

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Ruslanas Ignatenka a prisoner at HMP Swaleside on 9 November 2015

**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.

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 Ruslanas Ignatenka died on 9 November 2015, at HMP Swaleside, from a fatal blood loss after cutting his neck. I offer my condolences to Mr Ignatenka's family and friends.

The investigation identified a number of concerns about the management of Mr Ignatenka's risk at Swaleside. Prison Service suicide and self-harm prevention procedures did not operate effectively to protect him and an expected mental health referral did not take place. Mr Ignatenka said he had become dependent on 'Spice' a new psychoactive substance (NPS), which appears to have coincided with a change in his behaviour and was possibly the cause of his self-harm and ultimate suicide. I am satisfied that Mr Ignatenka was referred for help for this problem but I am concerned that the prison does not have an effective strategic approach to help eradicate the use of NPS. Finally, the emergency procedures were inadequate, with a significant delay before anyone called an ambulance after the emergency was identified.

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

August 2016

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Summary

Events

1. On 4 September 2006, Mr Ruslanas Ignatenka was sentenced to life imprisonment for murder. He had been at HMP Swaleside since 1 May 2014. On 23 August 2015, Mr Ignatenka barricaded his cell and self-harmed by cutting his leg. He was treated in hospital for two days. No one began ACCT suicide and self-harm prevention procedures or referred him for a mental health assessment.
2. On 27 August, Mr Ignatenka's smashed his cell and threatened staff. An officer recorded that Mr Ignatenka appeared paranoid and said he had been affected by taking 'Spice', a new psychoactive substance (NPS). He was held in the segregation unit for one day and then moved to the drug treatment wing. He said he found it difficult to stop taking Spice. On 1 October, he began a substance dependency treatment programme.
3. On 5 October, Mr Ignatenka damaged his cell and the wing pool table. Officers thought his mental health had been affected by using Spice and referred him for a mental health assessment the next day. On 21 October, a mental health nurse went to assess him but he was at work at the time. Wing officers told him that Mr Ignatenka used Spice. The nurse recorded that he would try to review Mr Ignatenka later but removed him from the mental health team list and never went back to assess him.
4. On Saturday 7 November, Mr Ignatenka told a supervising officer he was feeling extremely low. He said he had taken Spice the previous day and wanted help to stop. The officer advised him to get help as part of his treatment programme and emailed the safer custody team asking them to support Mr Ignatenka. He did not consider that Mr Ignatenka was at risk of suicide or self-harm, and did not begin ACCT procedures or refer him to the mental health team.
5. That night, Mr Ignatenka cut his arm. A manager began ACCT procedures and asked staff to check him once an hour. Mr Ignatenka was moved temporarily to the prison's healthcare centre and moved back to his wing the next day. On Sunday 8 November, an officer assessed Mr Ignatenka as part of ACCT procedures. No one held an ACCT case review, as should have happened.
6. On the night of 8/9 November, a night patrol officer checked Mr Ignatenka regularly at hourly intervals. At 3.04am, he found that Mr Ignatenka had put furniture in front of the door to impede access. Mr Ignatenka was lying on the floor and there was a lot of blood in the cell. He radioed a medical emergency code. Staff responded quickly and forced their way into the cell. A nurse assessed Mr Ignatenka and noted he had a deep cut on his neck and there was a large quantity of blood in the cell. The nurse could not find any signs of life and decided not to attempt cardiopulmonary resuscitation. At 3.50am, paramedics arrived and at 4.07am, recorded that Mr Ignatenka had died.

Findings

7. We are not satisfied that Swaleside fully recognised Mr Ignatenka's risk of suicide and self-harm and are particularly concerned that the prison did not begin ACCT procedures when he seriously harmed himself by cutting his leg at the end of August 2015. When staff began ACCT procedures shortly before his death, the procedures were not effectively managed to support him. Mr Ignatenka did not cooperate with the ACCT assessment but the assessor did not use other sources of information to help identify his main issues. A manager did not convene a multidisciplinary ACCT case review within 24 hours of the ACCT plan being opened as should have happened. This meant that there was no proper review of Mr Ignatenka's risk or discussion about what could be done to help reduce that risk. There was little evidence of active engagement with him. Observations remained at hourly from the time the ACCT plan was opened but these were all at predictable intervals. A number of staff had no recent ACCT training.
8. Although a supervising officer first referred Mr Ignatenka for a mental health assessment on 6 October, no one from the mental health team ever assessed him. A mental health nurse removed him from the mental health team's list without seeing him and presumed his irrational behaviour and distress was caused by his use of Spice, without an assessment.
9. Mr Ignatenka frequently said he had used and was dependent on NPS. Mr Ignatenka was appropriately referred for help from the substance misuse team. However, although there was an acknowledged problem with the availability of NPS at Swaleside, there was little evidence of a strategic approach to tackle the issue.
10. There was a considerable delay in calling an ambulance after the night patrol officer radioed a medical emergency code on 9 November.

Recommendations

- The Governor should ensure that prison staff manage prisoners at risk of suicide or self-harm in line with national guidelines, including that:
 - Staff begin ACCT procedures when prisoners self-harm.
 - ACCT assessors use all available information when a prisoner does not engage in the assessment process.
 - ACCT observations are made at irregular intervals.
 - A multidisciplinary case reviews is held within 24 hours of an ACCT plan being opened.
 - All staff in contact with prisoners have training in suicide and self – harm prevention procedures with appropriate refresher training.
- The Head of Healthcare should ensure that there is a clear mental health referral process, that all referrals for prisoners who self-harm are treated as urgent and that they have a structured mental health assessment, irrespective of ongoing substance misuse problems.

- The Governor should ensure there is an effective substance misuse strategy to help reduce the availability and demand for new psychoactive substances, that staff are vigilant for signs of its use, and are briefed about how to respond when prisoners appear to be under the influence of such substances.
- The Governor should ensure all prison staff understand their responsibilities during medical emergencies and that control room staff call an ambulance immediately an emergency medical code is called.

The Investigation Process

11. The investigator issued notices to staff and prisoners at HMP Swaleside informing them of the investigation and asking anyone with relevant information to contact him. No one responded.
12. The investigator visited Swaleside on 12 November 2015. He obtained copies of relevant extracts from Mr Ignatenka's prison and medical records.
13. NHS England commissioned a clinical reviewer to review Mr Ignatenka's clinical care at the prison.
14. The investigator interviewed 18 members of staff and a prisoner at Swaleside between December 2015 and March 2016. The clinical reviewer joined the investigator for four of the interviews.
15. We informed HM Coroner for Mid-Kent and Medway District of the investigation who gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.
16. One of the Ombudsman's family liaison officers contacted Mr Ignatenka's family, to explain the investigation and to ask if they had any matters they wanted the investigation to consider. His family wanted to know more details of the circumstances of Mr Ignatenka's death including how and when it was discovered.
17. Mr Ignatenka's family received a copy of the draft report. They said that the prison had contributed to the costs of repatriation but not to the funeral costs. We amended the report accordingly and contacted the prison.
18. The initial report was shared with the Prison Service. They made some factual inaccuracies comments and as a result the investigator made some amendments. The amendments did not affect our findings.

Background Information

HMP Swaleside

19. HMP Swaleside forms part of the Isle of Sheppey group of prisons which also includes Elmley and Standford Hill. Swaleside's main function is to hold life-sentenced prisoners, but it also holds prisoners serving determinate sentences. The prison can hold up to 1,112 men.
20. IC24 Integrated Care provides primary healthcare at Swaleside. There is 24-hour nursing cover, which includes a qualified nurse and a healthcare assistant at night. There is a 17 bed inpatient unit. Minster Medical Group provides GP cover from 9.00am to 5.00pm on Monday to Friday, while Medoc provides an out of hours GP service. Oxleas NHS Foundation Trust provides mental health services.

HM Inspectorate of Prisons

21. The report of the most recent inspection of Swaleside, in April 2016, has not yet been published. In initial feedback the inspectorate said there had been some improvements in ACCT procedures, which they had previously found inadequate, but too few case reviews were multidisciplinary. Illicit drugs were easily available but the number of psychosocial substance misuse programmes had been reduced because there were too few staff to unlock prisoners to attend. The Inspectorate was satisfied that there was adequate mental health provision to meet the needs of prisoners.

Independent Monitoring Board

22. Each prison in England and Wales has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community, who help ensure that prisoners are treated fairly and decently. In its most recently published annual report for the year 2014-2015, the IMB was concerned about prevalence of prisoners trading drugs, particularly prescribed medication and the new psychoactive substances), which led to the consequence of this including violent incidents. The IMB noted that members of the mental health team attended relevant reviews for prisoners who were at risk of suicide or self-harm.

Previous deaths at HMP Swaleside

23. Mr Ignatenka's death was the fifth death at (first self-inflicted) since December 2014. After two deaths at Swaleside in 2012, we recommended that staff should call an ambulance immediately in a medical emergency, and we identified the same issue in this investigation.

Assessment, Care in Custody and Teamwork

24. Assessment, Care in Custody and Teamwork (ACCT) is the care planning system the Prison Service uses for supporting and monitoring prisoners assessed as at risk of suicide and self-harm. The purpose of the ACCT process 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. Levels of supervision and interactions are set according to the

perceived risk of harm. There should be regular multi-disciplinary case reviews involving the prisoner. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011.

New Psychoactive Substances (NPS)

25. NPS are an increasing problem across the prison and immigration detention estates. They are difficult to detect, as they are not identified in current drug screening tests. Many NPS contain synthetic cannabinoids, which can produce experiences similar to cannabis. NPS are usually made up of dried, shredded plant material with chemical additives and are smoked. They can affect the body in a number of ways including increasing heart rate, raising blood pressure, reducing blood supply to the heart and vomiting.
26. As well as emerging evidence of dangers to both physical and mental health, it is possible that there are links to suicide or self-harm. Trading in these substances, while in custodial settings, can lead to debt, violence and intimidation.
27. In July 2015, we published a Learning Lesson Bulletin about the deaths associated with use of NPS. We identified dangers to physical and mental health, as well as risks of bullying and debt and possible links to suicide and self-harm. The bulletin identified the need for better awareness among staff 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 because of the links between NPS and debt and bullying.

Key Events

28. On 4 September 2006, Mr Ruslanas Ignatenka received a life sentence for murder. Mr Ignatenka was Lithuanian. He spent time in a number of different prisons. In August 2009, prison staff monitored Mr Ignatenka briefly under ACCT suicide and self-harm procedures, after he cut his left and right forearms. There is no record of any further self-harm or suicide attempts before Mr Ignatenka was transferred to HMP Swaleside on 1 May 2014.
29. At an initial health assessment at Swaleside, a nurse recorded that Mr Ignatenka did not have any history of drug or alcohol misuse, was not being monitored under ACCT procedures, and spoke English well. The next day, a prison GP examined Mr Ignatenka and did not record any significant health issues or concerns about suicide or self-harm.
30. Over the next year, officers noted in Mr Ignatenka's prison records that he worked well at his jobs in prison workshops and was polite to staff and other prisoners. No one recorded any concerns about Mr Ignatenka's mental health or risk of suicide or self-harm.

Events from Sunday 23 August 2015

31. On 23 August 2015, Mr Ignatenka and another prisoner, who had been convicted at the same time as him, barricaded themselves in their cells, which were opposite each other. Managers asked an officer to help, as he knew both prisoners well.
32. When Mr Ignatenka realised the officer had come to speak to him, he removed the barricade and let him into the cell. He told the investigator that Mr Ignatenka was paranoid and incoherent, so he could not have a meaningful conversation with him. He said that Mr Ignatenka had cut his legs and there was blood all over the cell. He persuaded both Mr Ignatenka and the other prisoner to allow staff into their cells and a nurse examined Mr Ignatenka and found that Mr Ignatenka had inserted pieces of glass into his right calf and ankle and needed hospital treatment. No one began ACCT procedures.
33. Mr Ignatenka was admitted to hospital and stayed for two days. The hospital discharge letter indicated that Mr Ignatenka had told hospital staff that he had kicked a glass and cut his right leg in five places and advised how the wounds should be treated. No one began ACCT monitoring when he got back from hospital on 25 August and no one referred him for a mental health assessment.
34. On 27 August, Mr Ignatenka smashed his cell and threatened staff. An officer recorded in the wing observation book that Mr Ignatenka seemed paranoid and had acted completely unreasonably. She wrote that Mr Ignatenka had said that he had taken 'Spice', a new psychoactive substance, a few days earlier and that it had messed his head up. A Supervising Officer (SO) noted in Mr Ignatenka's prison record that he was behaving in a bizarre and disconcerting way. No one referred him for a mental health assessment or submitted security information that Mr Ignatenka had admitted using Spice.

35. Officers took Mr Ignatenka to the prison's segregation unit and noted he was not currently and had not previously been managed under ACCT procedures. The next day, officers moved Mr Ignatenka to H Wing, the 'drug and alcohol-free unit' and for prisoners who wanted help with addiction problems.
36. On 24 September, Mr Ignatenka applied to join the 12-step substance dependency treatment programme run by RAPt, the Rehabilitation for Addicted Prisoners Trust, which he started on 1 October. At a substance misuse assessment, Mr Ignatenka told the RAPt programme manager that he had used alcohol, steroids, cannabis, ecstasy, heroin and cocaine in the past. Mr Ignatenka said that he had used Spice in prison and was finding it difficult to stop. He said that he used to burn and cut his arms. She recorded that Mr Ignatenka wanted to stop using drugs. She planned to review him a week later.

Events from Monday 5 October

37. On 5 October, Mr Ignatenka damaged his cell and started to rip the cloth from the wing pool table. On 6 October, a SO spoke to the RAPt programme manager, a trained counsellor, about Mr Ignatenka's issues. She recorded in the RAPt case notes, that the SO had called the mental health-in reach team because he believed Mr Ignatenka's mental health had deteriorated because he had used Spice. On 7 October, she emailed the mental health in-reach team manager and asked her when someone would assess Mr Ignatenka's mental health. She also wrote in the email that two officers had contacted the mental health in-reach team the day before. The mental health in-reach team manager was not working and the email did not get picked up for some time. No one reported Mr Ignatenka's suspected use of Spice to the security department.
38. The SO spoke to Mr Ignatenka the next day and noted that he did not appear mentally stable. The RAPt programme manager went to review Mr Ignatenka but the SO and an officer said he was asleep and asked her not to disturb him, as he was still likely to be under the influence of Spice.
39. A mental health nurse said that the mental health team received the mental health referral on 7 October. He noted in Mr Ignatenka's medical records that officers had reported that Mr Ignatenka had smashed up his cell and had made a suicide pact with another prisoner. None of the officers we spoke to recalled any mention of a suicide pact and the prisoner later told a prison chaplain that this was not the case. On 9 October, Mr Ignatenka declined to see the RAPt programme manager.
40. On 14 October, the mental health team held a weekly referral meeting and decided that the mental health nurse should triage Mr Ignatenka to determine if he needed a structured mental health assessment or mental health support. The meeting agreed that this was not urgent.
41. On 15 October, Mr Ignatenka attended a substance misuse class. A substance misuse worker recorded that Mr Ignatenka seemed motivated to tackle his substance misuse again.
42. On 20 October, prison managers discussed Mr Ignatenka at a Challenging Behaviour Meeting (a weekly meeting, chaired by the deputy governor, aimed at

strategically managing prisoners whose behaviour staff was particularly demanding). The mental health nurse was present, but there was no one from RAPt. The meeting noted that Mr Ignatenka used Spice and that he had had not yet had a mental health assessment, but the nurse would see him that week.

43. On 21 October, the mental health nurse recorded that he had tried to see Mr Ignatenka on the wing to assess him, but he was in a workshop at the time. He had discussed Mr Ignatenka's presentation and behaviour with wing officers, including an officer, who told him that Mr Ignatenka used Spice. He noted that he would try to see Mr Ignatenka again, but recorded that he had discharged him from the mental health team. He told the investigator that he considered Mr Ignatenka needed to address his substance misuse as a priority and he could not assess his mental health effectively, while he was using drugs. He never went back to assess Mr Ignatenka and neither did anyone else from the mental health team.
44. On 26 October, a substance misuse worker recorded that Mr Ignatenka had been attentive, engaged and confident in the RAPt programme that week.

Saturday 7 November

45. During the afternoon of 7 November, Mr Ignatenka told a SO that he had taken Spice the previous day and now felt extremely low and disappointed with himself. Mr Ignatenka asked him for help to stop using Spice. The SO advised him to get help as part of the RAPt programme and emailed the safer custody team that afternoon and asked them to support him. He copied the email to several staff. He did not consider Mr Ignatenka was at risk of suicide or self-harm so did not begin ACCT procedures.
46. At approximately 9.30pm, Mr Ignatenka pressed his emergency cell bell. The night patrol officer responded and saw through the door observation panel that Mr Ignatenka was standing by the door. He had a cut on his left arm and there was a lot of blood in the cell. Mr Ignatenka told him that he had cut himself with a razor blade and had flushed the blade down the toilet.
47. The night patrol officer did not radio a medical emergency code, as he did not consider this was a life threatening situation; Mr Ignatenka was talking to him and was coherent. He telephoned the night manager for help and she went to Mr Ignatenka's cell. Two officers and a nurse joined them and went into the cell. The manager said that Mr Ignatenka nodded when asked whether he had taken Spice. The nurse recorded that Mr Ignatenka had lacerations on both arms and dressed his wounds.
48. The night manager moved Mr Ignatenka to a cell in the healthcare inpatient unit while a biohazard cleaner cleaned the blood in his cell. She said this was because there were no spare cells elsewhere in the prison. At 10.40pm, she began ACCT procedures and noted that Mr Ignatenka had a deep cut on his inner left elbow and two other cuts on his left and right arm. She recorded that he appeared quite agitated and said that he had taken Spice for the past two to three days. She asked staff to check Mr Ignatenka once an hour until he was assessed as part of ACCT procedures. She noted that Mr Ignatenka did not

want to use the Samaritans telephone, call his family or speak to a Listener. (Listeners are prisoners trained by the Samaritans to support other prisoners.)

Sunday 8 November

49. Staff checked Mr Ignatenka hourly during the night and all of the next day. That morning, a mental health nurse noticed Mr Ignatenka talking to a prisoner through the window and thought he seemed fine. She told the investigator that she knew that the night manager had started ACCT procedures the night before, but she had no concerns about Mr Ignatenka while he was in the inpatient unit and did not think he would harm himself again. She wrote in Mr Ignatenka's medical record that he had no mental health issues, his risk of suicide and self-harm was low and he needed to go back to the wing as soon as possible. Mr Ignatenka moved back to his wing at lunchtime. No one completed a discharge assessment.
50. At around 1.45pm, a SO came on duty on Mr Ignatenka's wing. She noted that no one had yet assessed Mr Ignatenka and asked an officer, a trained ACCT assessor, to assess him. At around 3.00pm, the officer recorded that Mr Ignatenka had refused to engage with the assessment. She noted that he was quiet, did not make any eye contact with her and did not want to discuss any issues. She recorded that Mr Ignatenka had said that he was okay and wanted the frequency of observations reduced, as every hour was too much. She told us that she considered that Mr Ignatenka was at low risk of suicide or self-harm because he said he was okay during their brief conversation, but it was not her role to determine the level of risk or observations, which should be agreed at the first ACCT case review. A SO told the investigator that the officer had asked her to reduce Mr Ignatenka's level of observations, which she did not do. The officer said she could not remember this conversation.
51. The officer recorded in the ACCT document that Mr Ignatenka went outside briefly for some fresh air and spoke to other prisoners, but spent most of the afternoon in his cell. He did not collect his meal and did not say anything to her when she locked him in his cell at around 5.00pm. At around 5.30pm, the SO finished work. Mr Ignatenka should have had a first ACCT case review after the officer assessed him, but the SO said that she forgot.
52. The night patrol officer on the night of 8/9 November recorded that he had checked Mr Ignatenka at 8.00pm, 9.00pm, 10.00pm and 11.00pm, and did not note any concerns about him; he was awake and either sitting on his bed or looking out the window.

Monday 9 November

53. The night patrol officer checked Mr Ignatenka again at 12.05am and 1.05am and he was still awake. At 2.05am, Mr Ignatenka was in bed and the officer noted that he moved. He said that he did not see anything unusual or any signs of disturbance in Mr Ignatenka's cell.
54. At 3.04am, the night patrol officer went to Mr Ignatenka's cell and looked through the observation panel. Mr Ignatenka had put a heavy chair in front of the door and he was lying on the floor in front of the chair. He banged on the door, but Mr

Ignatenka did not respond. He said he could see a lot of blood in the cell but could not see what had happened or how badly Mr Ignatenka was hurt. He walked away from the cell to ensure that other prisoners did not overhear and radioed a 'code red' medical emergency.

55. CCTV (closed circuit television) shows that at 3.06am staff went to Mr Ignatenka's cell. An officer told the investigator that there was a lot of broken furniture in the cell. (Mr Ignatenka had dismantled the bed and barricaded the cell door with part of the bed and the chair.) At 3.08am, staff forced the door open and went in.
56. An officer said that Mr Ignatenka was lying behind the door. He had cut his neck and there was a lot of blood around the cell. His eyes were open but he was not moving. The night manager said that Mr Ignatenka's skin looked very grey. The nurse asked the control room to call an ambulance straightaway. The control room had not called one as soon as they received the code red as should have happened and there was a further delay after this, as ambulance service records show that they did not receive a call until 3.22am.
57. The nurse examined Mr Ignatenka, but could not find any signs of life. No one attempted to resuscitate Mr Ignatenka and the nurse recorded in Mr Ignatenka's medical record that he did not think cardiopulmonary resuscitation would be effective because of the size and position of the neck wound. (Normally staff are expected to attempt cardiopulmonary resuscitation unless there are clear signs that it would be futile. We accept the nurse made a considered judgement in this case.) Ambulance records show that paramedics arrived at the prison at 3.46am and got to Mr Ignatenka's cell at 3.50am. They examined Mr Ignatenka and the ambulance log indicated that he was dead when they arrived. At 4.07am, they recorded that he had died.

Contact with Mr Ignatenka's family

58. Mr Ignatenka's had named his sister as his next of kin and the address he had given for her was about 180 miles away. At 8.45am, a prison manager contacted two prisons, which were the nearest prisons to his sister's address, to ask whether they could send a family liaison officer to inform her of his death. Both prisons said that they did not have enough staff to help. The prison's family liaison officer then contacted the police, who agreed to inform her. When the police got to the address they found that Mr Ignatenka's sister had moved to Lithuania.
59. Before anyone was able to contact Mr Ignatenka's family in Lithuania, his sister telephoned the prison's chaplaincy and eventually spoke to the family liaison officer. A prisoner had phoned Mr Ignatenka's mother in Lithuania and told her that Mr Ignatenka was dead. The family liaison officer explained what had happened and offered condolences.
60. On 13 November, Mr Ignatenka's body was repatriated to Lithuania. The prison contributed to the costs of repatriation, and, after the initial report had been published, confirmed in writing that they would contact the family and pay for the funeral costs in line with national policy.

Support for prisoners and staff

61. After Mr Ignatenka's death the Governor debriefed the staff involved in the emergency response to give them the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.
62. The prison posted notices informing other prisoners of Mr Ignatenka's death, and offering support. Staff reviewed all prisoners subject to suicide and self-harm prevention procedures in case they had been adversely affected by Mr Ignatenka's death. Prison staff began ACCT procedures for the other prisoner (referred to in paragraph 31 above), to ensure he was appropriately monitored and supported.

Post-mortem report

63. A post-mortem examination established the cause of death as an incised wound to the neck made by a razor blade. Toxicology tests revealed no illicit drugs or medication. However, initial tests did not check for NPS. We understand that the coroner has now requested further tests to include NPS.

Findings

Identifying and managing risk of suicide and self-harm

64. Prison Service Instruction (PSI) 64/2011, which covers safer custody, requires staff to manage all prisoners who self-harm using ACCT procedures. We are concerned that no one began ACCT monitoring on 23 August 2015, when Mr Ignatenka seriously harmed himself by inserting pieces of glass in his right calf and ankle. A nurse noted Mr Ignatenka's self-harm in his medical record, but told the investigator that he expected officers would begin ACCT procedures. An officer told the investigator that he did not start ACCT monitoring because he had expected a manager to do this. We would have expected managers to ensure this was done.
65. Mr Ignatenka had been at Swaleside for over a year before he self-harmed in August 2015 and had never previously been considered at risk of suicide or self-harm while he was at the prison. After this episode, staff recorded that his behaviour deteriorated; he acted strangely and they were concerned about his use of new psychoactive substances and his mental health. Had someone responded appropriately in August and started ACCT procedures, staff might have considered and managed Mr Ignatenka's substance misuse, mental health and risk of suicide and self-harm holistically. This was a missed opportunity to address his risks together. Instead, staff responded reactively and in isolation to his substance misuse, mental health needs and apparent strange behaviour.
66. On 7 November, the night manager appropriately began ACCT monitoring when he cut himself. However, there were a number of deficiencies in the ACCT process in the short time before his death.
67. A strict interpretation of PSI 64/2011 would mean that staff should have held a pre-discharge case review before Mr Ignatenka returned to the wing after spending the night of 7/8 November in the healthcare centre. However, we accept that Mr Ignatenka was held there only temporarily, and had not yet been assessed or had a first ACCT case review.
68. PSI 64/2011 requires that if a prisoner refuses to be interviewed for an ACCT assessment, the assessor should carry out the assessment based on all available information about their risks. An officer said that she spoke to officers before she assessed Mr Ignatenka and they told her he had been using Spice, but she did not seek information from other sources. She did not consult anyone from the mental health team or the substance misuse team to inform her assessment. Despite his very recent serious self-harm just the day before, and his refusal to engage with the assessment, she told the investigator that she had regarded him as a low risk.
69. The PSI states that a case manager should hold a multidisciplinary first ACCT case review within 24 hours of an ACCT plan being opened, ideally immediately after the assessment interview. As the supervising officer on Mr Ignatenka's wing, a SO should have held a case review, but said she forgot to do this on Sunday 9 November. This meant that Mr Ignatenka never had a case review before he died, so there was never any full assessment of his risk or any actions set in a caremap to help reduce his risk. No one reviewed the frequency of

checks, which remained hourly. As Mr Ignatenka had not fully participated in the assessment interview, there was no effective interaction or discussion with him that day- only observational checks. We found that, contrary to the instructions in the PSI, all of the checks were conducted and recorded at regular hourly intervals. This would have allowed Mr Ignatenka to predict when the next check would be.

70. We were concerned that a number of staff did not have up to date ACCT training, which undermines the effectiveness of the system. An officer said that the last time she had had any training about suicide and self-harm, was four years previously. Another officer said that he had not had training for some years and a SO told the investigator that he had never had any ACCT training or mental health awareness training. We make the following recommendation:

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

- **Staff begin ACCT procedures when prisoners self-harm.**
- **ACCT assessors use all available information when a prisoner does not engage in the assessment process.**
- **ACCT observations are made at irregular intervals.**
- **A multidisciplinary case reviews is held within 24 hours of an ACCT plan being opened.**
- **All staff in contact with prisoners have training in suicide and self – harm prevention procedures with appropriate refresher training.**

Mental Health

71. No one referred Mr Ignatenka for a mental health assessment after he came back from hospital after he self-harmed on 23 August. On 6 October 2015, a SO spoke to the RAPt programme manager about Mr Ignatenka's issues. The manager recorded in the RAPt case notes that the SO had called the mental health-in reach team because he was worried that Mr Ignatenka's mental health had been affected by Spice. On 7 October, she emailed the mental health in-reach manager, who was not working at the time, and asked her when someone would assess Mr Ignatenka. Neither the SO nor the manager understood the mental health referral process. This meant that the mental health in-reach team did not receive the referral for some days.
72. A healthcare manager told the investigator that the policy is that someone from the mental health team should assess a prisoner, within 10 days of a referral for a routine assessment or within 72 hours if it is urgent. A mental health nurse went to make an initial assessment of Mr Ignatenka on 21 October, but he did not first establish that Mr Ignatenka was available and in fact, he was at work at the time. This was 11 working days after the original referral by the officer. The nurse discussed Mr Ignatenka's behaviour with officers and recorded that he would 'try to see him again'. He discharged him from the mental health team without seeing him and no one ever assessed him.

73. We are concerned that, without assessing him, the mental health nurse seemed to conclude that Mr Ignatenka's use of Spice was the cause of his problems. The nurse said Mr Ignatenka first needed to address his substance misuse problems before he could effectively assess his mental health. We do not consider that prisoners with dual diagnosis (mental health and drug problems) should be excluded from mental health services. Oxleas NHS Foundation Trust's own dual diagnosis policy requires that prisoners' mental health must be assessed where necessary, irrespective of their drug and/or alcohol use.
74. Mr Ignatenka should have been assessed as the mental health team had decided on 14 October and the mental health nurse should not have discharged him. Staff were unfamiliar with the referral process and healthcare staff did not seem sure about the required timescales. We make the following recommendation.

The Head of Healthcare should ensure that there is a clear mental health referral process, that all referrals for prisoners who self-harm are treated as urgent and that they have a structured mental health assessment, irrespective of ongoing substance misuse problems.

New psychoactive substances

75. Mr Ignatenka told several members of staff that he smoked 'Spice', a new psychoactive substance. Staff noted that Mr Ignatenka appeared to be under the influence of drugs, in particular on 27 August 2015, 5 October 2015, and 7 November 2015.
76. A substance misuse worker told the investigator that the availability of NPS is a serious problem at Swaleside and that officers are aware of the link between the use of NPS and suicide and self-harm. Another substance misuse worker told the investigator that the substance dependency treatment programme does not cover the dangers of using NPS but they had now started to distribute fact-sheets to make prisoners aware of the risks.
77. Officers believed that Mr Ignatenka's use of Spice contributed to his self-harming and irrational behaviour, yet no one informed the security department by making security information reports about his illicit drugs use. We found no evidence of a strategic approach to tackling the problem of NPS.
78. At their recent inspection in April 2016, HM Inspectorate of Prisons reported that illicit drugs were readily available at Swaleside. In July 2015, we published a Learning Lesson Bulletin about the deaths associated with use of NPS. We identified dangers to physical and mental health, as well as risks of bullying and debt and possible links to suicide and self-harm. The bulletin identified the need for better awareness among staff of the dangers of NPS; the need for more effective drug supply reduction strategies; and better monitoring by drug treatment services. It is important that prisons do all they can to eradicate the use of new psychoactive substances and other illegal drugs. We make the following recommendation:

The Governor should ensure there is an effective substance misuse strategy to help reduce the availability and demand for new psychoactive

substances, that staff are vigilant for signs of its use and are briefed about how to respond when prisoners appear to be under the influence of such substances.

Emergency Response

79. The night patrol officer radioed a code red medical emergency at approximately 3.06am on 9 November. However, the ambulance service records show that they did not receive a call from the prison until 3.22am, 16 minutes afterwards.
80. Prison Service Instruction (PSI) 03/2013 Medical Emergency Response Codes, contains mandatory instructions that prisons should have a protocol with guidance to staff about efficiently communicating the nature of a medical emergency, ensuring that there are no delays in calling an ambulance. It states that all prison staff must be made aware of and understand their responsibilities during medical emergencies and that an ambulance must be called as soon as a medical emergency is called over the radio network. It emphasises that it must not be a requirement for a member of the prison healthcare team or a manager to attend the scene before emergency services are called. The PSI makes it clear that an ambulance can be cancelled if it is later assessed that it is not required.
81. We are concerned that in Mr Ignatenka's case there was a considerable delay in calling an ambulance. We were not able to speak to the control room officer to account for the delay in this case and the prison was not able to offer any explanation. We have identified concerns about poor emergency procedures at Swaleside in previous investigations. While this does not appear to have affected the outcome for Mr Ignatenka, on other cases, such a delay could have been critical. We make the following recommendation:

The Governor should ensure all prison staff understand their responsibilities during medical emergencies and that control room staff call an ambulance immediately an emergency medical code is called.

**Prisons &
Probation**

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