Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Thomas Nicol a prisoner at HMP The Mount on 25 September 2015

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.

Mr Thomas Nicol was found hanged in his cell in the segregation unit at HMP The Mount on 21 September 2015. He was taken to hospital but he did not regain consciousness and died on 25 September. He was 38 years old. I offer my condolences to Mr Nicol's family and friends.

Mr Nicol was serving an indeterminate sentence, was almost two years past his minimum term, and was frustrated about his lack of progress towards release. His death is a sad reminder of the stress and uncertainty that prisoners serving indeterminate sentences can face. On 18 September 2015, three days after he arrived at The Mount, he cut himself and staff began to monitor him as at risk of suicide and self-harm. He was taken to the segregation unit without any recognition that this should be exceptional for someone at risk. His behaviour changed rapidly. He appeared paranoiac, began to threaten staff and was moved to an unfurnished cell for some time. I am concerned that procedures designed to protect such vulnerable prisoners did not operate effectively. Case reviews were not multidisciplinary and did not identify and put in place plans to reduce his risk. Staff did not use enhanced case review procedures when he was moved to an unfurnished cell and he never had a mental health assessment, which he should have had within 24 hours. I do not consider that the use of restraints was justified when Mr Nicol was taken to hospital unconscious and in a serious condition.

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 **June 2016**

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Summary

Events

1. In May 2009, Mr Thomas Nicol was remanded to prison charged with violent offences. In November 2009, he received an indeterminate prison sentence for public protection with a minimum period to serve of four years. Mr Nicol spent time in a number of prisons but the Parole Board never directed his release or considered he was suitable for an open prison. His last parole review in June 2015, considered Mr Nicol should do further motivational and psychological work. Mr Nicol was very frustrated about this decision.

2. On 15 September 2015, Mr Nicol was transferred to HMP The Mount. In the early hours of Friday 18 September, Mr Nicol cut his face with a razor blade, set fire to his cell, threatened staff and demanded to go to the segregation unit. He said he was upset about not moving to an open prison. The night manager began Prison Service suicide and self-harm prevention procedures (known as ACCT) and moved him to the segregation unit. A nurse agreed it would be safe to hold him in the segregation unit but was unable to assess him properly. She spoke to the mental health in-reach team leader about his presentation but no one referred him for a mental health assessment, which should have happened within 24 hours.

3. Over the next four days, Mr Nicol threatened staff, made improvised weapons, tried to break his fingers, threatened to gouge his eyes out and banged his head on the cell door. Segregation staff held ACCT case reviews every day, but a mental health nurse attended only the last case review. On Saturday 19 September, managers agreed that Mr Nicol should be held in an unfurnished cell to manage his risk. No one assessed his mental health or held an enhanced case review, as Prison Service instructions require. On Sunday 20 September, a senior Prison Service manager agreed that he could remain in the unfurnished cell for longer than 24 hours. Later that afternoon, staff assessed that his risk had reduced and moved him back to a standard segregation unit cell.

4. On the morning of Monday 21 September, Mr Nicol made weapons out of broken glass and torn clothing. He was moved back to an unfurnished cell until late that afternoon. The mental health in-reach team leader went to the segregation unit twice that day to see Mr Nicol, but segregation staff said that his risk was too high for her to speak to him or even observe him through the cell door.

5. At 8.57pm, an officer checked Mr Nicol. She thought he had a sheet tied around his neck but was not sure. She radioed for urgent assistance and went into Mr Nicol's cell four minutes later, when the night manager arrived with other staff. Mr Nicol had hanged himself by a sheet attached to the window. Staff tried to resuscitate Mr Nicol until paramedics arrived. Mr Nicol remained unconscious and paramedics took Mr Nicol to hospital, where he was placed on life support. A manager decided he should be restrained but restraints were removed after Mr Nicol was sedated. On 25 September, doctors withdrew life support and a doctor recorded Mr Nicol's death at 12.45pm.

Findings

6. Mr Nicol was very frustrated about his lack of sentence progression. Although he had sometimes been a discipline problem in prison before, he had never harmed himself before he went to The Mount. We do not consider that the prison managed his risk of suicide or self-harm effectively and in line with national Prison Service instructions, including a lack of healthcare input. No one assessed him properly or set targets to help reduce his risk. Prisoners assessed as at risk of suicide and self-harm should be segregated only in exceptional circumstances but no one recorded the exceptional reasons for Mr Nicol's segregation and there is no record that anyone considered whether any alternative accommodation in the prison would have been more appropriate.

7. Prison Service instructions require prisoners being managed under ACCT procedures and held in the segregation unit, to have a mental health assessment within 24 hours, yet no one referred him for an assessment, despite his increasingly strange behaviour, or after he was moved to an unfurnished cell. There is a lack of mental health provision at The Mount at weekends, which hindered appropriate assessment. When mental health staff went to see Mr Nicol on Monday 21 September, segregation staff prevented them even observing Mr Nicol through the observation panel in his door. No one held an enhanced case review, which should have happened after Mr Nicol was moved to unfurnished accommodation. This would have required more senior staff involvement and a multidisciplinary holistic review of his care.

8. We do not consider that the use of restraints when Mr Nicol was taken to hospital was justified.

Recommendations

- The Governor should ensure that staff manage prisoners at risk of suicide or self-harm in line with national guidelines, including ensuring that:
    - Prisoners at risk are not held in the segregation unit unless all other options have been considered and excluded and there are fully documented reasons to explain the exceptional circumstances.
    - A trained ACCT assessor completes an assessment within 24 hours of the ACCT being opened and attends the first case review.
    - Case reviews are multidisciplinary and include all relevant people involved in a prisoner's care, including mental health staff where appropriate and healthcare staff attend all first case reviews.
    - Staff set ACCT caremap actions which are aimed at reducing prisoners' risks to themselves and review them at each case review.
    - Staff use enhanced case management procedures for prisoners held in unfurnished accommodation and in other more complex cases.

- The Governor and Head of Healthcare should ensure that, in line with PSO 1700, prisoners identified as being at risk of suicide and self-harm held in the segregation unit or in unfurnished accommodation should have a mental health assessment within 24 hours.

- The Head of Healthcare should ensure that there is sufficient dedicated mental health capacity at weekends to meet prisoners' needs and to ensure that mandatory mental health assessments are completed.
- The Governor should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position and that assessments fully take into account the health of a prisoner and are based on the actual risk the prisoner presents at the time.

The Investigation Process

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

10. The investigator visited the prison on 1 October 2015, and obtained copies of relevant extracts from Mr Nicol's prison and medical records

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

12. The investigator interviewed 22 members of staff and seven prisoners. The clinical reviewer joined him for some of the interviews with staff. At the initial report stage, the National Offender Management Service (NOMS) responded to the recommendations.

13. We informed HM Coroner for Hertfordshire of the investigation who gave us the cause of death and the results of toxicology tests. We have sent the coroner a copy of this report.

14. One of the Ombudsman's family liaison officers contacted Mr Nicol's sister to explain the investigation. Mr Nicol's sister and the solicitor representing his family wanted the investigation to consider the following points:

    - How staff assessed and managed Mr Nicol's risk of suicide and self-harm.
    - Why Mr Nicol wanted to be segregated at HMP Erlestoke and The Mount.
    - How his time in The Mount's segregation unit was managed.
    - How staff responded to the emergency on 21 September.
    - How the prison managed contact with Mr Nicol's family after he died.

    Mr Nicol's family received a copy of the initial report. They raised a number of issues/questions that do not impact on the factual accuracy of this report and have been addressed through separate correspondence.

Background Information

HMP The Mount

15. HMP The Mount is a medium security prison holding more than 1,000 men. There is a segregation unit with 18 standard cells and two special (unfurnished) cells.

16. Hertfordshire Community NHS Trust provides primary healthcare services and GP services. There are daily GP sessions Monday to Friday, with out of hours provision at other times. There are no healthcare staff on duty between 6.30pm and 8.00am.

17. Prisoners with mild and moderate mental illness are supported by the GP and, sometimes, the mental health in-reach team. Prisoners with severe and enduring mental health problems are supported by the in-reach team with staff on duty between 8.00am and 4.00pm, Monday to Friday. There is no weekend or out of hours mental health service.

Her Majesty's Inspectorate of Prisons

18. The most recent inspection of HMP The Mount was in April 2015. Care for men at risk of suicide and self-harm was adequate, although some lessons from previous PPO investigations into deaths at the prison had not been fully embedded. Most prisoners said that staff treated them respectfully but were very busy. Inspectors found that the mental health in-reach team provided a good level of secondary mental healthcare.

19. The segregation unit was busy and records showed that it was usually full or nearly full. Although some prisoners back to the wings, too many (more than half of those segregated) were transferred to other prisons for their own safety.

Independent Monitoring Board

20. 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 most recently published report for the year to February 2015, the IMB commented that The Mount was a well run prison where staff endeavoured to provide a fair and decent service in a challenging environment. The IMB reported that the segregation unit was full most of the time. The average time prisoners spent in the segregation unit had increased.

Previous deaths at HMP The Mount

21. Mr Nicol's was the fourth death at The Mount since January 2014. One of the previous deaths was from natural causes and two were self-inflicted. There were no significant similarities with the circumstances of the other deaths.

Assessment, Care in Custody and Teamwork

22. ACCT is the Prison Service process for supporting and procedures prisoners at risk of harming themselves. The purpose of the ACCT is to try to determine the level of risk posed, the steps that might be taken to reduce this and the extent to which staff need to monitor and supervise the prisoner. Checks should 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. Regular multidisciplinary reviews should be held. The ACCT plan should not be closed until all the actions of the caremap have been completed. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011.

Segregation unit

23. Segregation units (sometimes known as care and separation units, as is the case at The Mount) are used to keep some prisoners apart from others. 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 a prison operational manager 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 restricted and prisoners are usually permitted to leave their cells only to collect meals, wash, make phone calls and have a daily period in the open air. The segregation unit at The Mount comprises 18 single cells and two special accommodation (unfurnished and without sanitation) cells. Each cell has an emergency call button and when this is pressed a light flashes outside the cell and it activates a buzzer which can be heard throughout the unit.

24. Special accommodation can be used: to prevent injury to another prisoner; to prevent damage to property; to prevent a prisoner causing a disturbance; and to prevent self-harm (but only in exceptional circumstances). Prisoners located in special accommodation must be observed by a member of staff at least five times an hour. A prison manager must chair a case review after 24 hours to decide if the prisoner should remain in special accommodation.

Key Events

25. On 20 May 2009, Mr Thomas Nicol was remanded to HMP Woodhill, charged with robbery, attempted robbery and possession of an offensive weapon. It was not his first time in prison. On 15 October, Mr Nicol received an indeterminate sentence for public protection with a minimum term to serve of four years before he could be considered for release. This mean he was eligible for release from 9 November 2013, if the Parole Board was satisfied that he was no longer a risk to the public.

26. Mr Nicol moved between several prisons over the next four years. He often worked in the prisons' kitchens and did not complete any offending behaviour programmes. In August 2013, at HMP Rye Hill, he asked for a psychologist to assess him to determine his suitability for programmes, but no one assessed him at Rye Hill or his next prison. In October 2013, Mr Nicol asked to go to a therapeutic community at HMP Blundeston but the prison was closed before he could be referred.

27. In February 2014, HMP Warren Hill began a therapeutic community and agreed to consider an application from Mr Nicol, but noted that he had not taken full responsibility for his offences, so might not be suitable. On 10 June, Mr Nicol transferred to HMP Coldingley. He said he was not happy to have been moved to Coldingley, as he was waiting to be transferred to Warren Hill's therapeutic community. The prison's offender management unit contacted Warren Hill, which said that Mr Nicol needed to have a psychology assessment before they could consider his application. There is no evidence that anyone spoke to Mr Nicol about this or arranged the assessment. Mr Nicol started working in the prison's kitchens, but frequently asked officers about the progress of his application to Warren Hill.

28. On 3 October, Mr Nicol said he wanted to be segregated until he was transferred to a prison where he could complete offending behaviour programmes. A manager authorised his segregation.

29. On 16 October, Warren Hill decided that Mr Nicol was not suitable for the therapeutic community because he had received a warning (for refusing an order to give an officer some tablets in May 2014) and because he was segregated. Mr Nicol was upset at this news and said he wanted to move to another prison. He remained in the segregation unit.

30. On 19 November, Mr Nicol transferred to HMP Erlestoke. At an initial health screen, a nurse recorded that Mr Nicol had no thoughts of suicide or self-harm. He had a single cell on a standard wing. On 25 November, he met his new offender supervisor and explained he was frustrated that he had not done any offending behaviour programmes. He arranged for a psychology assessment to assess Mr Nicol's suitability for programmes.

31. On 2 February 2015, the offender supervisor and Mr Nicol spoke to Mr Nicol's offender manager (probation officer) by video link. Mr Nicol was concerned about his next parole hearing and his offender supervisor encouraged him to speak to his solicitor about this. Mr Nicol repeated that he was frustrated that he had not been able to take part in any offending behaviour programmes, yet he was due to be considered for release soon. He said he would like to do the Self-Change Programme (an offending behaviour programme for prisoners with a history of

violent offending). After the meeting, the psychologist informed his offender supervisor that Mr Nicol was not suitable for the Self-Change Programme, but would benefit from offending behaviour work in a therapeutic community.

32. On 26 February, Mr Nicol had a Parole Board hearing and the panel asked his offender supervisor for more information about why he was unsuitable for the Self-Change Programme and how soon he could be transferred to a therapeutic community, if he was assessed as suitable.

33. On 6 March, the offender supervisor forwarded an application for Mr Nicol to join the therapeutic community at HMP Dovegate and contacted Warren Hill about reconsidering his previous application. On 19 March, the course facilitator at Erlestoke for the Self-Change Programme assessed Mr Nicol as unsuitable, because he had no insight into his aggression.

34. On 5 May, Warren Hill told the offender supervisor that they wanted Mr Nicol to expand the answers on his application to the therapeutic community. The same day, Dovegate turned down Mr Nicol's application to join their therapeutic community. They considered that Mr Nicol showed a lack of responsibility for his offences.

35. After a parole hearing on 2 June, the Parole Board concluded that Mr Nicol should remain in prison and they did not consider that his level of risk could not be managed in open conditions. The Parole Board said that Mr Nicol should engage in motivational work and consider working with a psychologist. Mr Nicol was frustrated by this and said he thought it was a backward step.

36. On 2 July, Mr Nicol went to the segregation unit and refused to leave. Officers forcibly took him back to his cell. Mr Nicol broke the observation panel in his cell door and officers then took him to the segregation unit. The duty governor recorded that Mr Nicol was being segregated for safety and security reasons and for causing criminal damage to his cell. A doctor found no medical reason why Mr Nicol should not be segregated.

37. At a disciplinary hearing on 3 July, Mr Nicol was told that he would be segregated for 14 days. He refused to eat and said he was frustrated about his lack of progress. He drank water and healthcare staff monitored him. On 10 July, he started eating again.

38. On 13 July, the Public Protection Casework Section of the National Offender Management Service (NOMS) wrote to Mr Nicol to confirm the Parole Board's decision and informed him that his next parole review would be in February 2017. The letter suggested that Mr Nicol should be assessed for the Self-Change Programme, a therapeutic community and/or one-to-one psychology work. It also suggested that Mr Nicol would benefit from a victim awareness course. When the offender supervisor spoke to Mr Nicol about the letter, he dismissed it and said he just wanted to be transferred to Scotland (where he was from originally) to get on with his sentence.

39. Mr Nicol refused to go back to a wing and remained in the segregation unit, subject to the standard segregation checks by officers, managers and healthcare staff. On 31 August, Mr Nicol said he wanted to transfer to a London prison. On 4

September, Mr Nicol told the duty governor that he would be prepared to transfer to HMP The Mount, and she arranged the move.

40. On 13 September, the duty governor noted in Mr Nicol's prison record that he was floating paper in a bowl of water and talking about prophecy. She described his behaviour as strange, but did not refer him to the mental health team or take any further action.

41. On 15 September, an officer recorded that Mr Nicol had been shouting that he would save other prisoners once he was released. This had kept other prisoners awake during the night. Mr Nicol transferred to The Mount the same day.

42. At an initial health screen at The Mount, a nurse recorded that Mr Nicol had no thoughts of suicide or self-harm and had not previously self-harmed in prison. He was not taking any prescribed medication and had no recorded mental health problems.

43. A prisoner who knew Mr Nicol from when he was at HMP Rye Hill, was in the cell next to him at The Mount. He said he was surprised to see Mr Nicol, who told him he had not yet managed to get a move to an open prison.

44. Another prisoner who knew Mr Nicol from Rye Hill, had a short conversation with him that day. He said Mr Nicol was laughing and joking. Later that day, Mr Nicol told a prisoner he wanted to move to a different wing where he knew some other prisoners.

Friday 18 September 2015

45. At 12.48am on Friday 18 September, Mr Nicol pressed his cell bell and asked to be taken to the segregation unit. He said he was upset about his sentence plan and about not being able to move to an open prison. He had cut his face with a razor blade, but refused treatment. The night manager told Mr Nicol that he could not move because the segregation unit was full and none of the segregated prisoners were willing to move to make space for him. Mr Nicol threatened to kill staff and, at around 1.15am, he started to set fire to objects in his cell. She and two other officers put out the fire. She started ACCT procedures and asked staff to check him five times an hour.

46. The night manager then went to the segregation unit and persuaded one prisoner to move. At around 2.40am, she moved Mr Nicol to the segregation unit. Segregation officers continued to check him five times an hour, because of his risk of suicide and self-harm.

47. At 8.15am, a general nurse began a segregation safety algorithm as part of the initial segregation health screen, which aims to exclude very mentally unwell and suicidal prisoners from segregation. She recorded that Mr Nicol was kneeling on the floor of his cell with his arms crossed. He had a plastic fork in his hand, and was rocking and groaning. She noted that she could not assess him because he would not speak to her but he had no history of mental health treatment. She ticked the assessment form to indicate that Mr Nicol's mental health would deteriorate significantly if he was segregated, but then crossed this out. She wrote that Mr Nicol did not need healthcare intervention before he was segregated, but that someone should discuss his segregation with the mental health in-reach team.

48. The nurse wrote in his medical record that she did not know whether Mr Nicol's behaviour was a "display" or the start of a mental health episode. She recorded that it was safe for Mr Nicol to remain in the segregation unit, as he had asked to go there and there was more staff interaction than on a residential wing.

49. The nurse discussed Mr Nicol's presentation with the mental health in-reach team leader after she had left the segregation unit. They thought the mental health in-reach team needed to assess him urgently. The team leader told the investigator that the nurse was just briefing the mental health in-reach team because they might need to be involved in Mr Nicol's care if his behaviour continued. There was no record of this conversation. The nurse said that a doctor would see Mr Nicol later that morning and the doctor's assessment would inform the urgency of a mental health referral. She did not refer Mr Nicol to the GP or the mental health team herself.

50. At around 9.30am, the Head of the Offender Management Unit was duty governor and saw Mr Nicol as part of her standard segregation unit rounds. She recorded that she thought he was okay. At around 10.00am, a chaplain saw Mr Nicol and recorded that he was polite and respectful and there were no issues.

51. At 2.45pm, a Supervising Officer (SO) tried to interview Mr Nicol to assess him as part of ACCT procedures, but Mr Nicol would not speak to him, and he did not complete the assessment. The SO then held the first ACCT case review on his own, contrary to the national instructions for ACCT management. The SO recorded that Mr Nicol was not engaging with staff. He assessed his risk of suicide or self-harm as raised, yet set the level of observations at once an hour. The SO did not record anything in the ACCT document to indicate the exceptional reasons for segregating a prisoner assessed as at risk of suicide or self-harm or that he had considered alternative accommodation.

52. At around 3.00pm, Mr Nicol told a GP, who was doing segregation rounds, that he did not want to see her. She told the investigator that she had spoken to Mr Nicol through the door observation panel and he had said everything was okay. She said that she had not seen his medical records. She was not particularly concerned about him and saw nothing to indicate he needed a mental health assessment.

Saturday 19 September 2015

53. During the early hours of 19 September, a night patrol officer recorded that Mr Nicol had a towel around his head and would not respond when she spoke to him. At 10.10am, an officer noted that Mr Nicol had put broken pieces of his radio aerial between his fingers and had threatened to attack staff if they went into his cell.

54. At 10.56am, a nurse recorded that she could not assess whether Mr Nicol was fit to attend a disciplinary hearing. (He had been charged with setting a fire in his cell and threatening to kill staff.) She wrote that he was standing in middle of his cell with a towel wrapped round his head. A SO, one of the segregation unit staff, told her that Mr Nicol had some weapons (the radio aerial and some sharpened plastic), so it was not safe for officers to open his cell door. The nurse noted that there was blood on the cell floor because Mr Nicol had cut his arm with the radio aerial. He

had also ripped up pages of the Koran, which had been in the cell, and scattered these around him.

55. At around 11.30am, a custodial manager asked Mr Nicol to pass him the aerial pieces and sharpened plastic, but he refused. He and a team of officers went into Mr Nicol's cell to physically restrain him and he tried to stab the officers using the improvised weapons. At 11.40am, the officers moved him to an unfurnished cell (without any furniture or sanitation, known as special accommodation). Officers told the nurse she could not go into Mr Nicol's cell and examine him because he was too violent. She did not speak to him through the door, but completed a safety algorithm indicating there were no healthcare reasons not to segregate him. In line with national instructions, officers were required to check Mr Nicol five times an hour because he was in an unfurnished cell.

56. Instructions require prison staff to hold an ACCT case review within two hours if a prisoner assessed as at risk of suicide or self-harm is held in an unfurnished cell. At 12.20pm, a SO and an officer held an ACCT case review but there were no healthcare staff present and neither was Mr Nicol. The SO recorded that Mr Nicol's behaviour was very bizarre and assessed him as at high risk of suicide or self-harm. He recorded that officers should check Mr Nicol five times an hour.

57. Around 4.00pm, the Head of Safer Custody, who was the duty governor that weekend, saw Mr Nicol, who threatened to pull his eye out if he did not open the cell door. He told Mr Nicol that he needed to stop acting strangely so that he could go back to his wing. An hour later, he went to see Mr Nicol again. Mr Nicol said he did not want any food and just wanted to fight. He told him he could not go back to his standard cell in the segregation unit until his behaviour improved.

58. At 6.35pm, an officer recorded that Mr Nicol appeared to be trying to break his own fingers. She told the prison's night manager and continued to check him until her shift ended. Mr Nicol was awake most of night.

Sunday 20 September 2015

59. At around 9.10am on Sunday 20 September, a SO recorded that Mr Nicol was standing in his cell wearing a mask made from his t-shirt. He had ripped up the blanket and tied a strip around his wrists. At 9.35am, Mr Nicol spat and swore when the Head of Safer Custody asked if he would leave the unfurnished cell to go back to a standard segregation unit cell. At around 10.15am, Mr Nicol told him he would not remove his "battle dress" and said that he needed to open the observation panel and come into the cell. He told Mr Nicol he would not open the observation panel as he was threatening staff.

60. At around 10.30am, a nurse went to see Mr Nicol to assess whether it was suitable for him to remain in the unfurnished cell. She recorded that the SO had told her that Mr Nicol was threatening to harm anyone who went into his cell, so it was not safe for her to go into the cell to see him.

61. As Mr Nicol had been in an unfurnished cell for nearly 24 hours, the Head of Safer Custody chaired a special accommodation case review with three segregation officers, two nurses and the SO to discuss whether Mr Nicol should stay in an unfurnished cell for his own protection and for the safety of staff. The Head of

Safer Custody recorded that Mr Nicol had threatened staff, urinated in his cell, spat at staff, threatened to gouge his own eyes out, break his own fingers and bang his head against the cell door. He noted that Mr Nicol had been referred to the mental health in-reach team, and he would be assessed on Monday 21 September. (There is no evidence of this referral in Mr Nicol's records.) The review agreed that he should remain in the unfurnished cell, subject to the agreement of the regional manager. After the case review, the Head of Safer Custody contacted the regional manager, who agreed that Mr Nicol could remain in the unfurnished cell for up to another 24 hours because of his violent behaviour and the risk to staff.

62. At 11.30am, a chaplain tried to speak to Mr Nicol but he did not reply. The SO held an ACCT case review, which the chaplain attended but Mr Nicol would not participate. No member of healthcare staff was present. The SO recorded that Mr Nicol had not self-harmed or threatened to harm himself since he had been in the unfurnished cell, but he continued to threaten staff. The review assessed Mr Nicol's risk of suicide or self-harm as raised, rather than high, but kept his level of observations at five an hour, the minimum level of observations for a prisoner in an unfurnished cell.

63. Mr Nicol ripped his blanket into strips and tried to tie them to his hands and feet. At about 3.00pm, a custodial manager asked Mr Nicol to give him the strips of blanket, but he refused. The manager and a team of officers went into the cell to get take the torn strips of blanket from him and to move him so that staff could clean his cell. They used control and restrain techniques and during the restraint, Mr Nicol tried to strangle the SO with a strip of blanket and he bit an officer. Officers moved Mr Nicol to the other unfurnished cell, cleaned his cell and then moved him back.

64. Around 3.40pm, a nurse examined Mr Nicol's hands, which he had put through observation panel in the cell door. She recorded that Mr Nicol had superficial cuts to his forearms and face and his fingers were swollen and painful. She said she would arrange for the nurse doing routine segregation rounds the next morning to give Mr Nicol pain relief medication, because she did not have anything with her and he did not seem in severe pain. The Head of Safer Custody saw Mr Nicol at the same time and arranged for him to have fresh blankets and some milk. When he gave him the milk, Mr Nicol said that he would think about returning to a furnished cell.

65. At around 4.10pm, Mr Nicol moved back to a standard segregation unit cell. Ten minutes later, at around 4.20pm, Mr Nicol collected his meal and thanked the officer who gave it to him.

Monday 21 September 2015

66. At 8.10am on Monday 21 September, segregation officers recorded that Mr Nicol had broken his spectacles, put the pieces of glass between his knuckles and wrapped them in torn strips of clothing. The officers contacted the orderly officer and recorded it in Mr Nicol's ACCT record.

67. At a management meeting that morning, the Governor asked the mental health in-reach team leader to ensure that someone from the mental health in-reach team saw Mr Nicol that day. She telephoned the segregation unit at around 9.00am, but staff told her that his behaviour was too disruptive for her to assess his mental

health. At 9.55am, an officer recorded that Mr Nicol had tied a strip of blanket to both wrists to form a garrotte to threaten staff.

68. At 10.15am, a custodial manager asked Mr Nicol to give him his broken glasses, the strip of blanket and any other improvised weapons, but he refused. He and a team of officers went into Mr Nicol's cell to remove the items and moved Mr Nicol back to an unfurnished cell. The duty governor told Mr Nicol that he would stay in the unfurnished cell until he stopped being aggressive and threatening staff.

69. At around 11.30am, a psychologist and the mental health in-reach team leader went to the segregation unit to see Mr Nicol but an officer told them that they could not assess him because it was too much of a security risk and Mr Nicol did not want to talk to them. Neither of them tried to speak to Mr Nicol themselves. The mental health in-reach team leader told the investigator that she had asked segregation unit staff to let her know if Mr Nicol changed his mind or his behaviour improved.

70. Around 3.00pm, the mental health in-reach team leader went back to the segregation unit to see Mr Nicol and attend his ACCT case review. She told the investigator that a SO had told her that Mr Nicol was too high risk to speak to or assess that afternoon. She had asked if she could observe him through the door observation panel, but the SO said that he posed too high a risk even for that. She did not question the supervising officer's judgement.

71. At the same time, as part of a segregation review, a nurse considered whether there were any healthcare reasons not to continue segregating Mr Nicol. She noted that he had self-harmed, but that his mental health would not be adversely affected by continued segregation. She signed the algorithm to say that Mr Nicol did not need any immediate healthcare intervention, although she recorded that staff should speak to the mental health in-reach team about his continued segregation. The Deputy Governor chaired the review and authorised Mr Nicol's continued segregation.

72. A SO chaired an ACCT case review, with the mental health in-reach team leader and a nurse. Mr Nicol did not attend. The mental health in-reach team leader said that if Mr Nicol's behaviour continued he might need to see a psychiatrist and they could not rule out an acute psychotic illness. She did not know whether Mr Nicol would agree to treatment or a mental health assessment. She said that someone from the mental health in-reach team would attend all ACCT case reviews and asked someone to contact her immediately, if Mr Nicol appeared settled enough for someone to be able to assess his mental health. They agreed that Mr Nicol's risk remained raised but his level of observations could be reduced to twice an hour. They considered that Mr Nicol wanted to harm others but no longer wanted to hurt himself. While Mr Nicol was in the unfurnished cell, he continued to be checked five times an hour, as required.

73. At 5.00pm, a nurse, accompanied by two officers, examined Mr Nicol's hand through the door observation panel. She noted that he engaged well with her, but his cell door could not be unlocked for security reasons. At around 5.20pm, Mr Nicol ate his dinner.

74. At 5.30pm, a manager agreed that Mr Nicol could move back to his standard cell in the segregation unit. Five officers took Mr Nicol back to his cell, but they did not restrain him. At 6.05pm, a nurse went to see Mr Nicol in his cell and strapped the fingers on his left hand, which were swollen. Mr Nicol was sitting on bed and appeared calm at the time.

75. At 6.10pm and 6.30pm, when an officer checked Mr Nicol he was lying on his bed and said he was okay. Around 7.30pm, an officer recorded that Mr Nicol was making his bed. Five minutes later, an officer noted that Mr Nicol was sitting up in his bed and he was in the same position at 8.10pm. When she spoke to Mr Nicol, at 8.40pm, he was standing by his window and said he was okay. She said Mr Nicol had a towel wrapped around his head. She did not regard this as unusual, as she had seen other prisoners do this when they were preparing to go to bed.

76. At around 8.45pm, Officer A checked Mr Nicol who showed him some cuts on his head. He tried to speak to Mr Nicol but could not understand him. Officer A told the investigator that most of cuts were not recent. Officer A went back to the segregation unit office and told Officer B about Mr Nicol's cuts. Officer B then rang the communications room and asked for the night manager to come to the segregation unit as Mr Nicol had self-harmed. Both officers went to Mr Nicol's cell and he had a towel wrapped around his head again. There was no visible bleeding from any of the cuts. Mr Nicol would not respond when Officer B spoke to him.

77. Officer B said that she did not think Mr Nicol's cuts were recent because she could not see any blood on his face. She phoned the communications room and said that she did not need the night manager urgently and could wait until the manager's routine check, later that night.

78. At about 8.57pm, Officer B walked past Mr Nicol's cell and opened the observation panel to check him. She said Mr Nicol was kneeling down and facing away from her. She thought he had a sheet tied around his neck, but could not see properly to be sure. She did not open the cell door because of Mr Nicol's previous aggressive behaviour and because segregation staff had assessed that at least three officers were needed before his cell could be unlocked. She telephoned for urgent assistance and kicked the door but Mr Nicol did not respond. Officer A asked whether they should go into the cell but she said they should wait for the night manager because of Mr Nicol's violent behaviour over the weekend, and because she could not be sure what had happened.

79. Officer B went back to the segregation unit office to check where the night manager was on the external CCTV. When she saw the night manager was nearby, she shouted Mr Nicol's cell number and said she was going in. At 9.00pm, Officer A unlocked the cell door and she climbed around the mattress that Mr Nicol had put in the doorway. Mr Nicol was kneeling against the window with his head on the window ledge and a sheet tied around his neck attached to the window.

80. Officer A cut the sheet and Officer B and the night manager lowered Mr Nicol onto the floor. Officer B called the communications room to ask for an ambulance, at the night manager's request. The ambulance service recorded that they received the call at 9.01pm. Officer A started cardiopulmonary resuscitation. Another officer arrived and attached a defibrillator, but this found no shockable heart rhythm, so the staff continued resuscitation.

81. The paramedics arrived and reached Mr Nicol's cell at 9.18pm. The paramedics took over Mr Nicol's treatment and at 10.00pm, took Mr Nicol to hospital. The ambulance log recorded that Mr Nicol was unconscious at the time. Two officers accompanied Mr Nicol in the ambulance and restrained him by an escort chain. (An escort chain is a long chain with a handcuff at each end, one of which is attached to the prisoner and the other to an officer.)

82. The night manager completed an initial risk assessment, which concluded that Mr Nicol was a high risk of escape and high risk to the public and noted that this was an emergency with no healthcare staff present. She decided that Mr Nicol should be restrained by an escort chain and that three officers should stay with him at the hospital. At 10.45pm, when Mr Nicol was sedated in hospital, she agreed that the restraints could be removed.

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83. At 2.15am on 22 September, the duty governor that night reduced the level of escort to two officers, but instructed them to use an escort chain to restrain Mr Nicol. At 11.26am, the duty governor reviewed the risk assessment and decided only one officer should stay with Mr Nicol who had been moved to the intensive care unit, and the escort chain should be removed. No restraints were used after that. At 3.00pm, hospital doctors stopped sedating Mr Nicol but his breathing was assisted by a ventilator. Mr Nicol remained on life support until 12.20pm on 25 September. At 12.45pm, a hospital doctor recorded that Mr Nicol had died.

Contact with Mr Nicol's family

84. After Mr Nicol went to hospital, staff tried to contact his sister, who he had named as his next of kin. However, the contact details in Mr Nicol's record were out of date. On 22 September, a prison family liaison officer was appointed and contacted the chaplaincy department at Erlestoke, Mr Nicol's solicitor and the Probation Service to see if they had recent contact details for Mr Nicol's sister. The family liaison officer went to the last known address for Mr Nicol's mother, but could not find anyone who knew her. On 23 September, the prison contacted the police who traced Mr Nicol's mother on 27 September and informed her of his death. The family liaison officer phoned her and arranged to visit her that evening and then spoke to his sister shortly afterwards. The prison contributed towards the cost of Mr Nicol's funeral in line with national instructions.

Support for prisoners and staff

85. No one debriefed the staff who had been involved in the emergency response after Mr Nicol was found hanged, or after his death. The staff were offered the support of the prison's care team.

86. After Mr Nicol died, the Governor issued notices to staff and prisoners informing them of Mr Nicol's death. Officers and members of the chaplaincy team supported prisoners. Staff reviewed prisoners who had been assessed as at risk of suicide and self-harm in case they had been adversely affected by Mr Nicol's death.

Post-mortem report

87. A post-mortem examination was not carried out. The coroner recorded Mr Nicol's cause of death as hypoxic brain injury caused by asphyxiation. A toxicology examination found no drugs or alcohol in Mr Nicol's bloodstream when he died.

Findings

Managing Mr Nicol's risk of suicide and self-harm in the segregation unit

88. When Mr Nicol arrived at The Mount in September 2015, he said that he had never harmed himself or attempted suicide before. There was no history of self-harm recorded in his prison or medical records. Mr Nicol was five years into an indeterminate sentence and two years past his minimum term (the period he had to serve before he could be considered for release). He had not yet completed any offending behaviour courses and the Parole Board had assessed him as unsuitable for release or for open conditions. It is apparent that his lack of progression towards release was a major concern for Mr Nicol and prison staff had been unable to allocate him to suitable programmes. During the early hours of 18 September, Mr Nicol cut his face and staff appropriately started ACCT suicide and self-harm prevention procedures. Very shortly afterwards, he was moved to the segregation unit.

89. In a Learning Lessons Bulletin we issued in June 2015, we examined learning from investigations into the self-inflicted deaths of prisoners who were segregated at the time of their deaths. We noted that segregation reduces some protective factors against suicide and should be used only in exceptional circumstances for those at risk of taking their own life. When prisoners at risk are held in segregation there are additional required safeguards, such as holding a mental health assessment within 24 hours and having an enhanced case review for prisoners at risk held in unfurnished accommodation. We found that often these procedures were not followed. This was also the case with Mr Nicol.

90. Prison Service Instruction (PSI) 64/2011, which covers safer custody, requires that prisoners assessed as at risk of suicide and self-harm should be held in segregation units only in exceptional circumstances and that the reasons must be clearly documented in the ACCT record and include others options that were considered but discounted. Mr Nicol was not in the segregation unit when the ACCT was opened but was moved there very shortly afterwards. There was nothing in the ACCT document to indicate that staff recognised that this was exceptional or that any other options had been considered.

91. PSI 64/2011 expects case reviews to be multidisciplinary where possible and there is a mandatory requirement that healthcare staff must attend the first case review. Mr Nicol refused to speak to a SO and no one completed an ACCT assessment. The SO held the case review alone, which is poor practice and contrary to the instructions in the PSI. Even when multidisciplinary attendance is not possible, it is implicit that ACCT reviews, which are based on teamwork, involve more than one member of staff. The SO did not invite anyone from the mental health in-reach team, despite the recorded sudden deterioration in his behaviour. The mental health in-reach team leader attended the last case review but there was no member of healthcare staff present at any of the others.

92. PSI 64/2011 requires caremaps to reflect the prisoner's needs, level of risk and the triggers of their distress. There were no entries in Mr Nicol's caremap. While we recognise that Mr Nicol not cooperate with the ACCT procedures, the PSI requires the ACCT assessor to do an assessment based on all the available information

and documents when prisoners are unwilling to engage. The SO should not have been the ACCT assessor, as he chaired the ACCT case review, but someone else should have assessed Mr Nicol using the information available. We are concerned that staff did not identify any issues, such as Mr Nicol's lack of progression, his sentence plan, location or mental health, which, if addressed, might have helped reduce his level of risk. None of the ACCT case reviews considered any caremap actions, yet this is fundamental to the ACCT process.

93. Prison Service Order (PSO) 1700, which covers segregation, says that staff should hold an enhanced ACCT case review within two hours of a decision to hold a prisoner on an ACCT in special (unfurnished) accommodation. No one held such a review. An enhanced case review team should include all relevant disciplines, including healthcare staff, and a higher level of operational management. PSI 64/2011 also indicates that prisoners whose behaviour is particularly challenging and disruptive should be managed under an enhanced ACCT case management process. Even if the enhanced case review was not a mandatory requirement, we would have expected staff to have considered using these procedures.

94. In order to deal with disruptive prisoners assessed as at risk of suicide or self-harm, staff need to make a full and proper assessment of all aspects and causes of their behaviour. The enhanced ACCT case management approach would have helped staff to consider Mr Nicol's risk, to himself and to others, more critically and holistically. More effective management of standard ACCT procedures would have ensured a multidisciplinary approach to managing Mr Nicol's risk. We make the following recommendation:

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

- **Prisoners at risk are not held in the segregation unit unless all other options have been considered and excluded and there are fully documented reasons to explain the exceptional circumstances.**
- **A trained ACCT assessor completes an assessment within 24 hours of the ACCT being opened and attends the first case review.**
- **Case reviews are multidisciplinary and include all relevant people involved in a prisoner's care, including mental health staff where appropriate and healthcare staff attend all first case reviews.**
- **Staff set ACCT caremap actions which are aimed at reducing prisoners' risks to themselves and review them at each case review.**
- **Staff use enhanced case management procedures for prisoners held in unfurnished accommodation and in other more complex cases.**

Mental health

95. A qualified healthcare professional (nurse or doctor) must complete a segregation health assessment for all segregated prisoners. This is not a full mental health assessment but a snap shot assessment of a prisoner's mental health, aimed at excluding very mentally unwell, suicidal prisoners from segregation. We do not consider that all the segregation health assessments for Mr Nicol were properly completed.

96. Nurses said that they could not assess Mr Nicol properly because they were told that he was too disruptive and aggressive to be unlocked, or because he refused to engage. Despite the nurses' inability to assess Mr Nicol, both nurses recorded he was fit for segregation. Prison managers agreed that Mr Nicol could be segregated, then that it was safe to accommodate him in an unfurnished cell.

97. As noted above, prisoners being monitored under ACCT procedures should be located in segregation units only in exceptional circumstances. When this happens, PSO 1700, which details the procedures to follow when segregating prisoners, requires that such prisoners should have a mental health assessment within 24 hours. This is also a requirement when such prisoners are held in unfurnished cells. Despite these mandatory instructions, Mr Nicol never had a mental health assessment.

98. A nurse said that she called the mental health in-reach team leader after she saw Mr Nicol at 9.30am on Friday morning. There is no record of that telephone call, although the team leader remembered discussing Mr Nicol's presentation with the nurse. Although the nurse had evident difficult completing the initial segregation health assessment, she did not consider that Mr Nicol needed an urgent mental health referral (despite the mandatory requirement of PSO 1700).

99. The mental health in-reach team leader told the investigator that there is no mental health cover at The Mount at weekends. If a prisoner has a mental health crisis, the prison relies on community services, for example an emergency admission to hospital, to assess and treat his mental health needs. Staff made no attempt to access mental health support for Mr Nicol on the weekend he was held in the segregation unit and in unfurnished accommodation. Without any mental health provision at weekends, it is difficult to see how the prison can fulfil the requirement to have a mental health assessment within 24 hours.

100. The mental health in-reach team leader and a psychologist eventually went to the segregation unit to assess Mr Nicol's health on Monday morning. An officer told the team leader that it was not safe for them to do so because Mr Nicol was considered a threat to staff. They accepted this. When the team leader returned that afternoon, the SO told her that it was not safe to assess Mr Nicol or even observe him through the observation panel in his cell door. Again, she accepted the advice and still did not assess Mr Nicol.

101. We are concerned that there was no dedicated mental health support available at weekends, other than a generic on-call community service. Partly due to reported security concerns, no one from the mental health team saw Mr Nicol before he died and he did not have a mental health assessment. Mr Nicol's mental health was not assessed as national instructions require. We make the following recommendations:

The Governor and Head of Healthcare should ensure that, in line with PSO 1700, prisoners identified as being at risk of suicide and self-harm held in the segregation unit or in unfurnished accommodation should have a mental health assessment within 24 hours.

The Head of Healthcare should ensure that there is sufficient dedicated mental health capacity at weekends to meet prisoners' needs and to ensure that mandatory mental health assessments are completed.

Emergency response

102. PSI 3/2013 requires prisons to have a medical emergency response code protocol, which states how staff communicate the nature of a medical emergency, and that the control room calls an ambulance immediately when a code is used. The Mount's local emergency response codes protocol states that a code blue should be used in a life-threatening situation, such as when a prisoner is not breathing or unconscious.

103. When Officer B found Mr Nicol unresponsive, she did not radio a code blue but instead called for urgent assistance. She said she was not sure whether it was a life-threatening emergency because Mr Nicol was facing away from her so she could not see what had happened properly. She did not consider that it was safe to open Mr Nicol's cell because of his violent behaviour over the weekend. However, she and Officer A went into Mr Nicol's cell once they knew that the night manager was nearby. Officer B asked the communications room to call an ambulance once they had identified the serious situation.

104. We accept that Officer B was not sure whether a code blue was necessary when she first found Mr Nicol unresponsive in his cell. Both she and Officer A assessed the risk of the situation and believed it was not safe for them to go into Mr Nicol's cell until help was nearby. We consider that the staff actions were reasonable in the circumstances and we are satisfied that there was an appropriate emergency response.

The use of restraints

105. The Prison Service has a duty to protect the public when escorting prisoners outside prison, such as to hospital. It also has a responsibility to balance this by treating prisoners with humanity. The level of restraints used should be necessary in all the circumstances and based on a risk assessment, which considers the risk of escape, the risk to the public and takes into account the prisoner's health and mobility.

106. A judgment in the High Court in 2007 made it clear that prison staff need to distinguish between the prisoner's risk of escape when fit (and the risk to the public in the event of an escape) and the prisoner's risk when suffering from a serious medical condition. The judgement indicated that prison staff must take into account medical opinion about the prisoner's ability to escape and keep this under review as circumstances change.

107. We recognise that in an emergency it might not be possible for a full medical assessment to be completed and it is preferable to get the prisoner to hospital quickly and review the risk assessment later if necessary. However, we are concerned that when Mr Nicol was taken to hospital a manager decided he should be restrained by an escort chain, although it was clear at the time that he was unconscious and in a very serious condition. The escort chain was removed but then reapplied without an appropriate risk assessment, which took into account Mr

Nicol's condition at the time. It was not until the next day, over 12 hours after Mr Nicol arrived at the hospital, that restraints were permanently removed. We make the following recommendation:

The Governor should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position and that assessments fully take into account the health of a prisoner and are based on the actual risk the prisoner presents at the time.

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