Mr James was extremely resistant and staff had to restrain him. When the paramedics arrived, staff moved Mr James onto the landing to be treated because of the large amount of blood in the cell and the severity of his wounds. The paramedics took Mr James to hospital by ambulance, where he was put in an induced coma on a ventilator until 9 July.

46. A custodial manager visited Mr James in hospital. He told her that he was in pain and was upset that he was in hospital. He said he recalled cutting himself, but did not know why he did it and had felt no pain at the time. He was adamant that he had not taken any illicit substances before the incident but was struggling with mental health problems, and Prisoner A supported this view at interview. Based on his behaviour, prison staff suspected that Mr James had taken Spice, a NPS.
47. The Safer Custody Manager visited Mr James in hospital, but said that Mr James did not want to speak much about the incident and appeared embarrassed by his actions. Mr James had said he could not recall much but had heard voices and wanted to kill himself. She tried to arrange for Mr James' partner to visit him but he said that he was not ready to see her yet. Mr James received intravenous antibiotics and plastic surgery to repair his forearm.

13 July 2016

48. The hospital discharged Mr James on 13 July with paracetamol, dihydrocodeine tablets (strong analgesic medication), and co-amoxiclav (an antibiotic). He returned to Elmley's inpatient unit, where staff observe prisoners hourly.
49. Mr James told a nurse that he felt mentally unstable, did not know why he had "mad thoughts" or had harmed himself. He said he felt "shattered", stressed, had been hearing voices and felt paranoid that something would happen to someone close to him. He denied thoughts of suicide or self-harm.
50. That day, the Safer Custody Manager chaired an ACCT review, with a custodial manager and Mr James. He denied having thoughts of suicide or self-harm, said he needed psychiatric help and wanted to remain in the inpatient unit. The Safer Custody Manager assessed that Mr James' risk of suicide and self-harm was raised, agreed that he should be checked hourly and scheduled the next case review for 14 July.
51. The Safer Custody Manager updated Mr James' ACCT caremap, and noted two issues: Mr James wanted psychiatric help (staff had referred him to the mental health team) and he did not want to return to a houseblock (it had been agreed that Mr James would remain in the inpatient unit until he was fit to return to a standard location).
52. Later that evening, a mental health nurse saw Mr James and despite him saying that he was hearing voices, noted that Mr James displayed no evidence of a mental health problem. Mr James denied thoughts of suicide or self-harm.

14 July

53. A prison GP saw Mr James and noted that his physical injuries were healing. Mr James said that there was "magic" in the cell and that he had heard voices before his incident of self-harm.
54. A manager in the inpatient unit and a consultant forensic psychiatrist completed an ACCT review. They noted that Mr James' mood and behaviour were settled. He said he had no thoughts of suicide or self-harm. They reduced his risk of

suicide and self-harm to low and set his observation levels at three times a day and hourly at night.

55. Afterwards, the psychiatrist assessed Mr James' mental health. Staff had told him that Mr James' self-harm incident was out of character and, based on his substance misuse history, they were concerned that he might have been under the influence of Spice (a NPS). Prison intelligence indicated that Mr James' cellmates were Spice users but there was no intelligence about him, and he was not tested for drugs. Mr James told the doctor that, while he had misused drugs since he was 18 years old, he had not taken any substances and did not believe that he had been given any inadvertently before his self-harm incident. Despite this, he had felt as though he was under the influence of drugs at the time. Mr James said he had heard voices coming from the television. He said he had not wanted to hurt himself and attributed his actions to the voices instructing him to do so.
56. The psychiatrist recorded that the most likely explanation for Mr James' actions, based on his history and bizarre presentation, was NPS misuse. He noted that Mr James' mental state appeared settled but that he had said he was uneasy at times and paranoid. Mr James said he had no current thoughts of suicide or self-harm. The psychiatrist prescribed promethazine and noted Mr James should remain in the inpatient unit as he continued to be at risk of self-harm based on recent events, his substance misuse history and his diagnostic uncertainty.
57. On 19 July, the psychiatrist saw Mr James and recorded that while he was a bit tense, he had improved. Mr James denied thoughts of suicide or self-harm. He said that his medication (promethazine) helped him sleep better but he still felt anxious and paranoid around people and preferred to stay in his cell. Mr James had not previously wanted to see his partner but was looking forward to a forthcoming visit. The psychiatrist prescribed a low dose of olanzapine (an antipsychotic used to treat schizophrenia and bipolar disorders) to treat Mr James' paranoia and transient psychosis.
58. On 22 July, Mr James was sentenced to a concurrent six months in prison, for further charges of threatening, abusive and insulting behaviour. The Head of Healthcare saw Mr James when he returned to Elmley, but recorded no concerns.
59. The next day, the Head of Healthcare completed an ACCT review with a nurse. Mr James was pleased that his court appearance had not resulted in an extended prison sentence. Mr James' risk of self-harm was assessed as low and no changes were made to his observation levels.
60. On 26 July, the prison received and responded to a letter from Mr James' grandmother. She raised concerns about Mr James and his mental health.
61. On 27 July, a manager in the inpatient unit completed an ACCT review with a RAPT worker (Rehabilitation for Addicted Prisoners Trust, a drug and alcohol service). The records do not explain why a RAPT worker was involved in Mr James' review, whether they discussed Mr James' potential drug use or reached any conclusions about it. The manager noted that Mr James' mood was good, he had no thoughts of suicide or self-harm and wanted to remain in the inpatient unit. She reminded him he would remain in the inpatient unit until he was fit to

return to a standard location. No changes were made to his risk of suicide or self-harm.

62. On 28 July, the psychiatrist reviewed Mr James' mental health. He recorded no significant change to his mental state and presentation. Mr James said he felt better, had no thoughts of suicide and self-harm and felt less paranoid. He said he did not think his medication was effective as he still had difficulties sleeping. The doctor doubled Mr James' olanzapine dose. Mr James said he had had a recent visit from his partner that went well.

August 2016

63. Throughout August, staff continued to review Mr James daily and the psychiatrist assessed his mental health. Mr James started to spend more time in his cell, only coming out to collect his meals. He told the psychiatrist that he felt better but his medication was not helping and it gave him nightmares, disrupted his sleep and he still felt anxious. He said he had no thoughts of suicide or self-harm. The psychiatrist replaced Mr James' prescription of promethazine and olanzapine with quetiapine (a drug similar to olanzapine, commonly used as an antipsychotic to treat schizophrenia, bipolar and major depressive disorders, and to aid sleep).
64. By 11 August, a nurse noted that Mr James was interacting well with staff and prisoners and spending more time out of his cell, taking part in activities such as playing pool and exercise. Mr James said that he felt better after taking quetiapine. He felt less anxious, no longer had bad dreams, paranoid thoughts or heard voices.
65. On 16 August, Mr James told a nurse that he now believed his previous cellmates had "spiked" him, which caused him to harm himself. Mr James told the psychiatrist that he had had no psychotic episodes and denied thoughts of suicide or self-harm. He said he felt safe in the inpatient unit and did not want to return to the houseblock, where he feared for his safety from prison staff. Mr James said he had had similar feelings about the police when arrested and referred to a previous arrest when police had referred to him as being cursed. Mr James said he thought this incident was linked to a negative experience in the army and believed that there was a conspiracy against him.
66. The psychiatrist noted that while Mr James' presentation and mental state had improved, he displayed signs of mental illness and paranoid beliefs. He noted that staff would continue to monitor Mr James.
67. Between 17 August and 6 September, staff noted Mr James interacted well and was taking his medication. During August, staff completed three ACCT reviews, which reported positively about Mr James' demeanour and mood.

From 6 September 2016 onwards

68. On 6 September, a multidisciplinary ACCT review was held. Staff, including the psychiatrist, a member of the chaplaincy team, a governor and a nurse, discharged Mr James from the inpatient unit. They noted that Mr James' mental state was stable and he would continue to receive the mental health support. Mr James' risk of self-harm was recorded as low and his observation level was

reduced to three times during the day and night. Staff agreed that Mr James should have a single cell and moved him to Houseblock 4.

69. On 10 September, a nurse from the mental health team assessed Mr James. He told her that he had no thoughts of suicide or self-harm. He believed that all prison and police staff were out to get him. Mr James said that a week before he had self-harmed in July, strange things (which he had not previously believed in) had started to happen to him because of witchcraft and magic. He described seeing pyramids and that when he had looked at his cellmate's legs, his feet appeared bigger and he had a tail. Mr James denied that he had taken illicit substances. She noted that Mr James had symptoms of paranoia. He said he had had stopped taking his medication in the afternoon, and said that he wanted to take it at night. She was concerned that Mr James' paranoia significantly increased his risk to others if he continued not to take his medication. She noted that she would discuss Mr James with the psychiatrist.
70. A prisoner told the investigator that he spoke to Mr James regularly. He said he noticed that Mr James sometimes talked about black magic and voodoo dolls and believed that the police had cast a spell on him after he was arrested. He said Mr James' mental health had deteriorated but it was not necessarily noticeable to others as he often isolated himself.
71. On 12 September, a SO and a custodial manager held an ACCT review. No one from the healthcare team attended. Mr James said that he had no thoughts of suicide or self-harm and now that he worked as a cleaner, he had started to think positively. The SO stopped ACCT monitoring, and noted all caremap actions had been completed.
72. On 14 September, a nurse spoke to the psychiatrist, who changed Mr James' medication to modified-release tablets of quetiapine to be taken at night.
73. On 26 September, staff recorded no concerns in Mr James' post-closure ACCT review. An officer said that Mr James was quiet and polite.
74. On 27 September, a nurse reviewed Mr James, who had been complying with his medication, and said it had improved his sleep. He said he had had no paranoid thoughts about staff and described them as friendly. He was looking forward to a visit from his baby son that weekend. Later that evening, when Mr James collected his medication from the medication hatch, he told a nurse that he wanted to reduce his dose of quetiapine. The next day, he failed to attend the mental health workshop. No reason was recorded in his medical record.

October 2016

75. On 5 October, staff gave Mr James a disciplinary warning for not attending work. An officer told the investigator that while Mr James usually attended work with no problems, staff had recently had to encourage him to attend on time.
76. From 6 October, after an assessment, the Head of Healthcare noted that Mr James was to be prescribed his medication in-possession, seven days at a time.
77. On 11 October, Mr James told a nurse that he no longer needed mental health support as there was nothing wrong with him. He reiterated that his self-harm

incident in July was due to witchcraft. She agreed to see him in three weeks' time.

78. On 12 October, Mr James refused to take his medication (quetiapine). He told the duty nurse that it gave him headaches (a common recognised side effect). The nurse told a colleague, who contacted prison staff on Houseblock 4. She told them that Mr James had stopped taking his medication and asked them to monitor his behaviour. As a result, the Head of Healthcare rescinded Mr James' entitlement to hold any medication in-possession and reduced Mr James' quetiapine dosage.
79. A nurse spoke to Mr James about not taking his medication and told her he did not believe it would make him better and had only taken it to help him sleep. She explained to Mr James that his mental health might deteriorate without medication and that his dosage had now been reduced. She made an appointment for Mr James to see the prison psychiatrist. Mr James said he had no thoughts of suicide or self-harm.
80. On 15 October, a nurse spoke to the Head of Operations about Mr James not taking his medication. Mr James was moved back to the inpatient unit so healthcare staff could monitor his risk of suicide and self-harm closely. He was monitored hourly and healthcare staff assessed him daily.
81. On 18 October, a psychiatrist assessed Mr James in a multidisciplinary team review. Staff noted that Mr James' mood was okay but he isolated himself in his cell a lot. He maintained that he did not want to take quetiapine because it made him groggy and gave him headaches, and did not want an alternative medication or further treatment. Mr James said he felt mentally well but occasionally heard voices. He said living in a single cell had a positive effect on his mental health. He said that while he had problems sleeping, he was eating well, had not had any psychotic episodes since July, and had no thoughts of suicide or self-harm. He wanted to return to the houseblock as soon as possible as he did not want to lose his job. The psychiatrist noted that, while Mr James showed no overt symptoms of psychosis, he should remain in the inpatient unit for further monitoring.

November 2016

82. On 1 November, the psychiatrist assessed Mr James. She recorded no concerns and noted Mr James had not had any visual or auditory hallucinations. While he continued not to take his medication, she noted that Mr James had not displayed any adverse effects. She and staff in the inpatient unit agreed that Mr James should be discharged but would continue to receive support from the mental health team. Mr James returned to his cell in Houseblock 4.
83. On 9 November, a manager in the mental health team saw Mr James on behalf of a nurse who was absent. The officers on Houseblock 4 had previously updated him about Mr James' progress. They said that they had no concerns about his mental health, and he had settled well. He recorded that Mr James had no thoughts of suicide or self-harm.

84. A prisoner told the investigator that he knew Mr James from the community and his personality could switch instantly. He said that when Mr James returned to the houseblock, he was not himself. He said Mr James sometimes appeared worried and stressed but tried to hide his feelings. Mr James had missed work a couple of times, complaining that he had a headache. Another prisoner, who lived in the cell next to Mr James, said that he too saw Mr James' differing personalities, which ranged from socialising with other prisoners on the landings and shadow boxing to isolating himself in his cell.
85. On 17 November, a nurse reviewed Mr James and recorded that he interacted well. His mood was good and he denied thoughts of suicide or self-harm and said he was looking forward to being released in January 2017. She agreed to review Mr James in four weeks' time.

December 2016

86. While Mr James continued to refuse his medication, the prison GP continued to prescribe it so that it would be available to him, should he change his mind. Staff noted a slight change in Mr James' behaviour. An officer told the investigator that Mr James became a little "lackadaisical" and staff had to encourage him more than usual to attend work.
87. An officer told the investigator that in early December, Mr James was either late or failed to attend work at the designated times. He gave Mr James a final warning on 11 December that he would lose his job if he did not comply with the requirements of his job.
88. A nurse had scheduled a review of Mr James' mental health on 15 December but the appointment did not take place because she was on long term sick leave.
89. On the evening of 17 December, an officer told a nurse that Mr James had not attended the medication hatch to collect his medication. She checked Mr James' medical record and noted that he had not collected his medication for some time. She did not know Mr James but decided to visit him. She told the investigator that Mr James' mood was calm and he said he felt well. He said that taking quetiapine made him feel worse and had had no positive effect. Despite Mr James declining her offer of a GP appointment, she referred him to the doctor to discuss his management plan.
90. On the afternoon of 18 December, an officer received a phone call from an officer in the visits hall, who said that Mr James' father had come to visit him. The officer told Mr James, but he did not want to see his father and told staff to tell him to "fuck off". She said that staff in the visits hall were told to tell Mr James' father that his son did not want to see him.

19 December

91. A prisoner, who had lived in the cell next to Mr James for about four weeks, said that he regularly spoke to Mr James and described him as "not a well man". He said Mr James displayed bipolar-like symptoms: his mood fluctuated, he sometimes looked depressed, was quiet and stayed in his cell for long periods, watching television. He sometimes paced up and down the landings, shadow

boxing and talking to other prisoners. He said he had a brief conversation with Mr James on 19 December. Mr James told him that he had not slept well.

92. An officer told the investigator that Mr James had told him that he regretted not seeing his father the day before. He said Mr James was quiet and wanted to ensure that staff had not relayed his message to his father in the manner in which he had expressed it. He said that he had spoken to a colleague and reassured Mr James that staff had only told his father that he did not want to see him. He said she spoke to Mr James afterwards to check on his welfare and reminded him of the support available from the mental health team.
93. At 11.58am, Mr James phoned his grandmother and told her that he had refused to see his father because he had not felt well and did not want to see anyone. He said he had felt depressed but was getting better. His grandmother asked why he had written a number of strange letters to his friends and partner. Mr James agreed that his letters were disturbing. She said his family were concerned about him and that his current behaviour might make others frightened of him. His grandmother asked him repeatedly why he refused to take his medication. She told him to ask healthcare staff to prescribe him alternative medication if his current medication was not suitable. She believed Mr James was not looking after himself but Mr James repeated that he was okay.
94. At around 4.55pm, just before all prisoners were locked in their cells for the night, A prisoner said Mr James came to his cell and asked to borrow a bowl. He had no concerns about Mr James.
95. Around 8.30pm, day staff handed over to the night manager. No one identified any concerns about Mr James. An operational support grade (OSG) was the night patrol officer on Houseblock 4. When he arrived, he was given a radio, sealed key pouch and an anti-ligature knife. The prison does not issue patrol officers with a torch, but the OSG had his own. He checked all cell doors were locked and checked on prisoners' welfare by looking through their cell door observation panels. He said he checked Mr James at around 9.15pm and recalled Mr James was lying in his bed, watching television.
96. Between 9.00pm and midnight, the OSG said he carried out pegging duties (a patrol of the houseblock landings) at least twice. This task did not involve checking on prisoners' welfare. He told the investigator that although night duty staff were required to record the time of their pegging duty on a standard night patrol report, he never did this. He had no concerns and the houseblock appeared settled. The night manager conducted a routine visit of Houseblock 4 at 10.35pm to check that everything was okay.

20 December

97. A prisoner told the investigator that at around 12.00am, the loud volume of a television and a groaning noise from Mr James' cell woke him up. He said the television volume sounded like it was on "number 100". He banged on their adjoining cell wall to get Mr James' attention, but he did not respond. Within about five minutes, he said he went back to sleep.

98. At 12.15.am, the OSG said he was in the office on the second landing and heard the loud volume of a television coming from a cell on the houseblock. The general level of noise on the houseblock usually lessened as the night progressed and prisoners went to sleep and turned off their televisions and radios. Occasionally, the sound from a prisoner's television or radio could be heard once it was quiet.
99. The OSG investigated, as he knew that prisoners might complain, and he found that the noise was coming from Mr James' cell. He opened the cell door observation panel, the cell light was off and he saw the television was on. He knocked on the door several times, but Mr James never responded. He tried to turn the cell night light on (from a panel outside the cell door) but it did not work. He did not shine his torch into the cell as he did not want to disturb Mr James whom he believed to be asleep, with the television on. He said that the light from the television enabled him to see Mr James lying in bed, facing the wall, with his head near the toilet and feet towards the window, covered by a blanket.
100. In line with Elmley's local prison guidelines, the OSG turned off the electrical power for Mr James' cell from outside his cell door. Mr James did not respond when the television switched off as a result. He later (at 2.05pm) recorded his actions in the houseblock observations book. At 3.15am, the night manager made her second routine visit of Houseblock 4, but said the OSG did not mention Mr James. The OSG said that he did not consider it important enough to tell the night orderly officer about cutting off the power.
101. At 5.05am, the OSG went to Mr James' cell as part of the routine morning roll count of prisoners. He shone his torch through the cell door observation panel and saw Mr James lying on his bed. He said he could not recall which way Mr James was facing or whether or not he was covered by a blanket. He was satisfied that Mr James appeared okay and asleep.
102. At 7.30am, the OSG handed over to Officer A. The OSG could not recall whether he had told the officer that Mr James' cell light was not working. The officer told the investigator that the OSG had not mentioned Mr James, but had told him that a prisoner's television had been on too loud. He had read the OSG's entry in the houseblock observation book, but said he was unaware that the electrical power to Mr James' cell had been turned off.
103. That morning, the majority of staff were involved in a security operation on another houseblock which meant that prisoners were not unlocked at the usual time of around 8.30am. Officer A helped with the security operation, leaving one officer alone on duty on Houseblock 4. At 9.45am, staff began unlocking prisoners on all the prison houseblocks.
104. Officer A started unlocking prisoners on Houseblock 4. When he unlocked Mr James' cell, he opened the door and said good morning. Mr James did not respond. He said that because of the location of Mr James' cell, the room was poorly lit and the cell was not as bright as others. As the door opened further, he noticed a little bit of blood on the wall. He took two steps into the cell and realised something was wrong. He saw Mr James lying diagonally across his bed on his back, with his head on a pillow between the wall and the end of his bed. Mr James' eyes were open, he had a severe cut to his stomach and his

intestines were hanging out onto the bed. There was a blood-soaked blanket draped over him onto the floor, where there was a pool of blood. He described Mr James as pale, motionless, not breathing and clearly dead.

105. Officer B immediately left the cell and closed the door as prisoners were on the landing. He radioed an emergency code red at 9.50am. An ambulance was called at 9.52am and the prison doctor at 9.53am. He shouted for staff to help and for prisoners to be locked in their cells. Officer A arrived in seconds and saw Officer B standing outside Mr James' cell, indicating that something was wrong. He looked through the cell door observation panel and saw Mr James, lying still on the bed, and some staining on the wall.
106. Another officer arrived at Mr James' cell in seconds. He went into the cell, checked Mr James for signs of life but found none. Another officer arrived and pressed the general alarm button for further staff assistance. She looked through the cell door observation panel but could not see anything wrong because of the poor lighting. Officer A and another officer returned prisoners to their cells.
107. A number of staff responded to the emergency alarm, and two SOs and a nurse went into Mr James' cell. The nurse asked the doctor to attend and immediately checked Mr James for signs of life, but found none. He was stiff, pale and his intestines lay out of his stomach. Staff agreed that Mr James was clearly dead and did not try to resuscitate him. A prison GP arrived at the cell within minutes of receiving the emergency call. He saw Mr James lying on his bed. Mr James was unresponsive, was not breathing, was cold and stiff. The GP declared Mr James' death at 10.03am. At 10.10am, paramedics arrived and examined him.

Staff and prisoner support

108. At 1.30pm, the Governor debriefed the staff involved in the emergency response and offered his support and that of the staff care team. Staff reviewed prisoners assessed as at risk of suicide and self-harm in case they had been affected by Mr James' death.

Contact with Mr James' family

109. A chaplain and a SO were appointed as Elmley's family liaison officers. They visited Mr James' grandmother, who was his next of kin, to explain what had happened and to offer support. In line with Prison Service policy, the prison contributed to the costs of Mr James' funeral. The chaplain held a chapel service, which was well attended.

Cause of death

110. A post-mortem examination concluded that Mr James died from a self-inflicted incised wound to his abdomen caused by a thin-bladed implement, such as a modified razor, and there was evidence of repeated attempts at causing the fatal wound. The toxicology found no illicit substances in Mr James' system and noted that tests had screened for 43 types of NPS.

Other information

111. The investigator was told that Mr James' cell light had not worked for a number of months but that Mr James had reported it to staff.

Findings

Assessment of risk and management of Mr James' risk of suicide and self-harm

112. Prison Service Instruction (PSI) 64/2011 on safer custody lists a number of risk factors and potential triggers for suicide and self-harm. In July 2016, before his serious self-harm incident, Mr James' mood was low and he was hearing voices which indicated possible mental health issues. Staff appropriately identified these risk factors. They started ACCT procedures to monitor and support Mr James, and the mental health team saw him promptly, prescribed medication for anxiety and referred him to the psychiatrist. Despite this, he seriously self-harmed three days later.
113. After Mr James returned from hospital on 13 July, staff appropriately continued ACCT procedures. He received some good care. He spent two months in the inpatient unit because of his poor mental and physical health, where mental health staff saw him daily and the psychiatrist assessed him regularly before a multidisciplinary team agreed that he should return to a standard houseblock.
114. Mr James appropriately remained under the care of the mental health team after he returned to Houseblock 4 in September. Mr James' paranoia continued, his peers said he isolated himself and acted strangely and staff were concerned that his refusal of medication in October might trigger a decline in his mental health. Despite this, Mr James continued to function in prison at a level below the threshold of someone staff might consider to be at risk.
115. Mr James complied with his medication until 12 October and while he continued to have some paranoid thoughts, he never harmed himself or tried to take his life between July and December, and Mr James consistently said he had no thoughts of suicide or self-harm. Staff appropriately assessed and monitored Mr James' risk over a reasonable period of time, and their decision that he should return to the houseblock in September was reasonable.
116. Mr James' period of monitoring in the inpatient unit in October 2016 did not indicate that his paranoid thoughts or his refusal of medication had put him at a heightened risk of suicide and self-harm. The level of monitoring and assessment of Mr James was appropriate given the concerns staff had about his possible increased risk of self-harm after he refused his medication. We conclude that it was reasonable for staff to return Mr James to the houseblock in November.
117. There was no indication in the days leading to Mr James' death that he was at high or imminent risk of suicide. While a missed mental health assessment on 15 December might have allowed staff to identify some concerns about Mr James, it would have been difficult for staff to anticipate his actions on 20 December. It was reasonable therefore that he was not subject to ACCT monitoring before his death.

ACCT procedures

118. We have some concerns about how staff managed ACCT procedures, after Mr James was identified as at risk of suicide and self-harm on 5 July. PSI 64/2011

requires ACCT case reviews to be multi-disciplinary but no one from the healthcare team (including the mental health team) attended Mr James' first ACCT review on 5 July. This was fundamental to staff identifying the appropriate care and support Mr James needed. Despite staff knowing his history of self-harm and his recent discharge from the inpatient unit, no one from the healthcare team attended the case review on 12 September when staff stopped ACCT monitoring, and there is no evidence that the mental health team were involved in this decision.

119. While Mr James' risk of self-harm was considered low at this time, a mental health nurse had noted only two days earlier that Mr James had stopped taking his medication, which might have increased his risk of self-harm. He had moved to Houseblock 4 less than a week earlier. However, there is no record that staff considered these factors when deciding to stop ACCT monitoring.
120. There was a lack of continuity in managing Mr James' risk; six different managers chaired the 12 case reviews (including one in hospital). We were particularly concerned that a SO, who stopped ACCT monitoring for Mr James, had only attended one ACCT review and the SO who made the decision with him, had not been involved in any of Mr James' previous ACCT reviews. We make the following recommendation:

The Governor and Head of Healthcare should ensure that prison staff assess and manage prisoners at risk of suicide or self-harm in line with national guidelines, including holding multi-disciplinary ACCT reviews with continuity of case management and involving all staff who can contribute to the care of a prisoner at risk.

NPS

121. Prison staff and the psychiatrist who assessed Mr James after the July incident understandably suspected that his serious self-harm might have been as a result of NPS use: he had a history of substance misuse in the community, prison intelligence indicated that his cellmates were known Spice users (which might have given him access to illicit substances) and staff described his self-harm as out of character.
122. Despite this, Mr James consistently denied taking drugs (though he said he felt like he had been under the influence of drugs) and anecdotally, all the prisoners we interviewed agreed that he did not take drugs, including NPS. Although in the aftermath of the July incident, Mr James said that he had not taken drugs inadvertently, by the following month, he suspected that his former cellmates had "spiked" him. It is not clear whether this was his paranoia or whether this had taken place.
123. Given Elmley's suspicions about Mr James' drug use, we might have expected them to test Mr James for drugs on his return to prison and to review his possible drug use as part of his care plan. However, Mr James was closely monitored in the inpatient unit for a reasonable period of time, and at no time between July and December did anyone report that Mr James appeared under the influence of drugs. We cannot know for certain whether or not Mr James took drugs, inadvertently or otherwise, in July, but with hindsight, it is unlikely in light of the

toxicology results that Mr James had taken any substances, including NPS, before his death.

Night patrol officer's duty and actions

124. The night duty officer is required to patrol the houseblock landings (called pegging) at various times throughout the night and record when they have done so. Pegging helps ensure the safety of prisoners and staff. During the night state, patrol officers should look into each cell and either turn on the light or shine their torch into the cell. The practice might disrupt prisoners' sleep and is generally reserved for prisoners subject to security issues or at risk. Mr James did not fall into either category and so, was not subject to additional monitoring or welfare checks during the night.
125. The night patrol officer (OSG) told the investigator that he completed his pegging duty throughout the night on 19 December. He had not (nor had he previously) completed a night patrol report, a requirement of his night duties, which should have noted the times that he completed the pegging tasks. In the absence of evidence, we cannot conclude whether he had done so. Elmley has no records to indicate whether night staff complete pegging duties on Houseblock 4. We make the following recommendation:

The Governor should remind night duty staff of their responsibility to complete the night patrol reports and ensure that they do so.

Prisoner safety checks at night

126. All prisons have a duty to ensure that cell accommodation, including its size, lighting, heating, ventilation and fittings are adequate for health and fit for purpose. Most prisons conduct daily fabric checks, which should include checking that the cell night light provides a dim light to illuminate a cell to help staff check prisoners at night. When the OSG attended Mr James' cell in response to his loud television, he found that the night light was not working. He did not use his torch (as he said he did not want to wake Mr James) and considered that the light emitted from the television provided enough brightness to judge that Mr James appeared asleep.
127. Based on evidence from a neighbouring prisoner, it was possible that Mr James had already harmed himself by the time the OSG attended his cell. We cannot know whether he was still alive at that time. The day staff who discovered Mr James did not realise something was wrong until they went into the cell, and it would have been even more difficult for the OSG to see at night with reduced lighting. Despite this, he had a torch, and we see no reason why he did not use it, especially as he had reason to check on Mr James. Using a torch might have provided better lighting but we cannot know whether or not he would have identified Mr James' actions and whether it might have changed the outcome for Mr James. We make the following recommendation:

The Governor should ensure that staff satisfy themselves of a prisoner's safety at night, and if they cannot see them properly at checks, they use the cell night light and/or torch and tell their manager if they are concerned.

Cell maintenance

128. The OSG told the investigator that switching off the power in a prisoner's cell (due to loud noise) was not sufficiently important to tell the night manager, and there was no requirement for him to do so. He also failed to tell anyone that Mr James' cell night light was not working. The night manager said that if a cell bell or night light did not work, staff should report it to the prison works' department and prisoners should not occupy the cell. She was unaware that Mr James' night light was not working. We do not know how long Mr James' night light had not worked or whether staff knew about it. Between 1 and 20 December 2016, no one had submitted a maintenance request to fix Mr James' cell light. It is important that cell night lights work properly at all times to keep prisoners and staff safe. We make the following recommendation:

The Governor should ensure that cell night lights are in good working order at all times.

Clinical care

129. We agree with the clinical reviewer that overall, the care Mr James received at Elmley was equivalent to that he could have expected in the community, particularly the emergency response when he was found unresponsive.

Mental healthcare

130. Mental health services were heavily involved in Mr James' care but did not decide on a diagnosis for him and therefore did not have a long-term plan to manage his needs. Although they were aware of his paranoia, the mental health team were unable to reach a diagnosis and they believed that NPS might have caused Mr James' behaviour rather than a primary psychotic illness. Retrospectively, in light of the toxicology results, the clinical reviewer noted Mr James' symptoms of withdrawal, sleeplessness, anxiety and paranoia and concluded that it was more likely that Mr James had psychosis.
131. Mr James did not consistently show signs of mental ill health that were significant enough to indicate to staff that he was at risk of suicide or self-harm, though all the prisoners we interviewed had concerns about his mental health. The clinical reviewer noted that it was likely that he had an acute psychotic episode when he cut open his abdomen, perhaps caused by anxiety and fuelled by his impulsive behaviour. Mr James had never said he wanted to take his own life and we found no evidence of such an intention.
132. The clinical reviewer notes that it was likely that Mr James' refusal to take medication contributed to his self-harm and death. A psychiatrist had continued to prescribe Mr James' medication (quetiapine) despite his refusal to take it. She said that she wanted Mr James to have the option to take the medication because of the short and long-term risk of a mental illness re-developing. While we recognise that it would have been difficult to ensure Mr James took his medication unless he was admitted to hospital under the Mental Health Act, Mr James' presentation and behaviour gave them little reason to do so or to restart ACCT procedures in the days leading to his death.

Mental health appointment

133. There were no arrangements to cover the nurse's sick absence, which meant that Mr James' mental health review, which was scheduled for 15 December, did not take place. While there was no evidence to suggest that Mr James was in crisis, it is difficult to assess the impact such a review might have had or whether it might have changed the outcome for him. With hindsight, staff missed an opportunity to identify any issues he might have had in the days before his death. In another case, such a review might have identified a serious risk. We make the following recommendation:

The Head of Healthcare should ensure that in the event that mental health staff are unable to attend a prisoner's mental health review, it is covered by a member of the mental health team or rescheduled promptly, and the change is recorded.

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