

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Tom Piggott a prisoner at HMP High Down on 27 May 2018

A report by the Prisons and Probation Ombudsman

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 Tom Piggott died in hospital on 27 May 2018 having been found hanging in his cell at HMP High Down the day before. Mr Piggott was 29 years old. I offer my condolences to Mr Piggott's family and friends.

This is a disturbing case. Mr Piggott had a significant learning disability, mental health problems, and a lengthy history of substance misuse, self-harm and attempted suicide. **His behaviour was often challenging.** He was serving an indeterminate sentence for public protection and was ten years past his minimum tariff of less than two years. He despaired both about his prospects of release and about how he would cope in the community if he was released. His death is a sad reminder of the stress and uncertainty that prisoners serving indeterminate sentences can face.

It was hard to visualise a positive outcome for Mr Piggott, who had spent all his adult life in prison, but several staff of various disciplines worked hard to try to support him towards release.

Mr Piggott's mental health deteriorated in the weeks before he died. A psychiatrist referred him for assessment for transfer to a secure mental health unit but this was not scheduled to take place until two weeks after his death.

Mr Piggott was monitored under suicide and self-harm prevention procedures (known as ACCT) from January 2018 until his death. While there is much to commend in High Down's management of Mr Piggott's risk to himself, improvement is also needed, particularly in relation to the assessment of risk.

We have also recommended changes in managing prisoners with deteriorating mental health and the introduction of a clear protocol for the management of prisoners in the healthcare unit, where Mr Piggott was located for the last two months of his life.

Mr Piggott's care was also complicated by drug use and, sadly, once again, we highlight the difficulties prisons are under in tackling this issue.

We also have concerns about the night Mr Piggott died, when a nurse falsified her observation records. Well-being checks were not sufficiently robust and there was a delay in entering Mr Piggott's cell once he had been found hanging.

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

Sue McAllister, CB
Prisons and Probation Ombudsman

April 2019

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Summary

Events

1. Mr Tom Piggott was sentenced to an indeterminate sentence for public protection (IPP) in February 2007, with a tariff of less than two years. He had a significant learning disability, was later diagnosed with personality disorders and his behaviour was often challenging. Mr Piggott began self-harming soon after he got to prison and was often managed under Prison Service suicide and self-harm procedures (known as ACCT). He had a history of substance misuse and this continued to be a problem in prison.
2. He progressed to open conditions in 2012, but absconded and was returned to a closed prison, where he found it difficult to cope. In February 2013, he was found hanging in his cell. He was cut down and subsequently transferred to a medium secure psychiatric unit. In December 2015, he became violent while under the influence of psychoactive substances (PS) and was returned to prison, as the unit could no longer manage his behaviour.
3. He remained under the care of the mental health team in prison and his behaviour fluctuated, typically deteriorating when a parole hearing was imminent. He frequently voiced his concern both at remaining in prison and at being released, as he had been in prison all his adult life.
4. In October 2017, he was transferred to the inpatient unit at HMP High Down after he told staff he intended to kill himself.
5. Mr Piggott's behaviour varied at High Down. He was intermittently subject to ACCT procedures and was suspected of being under the influence of PS on several occasions. Psychiatrists believed he was suffering from drug-induced psychoses.
6. From January 2018 until his death, Mr Piggott was managed under ACCT.
7. In February 2018, the Parole Board deferred a decision about Mr Piggott's potential release until July. Mr Piggott self-harmed and banged and rocked his head. He also made a ligature and swallowed razor blades.
8. During the last two weeks of his life, Mr Piggott's mental health deteriorated further. He refused to take any medication and would not engage. He also needed support with his physical care and hygiene. Psychiatrists referred him for an assessment for admission to a medium secure unit. This was scheduled for 11 June, two weeks after his death.
9. On the morning of 25 May, Mr Piggott banged his head continuously until it bled. Staff considered whether constant supervision was appropriate, but a psychiatrist recommended an increase in his nursing observations. Although a nurse completed many overnight checks, she did not accurately record their number or timing.
10. On 26 May, at 4.50am, the nurse checked on Mr Piggott in his cell. She believed he was kneeling in prayer but, a minute later, an officer discovered him hanging.

There was a delay of over three minutes before officers unlocked the cell door. Staff began resuscitation and Mr Piggott was taken to hospital. He died there the next day after his life support was switched off.

Findings

Management of ACCT

11. Mr Piggott was a young man who expressed despair at being in prison many years after the expiry of his minimum tariff. He had learning difficulties, mental health problems and displayed complex behaviours, including indiscipline, PS use, self-harm and attempted suicide.
12. He was subject to ACCT monitoring from January 2018 onwards. Case reviews were multidisciplinary and staff made considered and concerted efforts to reduce Mr Piggott's risk to himself.
13. The investigation nevertheless identified procedural failings in the operation of the ACCT process, meaning that Mr Piggott did not always receive an appropriate level of support. These failings included inadequate use of caremaps, ACCT observations carried out at regular intervals, inappropriate assessment of risk and case reviews not being held in line with Prison Service policy. There was no ACCT review when Mr Piggott began banging his head until it bled on the morning of 25 May.

Clinical care

14. The clinical reviewer concluded that overall Mr Piggott's clinical care was equivalent to that he could have expected to receive in the community.
15. However, we are concerned that there was not a clearer protocol for the management of prisoners with deteriorating mental health, with clearer communication between healthcare staff.

Management of the healthcare unit

16. At the time of Mr Piggott's death, staff said the healthcare unit was in a state of crisis. There were concerns that PS was available on the unit and some very disruptive prisoners were located there for security reasons.

Nursing observations, 26/27 May

17. The nurse responsible for completing observations on the night of 25 May falsified her records. The nurse was immediately suspended and referred to the Nursing and Midwifery Council. We have not therefore made a recommendation about this.

Entering Mr Piggott's cell

18. We are concerned that when Mr Piggott was found hanging, a nurse had observed him one minute earlier but had had no concerns. We are not convinced that the nurse's earlier check was sufficiently robust.

19. There was a delay of two and a half minutes between an officer seeing Mr Piggott hanging and officers unlocking the cell and cutting him down. This was not in accordance with Prison Service policy and may have affected the outcome for Mr Piggott.

Psychoactive Substances (PS)

20. Mr Piggott had a history of using PS which psychiatrists believed contributed to his deteriorating mental health. We cannot say whether he was able to access PS in the healthcare unit. We recognise the efforts made by High Down to tackle drug use and supply and have called for a national strategy and support to assist them.

Family liaison

21. The prison did not return all of Mr Piggott's belongings or contribute to funeral expenses until the investigator highlighted these issues on 1 August. They had not been in contact with Mr Piggott's next of kin since 4 June.

Staff support

22. No debrief was held for staff following Mr Piggott's death.

Recommendations

- The Governor and Head of Healthcare should ensure that staff manage prisoners at risk of suicide or self-harm in line with national guidelines, including in particular that:
 - all known risk factors are considered when determining the level of risk of suicide and self-harm;
 - ACCT caremap actions are specific and meaningful, aimed at reducing a prisoner's risk and identify who is responsible for them;
 - observations are carried out at unpredictable intervals;
 - ACCT reviews are held whenever an event occurs that could mean a prisoner is at increased risk, and
 - all case reviews are included in the ACCT documentation.
- The Governor and Head of Healthcare should ensure that there is a clearly agreed protocol for the management of prisoners with complex and/or deteriorating mental health which includes decisions around level of observations and crisis management.
- The Governor and Head of Healthcare should ensure that there is a clear protocol for the management of prisoners in the healthcare unit, including an admission and discharge pathway, plans for dealing with disruptive patients and that staff are supported when working in this difficult environment.
- The Head of Healthcare should ensure that healthcare staff assure themselves of a prisoner's well-being when completing nursing observations and are alert to behavioural changes.

- The Governor should ensure that all staff are made aware of and understand their responsibilities during medical emergencies, including opening cells when there is an immediate danger to life.
- The Governor and Head of Healthcare should ensure that signs of drug use are recorded in prisoners' records and all staff should submit intelligence reports when they are aware of suspected drug use.
- The Governor should ensure that, following a death in custody, family liaison is appropriate, including keeping in touch with the family, returning the deceased prisoner's possessions and contributing towards funeral expenses, in line with PSI 64/2011.
- The Governor should ensure that following a death in custody all staff involved have the opportunity to attend a debrief, in line with PSI 64/2011.
- The Chief Executive of HMPPS should provide the Ombudsman with a revised date for issuing detailed national guidance on measures to reduce the supply and demand of drugs in prisons, and an assurance that this new date will be met.

The Investigation Process

23. The investigator issued notices to staff and prisoners at HMP High Down informing them of the investigation and asking anyone with relevant information to contact her. No one responded.
24. The investigator visited HMP High Down on 4 June 2018. She obtained copies of relevant extracts from Mr Piggott's prison and medical records.
25. The investigator interviewed twelve members of staff and one prisoner at High Down in July and September.
26. NHS England commissioned a clinical reviewer to review Mr Piggott's clinical care at the prison. He conducted joint interviews with the investigator. We did not receive his report until 28 November and apologise for the delay this has caused in issuing this initial report.
27. We informed HM Coroner for Surrey of the investigation. He gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.
28. Another investigator contacted Mr Piggott's sister to explain the investigation and to ask whether she had any matters she wanted the investigation to consider. She wanted to know:
 - what medication was Mr Piggott prescribed?
 - how was Mr Piggott supported when he was assessed as being a risk to himself?
 - what decisions and plans had been made in relation to Mr Piggott's IPP status and release?
 - why had the prison family liaison officer not been in contact since delivering Mr Piggott's possessions?
 - why were the funeral costs not paid as the prison had agreed?
 - did the prison have any further possessions of Mr Piggott's which had not yet been returned?
29. Mr Piggott's sister received a copy of the draft report. They did not make any comments.
30. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.

Background Information

HMP High Down

31. HMP High Down is a local prison in Surrey which holds up to 1,150 men. Central and North-West London NHS Foundation Trust provides primary health services and in-reach mental health care. The healthcare unit has inpatient facilities with 24-hour nursing cover.

HM Inspectorate of Prisons

32. The most recent inspection of HMP High Down was conducted in May 2018. Inspectors reported that standards had declined since the previous inspection. They noted that this was partly due to the uncertainty about the prison's future role and whether it was going to become a training prison.
33. Inspectors found that violence had increased, much of which was related to the ready availability of illicit drugs, particularly PS. While there was a drug supply reduction strategy in place, which had recently been enhanced, inspectors noted that this would need to be constantly reviewed if it were to have an impact on the flow of drugs into the prison. Inspectors found that analysis of violence was being developed but too little was being done to make the prison safer. Victims were not adequately supported nor were perpetrators effectively challenged.
34. Inspectors were the most concerned about the lack of purposeful activity, with about 47% of prisoners locked in their cells during the working day. Inspectors found that support for those at risk of harm to themselves was variable and they found some examples of inadequate support for prisoners in crisis. They found that healthcare staff rarely attended case reviews and caremaps were often weak.
35. Inspectors noted that, of the prisoners located in the 23-bed healthcare unit when they inspected, 14 were there for mental health needs, others had physical needs and some were located there for operational reasons or because they were vulnerable. The unit could be extremely noisy and disruptive. They also noted that a committed team of nurses and officers worked collaboratively on the unit to deliver respectful care. Inspectors found that regular input from the psychiatrist, GP and learning disability nurse was valued and enhanced prisoner's care.
36. Inspectors noted that prisoners requiring treatment in a psychiatric hospital were rarely transferred within the Department of Health's guideline timetable, but were usually accommodated within the healthcare unit which helped to mitigate risk.

Independent Monitoring Board

37. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report for the year to December 2017, the IMB said that the inpatient unit with 23 beds had been full for most of the year due in part to prisoners with challenging behaviour being assessed for possible transfer to mental health facilities.

Previous deaths at HMP High Down

38. Since 2015, there have been 13 deaths at High Down, including that of Mr Piggott. Of these, one was self-inflicted, the rest being due to natural causes. There have been four further deaths since Mr Piggott died, three of which were due to natural causes and the fourth remains unclassified at the time of this investigation. Our investigation into the self-inflicted death in 2015 raised issues about ACCT management and mental health care.

Assessment, Care in Custody and Teamwork

39. ACCT is the care planning system the Prison Service uses to support prisoners at risk of suicide or self-harm. The purpose of the ACCT is to try to determine the level of risk posed, the steps that staff might take to reduce this and the extent to which staff need to monitor and supervise the prisoner. Checks should be done at irregular intervals to prevent the prisoner anticipating when they will occur. Part of the ACCT process involves assessing immediate needs and drawing up a caremap to identify the prisoner's most urgent issues and how they will be met. Staff should hold regular multidisciplinary reviews and should not close the ACCT plan until all the actions of the caremap are completed.
40. Enhanced case management can be used to support prisoners whose behaviour is so challenging and disruptive that they need additional case management to manage their heightened or exceptional risk of harm to self, others and/or from others. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011, *Management of prisoners at risk of harm to self, to others and from others (Safer Custody)*.

Psychoactive Substances (PS)

41. Psychoactive substances (formerly known as 'new psychoactive substances or 'legal highs') are a serious problem across the prison estate. They are difficult to detect and can affect people in a number of ways including increasing heart rate, raising blood pressure, reducing blood supply to the heart and causing vomiting. Prisoners under the influence of PS can present with marked levels of disinhibition, heightened energy levels, a high tolerance of pain and a potential for violence. Besides emerging evidence of such dangers to physical health, there is potential for precipitating or exacerbating the deterioration of mental health with links to suicide or self-harm.
42. In July 2015, we published a Learning Lessons Bulletin about the use of PS (still at the time NPS) and its dangers, including its close association with debt, bullying and violence. The bulletin identified the need for better awareness among staff and prisoners of the dangers of PS; the need for more effective drug supply reduction strategies; better monitoring by drug treatment services; and effective violence reduction strategies.
43. HM Prison and Probation Service (HMPPS) now has in place provisions that enable prisoners to be tested for specified non-controlled psychoactive substances as part of established mandatory drugs testing arrangements.

Transfer of prisoners to psychiatric hospitals under the Mental Health Act

44. PSI 50/2007, *Transfer of Prisoners to and from Hospital Under Sections 47 and 48 of the Mental Health Act 1983*, and NHS England's *Good Practice Guide – The transfer and remission of adult prisoners under s. 47 and s. 48 of the Mental Health Act*, outline the process for transferring a prisoner to hospital under the Mental Health Act. The NHS guidance recommends that all such transfers take place within 14 days of the Secretary of State issuing a warrant for transfer.
45. In October 2007 a revised version of *Procedure for the transfer of prisoners to and from hospital under sections 47 and 48 of the Mental Health Act (1983)* was issued. This document acknowledges there had been unacceptable delays in transferring prisoners, and provides a best practice flowchart for all key stakeholders.
46. Two independent medical practitioners, one of whom must be approved under Section 12(2) of the Mental Health Act (1983), need to assess the same form of mental disorder and the need for inpatient treatment before the Secretary of State will issue a warrant for transfer. These assessments are valid for two months.

Segregation Units

47. Segregation units are used to keep prisoners apart from other prisoners. This can be because they feel vulnerable or under threat from other prisoners or if they behave in a way that prison staff think would put people in danger or cause problems for the rest of the prison. Segregation is authorised by an operational manager at the prison who must be satisfied that the prisoner is fit for segregation after an assessment by a member of healthcare staff.

Parole Board

48. The Parole Board for England and Wales is an independent public body. Its role is to make risk assessments about prisoners to decide whether they can safely be released into the community once they have served the minimum term imposed by the courts.

Indeterminate Public Protection Sentences (IPP)

49. Indeterminate public protection sentences were intended to protect the public against offenders whose crimes were not serious enough to merit a life sentence but who could only be released once they had served their minimum tariff and had demonstrated to the satisfaction of the Parole Board that they had sufficiently reduced their risk. IPP sentences were abolished for new cases in 2012, but IPP prisoners sentenced before that continue to serve their sentences and will only be released when the Parole Board considers them suitable.

Key Events

October 2006 – February 2013

50. In 2006, Mr Tom Piggott appeared in court, charged with robbery. He was remanded into custody and taken to HMYOI Aylesbury. In February 2007, he was sentenced to an Indeterminate Sentence for Public Protection (IPP) with a tariff (the minimum amount of time he had to spend in prison) of 1 year 267 days.
51. At Mr Piggott's first Parole Board hearing in November 2008, it was noted that he had a significant learning disability and needed psychological assistance before he could do any offending behaviour courses. Mr Piggott was disruptive during his first two years in prison, destroying property, assaulting staff and setting fires.
52. Mr Piggott started self-harming frequently, usually by cutting, and was intermittently subject to Prison Service suicide and self-harm monitoring, known as ACCT. He was prescribed antidepressants and was under the care of the mental health team to address his anxiety.
53. During 2009, Mr Piggott's self-harming became less frequent and his behaviour improved. In March 2011, the Parole Board recommended his transfer to an open prison. On 11 November 2011, Mr Piggott transferred to HMP Hollesley Bay, an open prison. He started to self-harm again and received support from the mental health team and substance misuse services. On 2 June 2012, he absconded from Hollesley Bay.
54. On 23 July, Mr Piggott was found and taken back to HMP Nottingham. He said he had been bullied and unable to cope at Hollesley Bay. He started to self-harm again with increasing frequency. He transferred to HMP Ranby and then HMP The Mount. On 19 February 2013, staff found Mr Piggott hanging in his cell. He was cut down and he recovered without treatment. Staff applied for Mr Piggott to be transferred to a secure psychiatric unit.

March 2013 – November 2015, Eric Shepherd Unit

55. On 7 March, Mr Piggott was sectioned under the Mental Health Act and transferred to the Eric Shepherd Unit, a medium secure psychiatric hospital for those with learning disabilities. A report by a psychiatrist noted that Mr Piggott had a low IQ, with a demeanour characterised by despondency, negativity and hopelessness. The psychiatrist recorded that Mr Piggott was vulnerable and perceived hostility in others, or that they were bullying him.
56. Mr Piggott was diagnosed with anti-social personality disorder which is characterised by impulsive, irresponsible and often criminal behaviour, and a lack of regard for other people's feelings. The report also noted that Mr Piggott potentially had emotionally unstable personality disorder which is characterised by experiencing such strong emotions that an individual struggles to cope. The psychiatrist also noted that Mr Piggott had Attention Deficit Hyperactivity Disorder (ADHD), which can include problems paying attention and excessive activity.
57. While at the unit, Mr Piggott received one-to-one and group therapy sessions which focused on key areas such as coping with stress, emotional management,

substance misuse and anger management. In June 2014, a Mental Health Act tribunal supported Mr Piggott's transfer to a low secure psychiatric unit.

58. Mr Piggott had several home leaves from the unit. In October, staff suspected that he had returned to the unit after a home visit with PS in his possession and that he was under the influence of PS himself. He was aggressive and assaulted staff. A psychiatrist concluded that Mr Piggott was a major risk to himself and others. Staff applied for Mr Piggott to be returned to prison as they could no longer manage his behaviour.

December 2015 – 10 October 2017, HMPs Bedford, Wayland and Coldingley

59. The Secretary of State approved Mr Piggott's return to prison, and on 9 December Mr Piggott was taken to HMP Bedford. Mr Piggott self-harmed and staff opened an ACCT. A doctor continued his prescription of citalopram (an antidepressant), atomoxetine (used to treat ADHD), olanzapine (an antipsychotic) and quetiapine (an antipsychotic). Mr Piggott was regularly reviewed by mental health nurses and a psychiatrist.
60. In January 2016, Mr Piggott transferred to HMP Wayland. During 2016, he was often subject to suicide and self-harm monitoring procedures due to his frequent self-harm by cutting and swallowing razor blades. He also attempted to hang himself and made a ligature on another occasion. In June, a parole hearing was deferred for psychological and psychiatric assessments.
61. In February 2017, Mr Piggott appeared to be under the influence of drugs and became violent. He was restrained and segregated for a few days. He refused to engage with a psychological assessment for the Parole Board. In March, the Parole Board adjourned, deferring their recommendation pending an updated psychological risk assessment and an assessment to determine what services would be available to Mr Piggott in the community if he were released.
62. In August 2017, Mr Piggott allegedly assaulted an officer, was segregated and subsequently transferred to HMP Coldingley. Over the following months, Mr Piggott's behaviour fluctuated. He tested positive for PS and was referred to the substance misuse team but refused to engage with them. He was segregated at times as he said he was at risk from other prisoners and would kill himself if moved to a standard residential wing. He said he had lost all hope of getting released. His parole hearing, scheduled for October, was adjourned as his psychology report had not been completed. No date was set for the next hearing but it was indicated that it was likely to be mid-2018.
63. A learning disabilities nurse first met Mr Piggott when he transferred to Coldingley and had regular ongoing contact with him. The nurse said Mr Piggott was vulnerable to peer pressure from other prisoners and looked after illicit items for them. He believed that Mr Piggott also found it difficult to manage his own emotions and anxiety, and sometimes felt he was not being listened to. This, in turn, impacted on Mr Piggott's risk of self-harm, which he used as a coping mechanism. The nurse said that Mr Piggott wanted to be released but was also anxious about this prospect, having been in prison all his adult life. Mr Piggott was also reviewed several times by a psychiatrist while at Coldingley.

64. On 10 October, while in the segregation unit, Mr Piggott made a ligature and suspended it from the light fitting. He told staff that he had been in prison a long time, could see no positive end and intended to kill himself. Mr Piggott was already subject to ACCT procedures and his observations were increased to constant supervision. As a result, staff requested that he be transferred to a prison with an inpatient unit which provided 24-hour healthcare.

11 October 2017 – 24 May 2018, HMP High Down

65. On 11 October 2017, Mr Piggott transferred to HMP High Down and was admitted to the healthcare unit. The learning disabilities nurse also worked at High Down and he continued to meet regularly with Mr Piggott. Mr Piggott told him that he had tied the ligature as he had not been given the job he wanted at Coldingley and he was also being bullied by other prisoners to hold illicit items for them.
66. The psychiatrist also worked at High Down and, along with his manager, a consultant psychiatrist, he continued to review Mr Piggott regularly. Having assessed Mr Piggott, they decided not to prescribe him any antidepressant or antipsychotic medication. This was intended to help him cope in prison without the need for medication.
67. Mr Piggott moved from the healthcare unit to a standard wing on 24 October. His ACCT observations were gradually reduced over the following two months. He engaged with the substance misuse team about his PS use.
68. Mr Piggott told his offender supervisor that he was concerned about his release. His next parole hearing had been set for 8 February 2018. The offender supervisor noted that Mr Piggott's behaviour deteriorated when the possibility of release got nearer. She assessed that his risk was strongly connected to times when he felt no sentence progression was possible, or, conversely, when the opportunity for release was a possibility. Mr Piggott said that he felt at risk of being bullied or being made to do things for others on the wing and was in debt due to PS use. He would not tell staff where he got the PS.
69. Throughout December 2017 and January 2018, Mr Piggott was intermittently subject to ACCT procedures and suspected to be under the influence of PS on several occasions. He was assessed by two forensic psychologists and a psychiatrist in preparation for his parole hearing. All three reports concluded that Mr Piggott was not ready for release and the potential options were to transfer him to a low or medium secure psychiatric unit or to a therapeutic community in prison.
70. A new offender supervisor was allocated on 24 January 2018. She met him the next day to assess him for his parole report for his upcoming parole hearing. She concluded that he was unlikely to be suitable for release at present and should be referred to a medium secure psychiatric unit.
71. On 30 January, staff opened an ACCT. Mr Piggott said he said he was distressed as his parole hearing was approaching and he thought people were trying to jeopardise his release. He said he had no current thoughts of suicide and wanted to stay alive for his family. The next day, Mr Piggott said he was

being bullied and had been assaulted a week earlier but would not name the prisoners responsible.

72. Due to Mr Piggott's complex needs, a mental health nurse shared his care with the learning disabilities nurse. She said that initially, following transfer, he was a "bubbly" and "likeable" prisoner, but when his parole hearing was approaching, his needs became more complex and he started presenting differently. On 3 February, staff suspected Mr Piggott was under the influence of PS, and he self-harmed by cutting himself. The next day he was admitted to the healthcare unit as he said he wanted to be located there. He told staff he was stressed about his upcoming parole hearing.
73. On 8 February, the Parole Board deferred the decision about Mr Piggott's release until 12 July. The Board directed that a multi-disciplinary Care Plan Approach (CPA) meeting involving community and prison professionals needed to take place. This would determine what services and accommodation would meet Mr Piggott's needs in the community. (The CPA is a written plan that describes the day to day care that will be provided, along with a care coordinator whose role is to implement the care plan.)
74. The offender supervisor told the investigator that the Parole Board had requested that, in the meantime, she provide them with regular email updates. She said this was very unusual and she had never been asked to provide updates before. She believed that the Board was concerned about the length of time a decision on Mr Piggott's release had taken and that this could potentially worsen his mental state.
75. The learning disabilities nurse continued to meet with Mr Piggott regularly. The nurse said that although Mr Piggott initially seemed quite pleased with the result of the parole hearing, he then realised there was still no definite outcome in sight. He said that Mr Piggott's behaviour was much more changeable after this, alternating between less communicative to disruptive and aggressive. The consultant psychiatrist told the investigator that Mr Piggott found the prospect of being released from prison very stressful and his behavioural changes were potentially related to his use of drugs.
76. On 11 February, Mr Piggott admitted he had used PS. Over the following two weeks, his behaviour was disruptive. He flooded and smashed his cell and was abusive to staff. He also smeared faeces across his cell. At times he lay on his bed and refused to engage. Staff suspected that Mr Piggott was suffering from a drug-induced psychosis due to PS use. He refused to engage with substance misuse services or be tested for PS. Mr Piggott was reviewed regularly by the psychiatrist and the learning disabilities nurse and, on 27 February, after his mental state improved, he moved back to a standard wing.
77. Mr Piggott remained subject to ACCT procedures and staff regularly reviewed his level of risk. An officer told the investigator that Mr Piggott was an impressionable prisoner who was used by other prisoners on the wing to try new batches of PS when they arrived in the prison.
78. On 6 March, during an ACCT review, staff noted that he had self-inflicted scratches on his face. The next day the offender supervisor noted that she was

concerned about Mr Piggott who, she thought, was thinner, slower in response and unkempt. He had not been taking his medication for ADHD and was low in mood. She spoke to healthcare staff who said they would assess him. The learning disabilities nurse reviewed Mr Piggott and was told that he had not taken his medication for four days. He spoke about Mr Piggott during the healthcare multi-disciplinary team meeting and the consultant psychiatrist agreed to review him if his presentation continued to concern staff.

79. A prisoner said that he became friends with Mr Piggott when he first came to High Down. He said that Mr Piggott found it difficult to deal with the length of his sentence and parole hearings. He said that when Mr Piggott returned to the wing from the healthcare unit, he was “totally different. His behaviour was different, his mannerisms were different, the look in his eyes and face were different ... it was like something was missing from him”. He also said Mr Piggott started self-harming and kept repeating to him that he “can’t do it”. The prisoner said this referred to the amount of time Mr Piggott had spent in prison and never being released. He also said that Mr Piggott was told different things about his release and felt very uncertain about the future. He said that Mr Piggott no longer talked to other prisoners and was paranoid. He said that when Mr Piggott first arrived at High Down he took PS but, on his return to the wing in March, he did not think Mr Piggott used any drugs.
80. On 12 March, Mr Piggott refused to return to his cell. He was restrained by staff and carried to his cell. He told officers that he liked the pain of being restrained. On 14 March, Mr Piggott refused to provide a urine sample for a drugs test, which had been requested by the mental health team, as they suspected his behaviour might be due to PS use.
81. On 21 March, the consultant psychiatrist reviewed Mr Piggott. He discussed Mr Piggott’s behaviour with the wing supervising officer, who said that Mr Piggott had been very subdued and was refusing his ADHD medication (atomoxetine). He said that he believed Mr Piggott was under the influence of drugs as he was slurring his words and was difficult to engage with. He recommended that Mr Piggott move to the healthcare unit for a period of assessment and abstinence from drugs. He said that, in general, drugs were much less available in the healthcare unit than the rest of the prison, although it was not impossible to get drugs into the healthcare unit. Mr Piggott was transferred later that day. The psychiatrist also wrote to a consultant to determine what services would be available to Mr Piggott in the community.
82. Over the next few days, Mr Piggott was very subdued, did not engage with staff and refused his medication. A mental health nurse had known Mr Piggott since January and said that when he returned to healthcare the last time, he was noticeably different to previous occasions. On 26 March, the psychiatrist reviewed Mr Piggott and planned for nurses to observe him hourly, for his food and fluid intake to be monitored, for a urine drug test to be carried out and to discuss him in the multidisciplinary team meeting the next day.
83. Mr Piggott’s behaviour fluctuated over the following weeks. He sometimes self-harmed by cutting or repeatedly banging his head and fists on the cell walls. He told staff he felt frustrated, having lost hope in the system and having little hope

of being released. His engagement with staff also fluctuated between talking normally outside his cell to rocking on his bed, not responding to anyone. The psychiatrist concluded that his changeable behaviour was due to taking PS but also told the investigator that other stressors, such as his upcoming parole hearing, may have influenced Mr Piggott's behaviour.

84. On 16 April, the psychiatrist assessed Mr Piggott. Mr Piggott appeared distressed and told him that he could hear voices. Mr Piggott said he was scared of people on the wing as they were bullying him and wanted to harm him. Mr Piggott said he thought he should try taking medication and the psychiatrist prescribed him an antipsychotic (olanzapine) which he agreed to take. He said he had no thoughts of suicide or self-harm. Mr Piggott's behaviour varied over the following week. Sometimes he engaged with staff, but at other times he would self-isolate or self-harm.
85. On 24 April, the consultant psychiatrist reviewed Mr Piggott. The psychiatrist noted that there had been some improvement in his mental state since he had started taking olanzapine although Mr Piggott said that he could still hear voices. Mr Piggott said he tried not to think about the future and the psychiatrist tried to reassure him that the Parole Board was seriously considering his release.
86. On 27 April, Mr Piggott was rocking in his cell, hitting his head gently against the wall. The psychiatrist assessed him and, at his request, Mr Piggott was taken to hospital in an ambulance. He returned later that day. The psychiatrist telephoned hospital staff, who said that they thought his state was likely to have been induced by taking PS and he had been trying to self-harm while in hospital. Over the following days, Mr Piggott continued to self-harm, banged his head and rocked in his cell throughout the night.
87. On 1 May, the consultant psychiatrist noted that there had been a change in Mr Piggott's behaviour since he had last seen him, he was not engaging and continued to bang his head on the floor. Staff in the ACCT review noted that he had made a noose and put it round his neck as he said he feared being released.
88. On 4 May, several staff from the prison and community met to agree a Care Plan Approach if Mr Piggott was released under Section 117 of the Mental Health Act 1983. Section 117 provides for the provision of mental health care in the community after release from prison. Mr Piggott refused to attend the meeting and remained rocking in his cell not responding to staff.
89. Staff at the meeting concluded that there were no services available in Bedford, where Mr Piggott was from, and they needed to find suitable services elsewhere. They also agreed that, due to Mr Piggott's current presentation, he should be referred for a gatekeeping assessment to assess his suitability for transfer to a medium secure psychiatric unit. Neither psychiatrist could attend at the meeting but the learning disabilities nurse was present.
90. On 8 May, staff held an ACCT review. Mr Piggott was dirty, did not engage with staff or make eye contact. After the review, he asked an officer for a razor to shave with. When given it, he immediately broke the blades from the razor and swallowed them. His observations were increased to twice hourly. The learning disabilities nurse went to see Mr Piggott, who said that he wanted to be

transferred to hospital as he had felt supported when last there. He said the voices in his head were too much and he wanted more medication. The nurse noted that he intended to discuss the request for Mr Piggott's gatekeeping assessment with the consultant psychiatrist when he returned from annual leave.

91. Mr Piggott was taken to hospital, where he continued to bang his head. The psychiatrist also went to healthcare to assess Mr Piggott, but he had already been admitted to hospital for examination because he had swallowed the razor blades.
92. On 9 May, a scan showed that the razor blades were passing through Mr Piggott's system naturally and he returned to High Down. The hospital discharge letter recorded that Mr Piggott said he had swallowed the razor blades to kill himself.
93. Mr Piggott would not engage in an ACCT review on 10 May. The offender supervisor recorded that she was very concerned about him. The psychiatrist reviewed Mr Piggott and recorded that there had been a notable change in him since 1 May: he was not engaging or responding verbally and he required a complex case discussion about the management of his care. The offender supervisor told the investigator that she was concerned that Mr Piggott was a risk to himself. She was concerned that he "would become so desperate and unreachable" that he might kill himself accidentally.
94. The learning disabilities nurse said it was very difficult to know how to assist Mr Piggott. The psychiatrist tried to assess him on 11 May. He did not engage with him, covered his face with a blanket and remained lying on his bed. The psychiatrist noted that he would discuss the case with his manager once he returned from annual leave the following week.
95. On 13 May, a nurse went into Mr Piggott's cell. He did not respond and remained lying on his bed. She noticed that this was soaked in urine and staff later assisted Mr Piggott to have a shower, change his clothing and his bedding. They had to cut off his clothes and use a wheelchair to do so. Mr Piggott did not engage with staff but was compliant.
96. On 14 May, the psychiatrist noted that healthcare staff had recently become more concerned about Mr Piggott's presentation. The psychiatrist was also concerned that Mr Piggott had been refusing any medication since 9 May. He discussed Mr Piggott's care with his manager and they agreed to refer him to a medium secure psychiatric unit in East London. That evening Mr Piggott was again found to be lying on a urine-soaked bed and staff again assisted him to have a shower and cleaned his room. On 15 May, the psychiatrist urgently referred Mr Piggott to the secure unit in East London. The learning disabilities nurse told Mr Piggott. He did not engage but remained lying on his bed with his blanket over his face.
97. On 16 May, the secure psychiatric unit in East London rejected Mr Piggott's referral as he was not from their catchment area. The psychiatrist therefore referred him to the Eric Shepherd Unit where he had previously been a patient. He reviewed Mr Piggott.

98. Over the following few days, Mr Piggott remained in bed, not engaging with staff and refusing medication. He regularly had to be assisted to shower and had his room cleaned. On 17 May, an occupational therapist and the psychiatrist attempted to assess Mr Piggott, but he would not engage with them. He did verbally respond when given his canteen, which consisted of confectionery.
99. On 18 May, at an ACCT review, Mr Piggott's observations were reduced to hourly and he was assessed as being a low risk to himself. He did not engage with staff during the review and continued to lie in bed with his eyes closed. A nurse told the investigator that the last couple of weeks marked "a very, very remarkable change in his presentation". She said that this concerned her, since they were not able to assess him properly while he was not speaking to staff. She said that he was assessed as being a low risk to himself because he had not self-harmed.
100. On 21 May, the psychiatrist noted that Mr Piggott continued to refuse all medication and that he should be encouraged to take his antipsychotic medication. He was lying in bed with his head covered and did not engage with him. The next day, during an ACCT review, Mr Piggott continued to lie on his bed, with a blanket over his face and did not acknowledge staff. His observations remained the same. Healthcare staff checked that the Eric Shepherd Unit had received their referral. The Unit confirmed that it had but that, although it had been allocated to a doctor for assessment, the date for the assessment had not yet been set.
101. A nurse working nights that week said that there was concern that PS was coming into the healthcare unit at the time. Several other staff told the investigator that the healthcare unit was going through a particularly difficult period. Some prisoners were there for clinical reasons and some for security reasons, as there was nowhere else they could be appropriately located. Some of these prisoners were particularly disruptive and could be abusive, although she never witnessed this being directed at Mr Piggott.
102. On 22 May, a substance misuse worker went to Mr Piggott's cell but he refused to talk to him. On 23 May, Mr Piggott was discussed at the monthly safer custody meeting chaired by the Governor. She requested that the acting Deputy Governor hold an enhanced ACCT case review, as she was concerned about Mr Piggott's current presentation and risk to himself.
103. On 24 May, at 3.50pm, the acting Deputy Governor held an enhanced case review with staff from probation, safer custody, the healthcare unit and mental health teams. The psychiatrists were not available at the time. Mr Piggott refused to come out of his cell for the review. He told the investigator that the purpose of the review was to keep Mr Piggott safe until he could be assessed for transfer to a secure psychiatric unit on 11 June.
104. Those present at the review discussed Mr Piggott's fluctuating behaviour and the difficulties this presented. The acting Deputy Governor said it was difficult to assess Mr Piggott's mental capacity as he had not been engaging with staff, so this was to be assessed daily by nursing staff. He said that if Mr Piggott had capacity, staff were to encourage him to shower, eat, come out of his cell or get out of bed. If Mr Piggott lacked capacity, staff were to try to clean him and

change his bedding. His food intake was also to be monitored and if he started declining food, a refusal log would be opened.

105. Mr Piggott's risk was assessed as unchanged and remained at low. The next ACCT review was scheduled for 31 May.
106. The acting Deputy Governor typed up the enhanced case review that evening, gave a copy to the orderly officer to place in Mr Piggott's ACCT document, recorded the information in Mr Piggott's computerised record and emailed it to those at the meeting. (No copy was ever placed in Mr Piggott's ACCT document.)

Events of 25 and 26 May

107. On 25 May, Nurse A, who had no prior knowledge of Mr Piggott, noted that he was banging his head against his cell wall. Staff gave him a pillow and tried to calm and reassure him but he ignored them and continued to bang his head. The nurse spoke to a prison GP, who agreed to assess Mr Piggott that morning. The nurse also telephoned Nurse B and told her about Mr Piggott's current behaviour.
108. At 10.25am, Nurse B emailed the psychiatrist, who was working at another prison, and passed on the information that Mr Piggott was banging his head against a wall. The psychiatrist asked whether Mr Piggott was purposefully self-harming rather than self-soothing. He asked staff to increase Mr Piggott's ACCT observations if he was thought to be deliberately self-harming and relocate him to a 'safer cell'.
109. Nurse B replied that Mr Piggott was continuing to bang his head to the extent that it was now bleeding. She said there were no 'safer cells' available to move him to. (Safer cells are designed to have minimal ligature points to help prevent prisoners hanging themselves.) She suggested constant supervision might now be appropriate for Mr Piggott, or restraining him. The psychiatrist confirmed constant supervision would be appropriate if staff thought it clinically necessary and asked her to tell the acting Duty Governor. The psychiatrist told the investigator that he thought that Nurse B had assessed Mr Piggott in person and he trusted her judgement.
110. At 10.54am, a prison GP recorded that he had assessed Mr Piggott, who had continued to bang his head on the wall and was bleeding slightly as a result. He recorded that Mr Piggott might need depot injections (antipsychotic medication) and sectioning under the Mental Health Act to be able to administer these. Mr Piggott refused to talk to him and would not allow him to take his pulse. He prescribed him lorazepam, a sedative, in case he agreed to take it.
111. The GP advised Nurse A to contact the acting Deputy Governor, which he did, and advised him that Mr Piggott had been banging his head against the wall for two hours. The Deputy Governor told the investigator that he could not go to the healthcare unit at that time as he was in meetings. He contacted a Custodial Manager (CM), the orderly officer, and asked him to assess Mr Piggott.
112. The CM went to Mr Piggott's cell, but he refused to engage with him. Nurse A dressed the cut on his head, but Mr Piggott immediately removed the dressing.

The CM updated the acting Deputy Governor and told him that the psychiatrist was coming into the prison that afternoon. The Deputy Governor asked the CM to update the ACCT document and wait for the psychiatrist to assess Mr Piggott. At 11.30am, Nurse B emailed the psychiatrist, telling him that the manager and GP were dealing with Mr Piggott.

113. At 2.15pm, Nurse A noted that he had spoken to a healthcare manager, who suggested that he should speak to the psychiatrist when he arrived at the prison before beginning Mr Piggott's constant supervision.
114. The psychiatrist arrived at the prison and was told that Mr Piggott remained on hourly ACCT observations. He assessed Mr Piggott at 2.30pm. He noted that there was litter on the floor of his cell, and that ants were visible. Mr Piggott was lying on his bed. He did not respond to him or engage with him. He noted that Mr Piggott's behaviour was similar to when he had last assessed him. He considered that he needed nursing support but did not require admission to hospital at that time.
115. The psychiatrist noted that he would email the Eric Shepherd Unit to inform them of Mr Piggott's worsening mental state and ask for his assessment to be expedited. He noted that he should remain on one ACCT observation per hour, his nursing observations should be increased to two per hour, his urine should be tested when possible, his cell should be cleaned and he should be encouraged to eat and drink and take his medication.
116. The psychiatrist told the investigator that he thought an ACCT review had taken place that morning and that staff had decided not to increase Mr Piggott's observations. He said he increased the nursing observations not because he was necessarily concerned about Mr Piggott's risk to himself, but because he wanted to support him generally and observe him, for example, to see whether he had taken drugs. He said that when he assessed Mr Piggott, he was no longer banging his head and seemed less distressed than on some previous occasions when he had assessed him.
117. An officer had been on duty in healthcare every evening that week and was responsible for doing Mr Piggott's ACCT checks. She said that throughout the week Mr Piggott had not responded to her but had largely appeared asleep during her shifts. She said he never rang his cell bell. She checked Mr Piggott that evening from 8.50pm, every hour at ten minutes to the hour.
118. Nurse C had been working night shifts in the healthcare unit since mid-May. She said that Mr Piggott had always been asleep during her shifts and she had not had any conversations with him. She said that on 25 May, a very disruptive prisoner had been admitted to the healthcare unit, smashing items and shouting. The noise could be heard throughout the healthcare unit and Mr Piggott was in a cell next to the prisoner. She said the prisoner was abusive towards her but she did not hear him being abusive towards Mr Piggott. Other healthcare staff also confirmed that the unit was particularly noisy that night.
119. Nurse C was responsible for doing the nursing checks throughout the evening from 8.30pm onwards, including the twice hourly checks on Mr Piggott. She recorded that she observed Mr Piggott as shown below:

8.30pm	9.05pm	10.20pm	11.15pm	12.15am	1.15am	2.15am	3.15am	4.20am
8.50pm	9.20pm	10.50pm	11.45pm	12.45am	1.45am	2.45am	3.45am	4.50am
	9.35pm							
	9.50pm							

120. However, the CCTV footage shows that the checks which Nurse C actually carried out were as follows:

8.43pm	9.50pm	10.10pm	11.11pm	12.11am	1.26am	2.34am	3.53am	4.50am
8.53pm		10.16pm	11.41pm	12.37am	1.46am			
		10.28pm						

121. Not only are the checks inaccurately recorded in terms of their timing, but from 2.00am onwards, Nurse C only checked Mr Piggott once per hour. She documented 20 checks throughout the night, although she only carried out 15.
122. Nurse C told the investigator that when she checked Mr Piggott at 4.50am, he had moved from his bed, was kneeling on the floor and had his hands in a praying position. She said he was sideways to her, facing his bed. She said she was not concerned and checked on the other prisoners on the corridor. She returned to Mr Piggott's cell a minute later and Officer A reached the cell ten seconds after that to complete Mr Piggott's ACCT observation. She said that Mr Piggott's hands were no longer in a praying position but were by his side.
123. Officer A looked through the observation panel and saw that there was a ligature hanging from the light fitting. Nurse C told the investigator that she had not noticed this before. She said that there was a dim light on in Mr Piggott's cell and she had not used her torch to complete her observations. Both staff members looked through the observation panel for just under a minute.
124. They both went to the office to fetch Officer B. Officer B said that Officer A said, "I think we might have a problem". They both went back to Mr Piggott's cell, arriving around 20 seconds after Officer A had left it. Officer B said that when he first looked through the observation panel it looked as if Mr Piggott was kneeling, naked, in the middle of his cell. He then turned on the light and saw a bedsheet around Mr Piggott's neck which was secured to the ceiling light. He told Officer A to radio a code blue emergency. (This indicates that a prisoner is unconscious or having difficulty breathing.)
125. Officer A radioed a code blue while Officer B continued to shout Mr Piggott's name and to bang on his door. Officer A said that they were considering whether to go into Mr Piggott's cell when Nurse D arrived. He had immediately responded to the code blue and arrived at the cell about a minute after hearing the code called.

126. Nurse D said that both officers were distressed. They told him that Mr Piggott was hanging and asked whether they needed to wait for response staff before going into the cell. He said they had to unlock the door immediately. Officer B did so and they went straight into the cell. This was three and a half minutes after Nurse C had first looked into Mr Piggott's cell.
127. Nurse D supported Mr Piggott while Officer B cut the ligature with his anti-ligature knife. They laid Mr Piggott on the floor and the nurse checked for signs of life. Nurse D said that he appeared greyish. He asked the officers to request an ambulance and began chest compressions. The ambulance had already been requested automatically at 4.59am following the code blue call. Nurse C brought the emergency equipment into the room. An officer took over chest compressions while the nurses attached the defibrillator and administered oxygen.
128. Paramedics arrived at 5.14am, took over Mr Piggott's care and obtained a pulse. Having stabilised Mr Piggott, they took him to hospital in an ambulance at 6.21am.

Contact with Mr Piggott's family

129. The duty Governor telephoned Mr Piggott's sister. He told her what had happened and that Mr Piggott had been taken to hospital. A CM was appointed as family liaison officer and met Mr Piggott's family at the hospital.
130. On 27 May, at 1.00pm, Mr Piggott's life support was turned off. He died at 1.25pm with his family present. A CT scan showed that Mr Piggott had hidden an item in his rectum. Police later told the investigator that this was a small, empty plastic bag with a paperclip attached to it.
131. The CM remained in contact with the family over the following few days. She offered them a contribution to Mr Piggott's funeral expenses in line with Prison Service instructions and confirmed that she would return Mr Piggott's belongings. The last time the CM contacted Mr Piggott's sister was on 4 June, when she returned some of Mr Piggott's belongings.
132. On 1 August, following concerns raised by Mr Piggott's sister, the investigator asked the prison why Mr Piggott's funeral expenses had not been paid as agreed. On 8 August, the prison confirmed that they were sending a cheque to cover the expenses to Mr Piggott's next of kin that day. A Supervising Officer (SO) also located two bags of Mr Piggott's belongings in the prison which had not been given to Mr Piggott's sister. He told the investigator that the CM had been on sick leave since July and had not told anyone about these outstanding actions.
133. On 8 August, the Head of Safety telephoned Mr Piggott's sister and apologised for the lack of communication from the prison caused by the CM's absence on sick leave. Mr Piggott's sister was given the contact details of a new family liaison officer and the prison arranged for the remainder of Mr Piggott's belongings to be returned to her.

Support for prisoners and staff

134. No debrief was carried out either after Mr Piggott was found hanging or when he subsequently died, contrary to Prison Service policy. Around three to four days later, healthcare staff were given a debrief, but the only member of prison staff present was the SO who worked in Safer Custody. Despite this, staff said that they had felt adequately supported in general.
135. The prison posted notices informing other prisoners of Mr Piggott's death, and offering support. Staff reviewed all prisoners assessed as being at risk of suicide or self-harm in case they had been adversely affected by Mr Piggott's death.

Post-mortem report

136. The post-mortem report indicated that Mr Piggott's cause of death was hanging. No drugs, including PS, were detected in his system. However, the report noted that there are over 400 types of PS, which are rarely detectable as they are quickly metabolised in the body.

Findings

Management of ACCT

137. Mr Piggott had been assessed as a risk of suicide and self-harm intermittently since he first arrived in prison in 2007. He was subject to ACCT monitoring from 29 January 2018 until he died. Staff held 32 case reviews during that time. Virtually all of these case reviews were multidisciplinary, involving prison staff, nurses, psychiatrists, managers and probation staff. Staff made concerted efforts to work together to reduce Mr Piggott's risk to himself. Staff we spoke to from all disciplines were aware of the difficulties faced by Mr Piggott and demonstrated understanding, compassion and careful consideration in trying to assist him in reducing his distress. Even during Mr Piggott's last weeks, when he would not engage with staff, they continued to try to involve him in his care. Staff did not give up.
138. The Governor was aware of the risks presented by Mr Piggott and the Deputy Governor chaired an enhanced ACCT case review three days before he died. Nevertheless, staff interviewed by the investigator said that they were shocked by Mr Piggott taking his own life. They had been more concerned he had been at risk of deliberate self-harm or harm through neglecting his own physical care.
139. Despite all this good work, the investigation identified procedural failings in the operation of the ACCT process, meaning that Mr Piggott did not always receive an appropriate level of support.
140. PSI 64/2011 states that caremap actions should be detailed and time-bound and aimed at reducing risk. They should reflect prisoners' needs, level of risk, and the triggers of their distress. Mr Piggott was subject to ACCT monitoring for four months, but there were only five actions on his caremap, the last of which was added on 1 May. While we recognise that numerous agencies were working together to try to assist Mr Piggott and reduce his risk to himself, these efforts were not adequately reflected on his caremap.
141. For much of his time at High Down, including the last week of his life, Mr Piggott's observations were carried out at very regular intervals (for example, on the hour, every hour) rather than unpredictably as the PSI instructs.
142. Between 22 April and 16 May (other than over a period of a few hours on 1 May when his risk was briefly assessed as low), Mr Piggott was continuously assessed as representing a raised risk to himself. However, from 16 May onwards, his risk to himself was assessed as low and, from 18 May, his observations were reduced to hourly from twice per hour, although there had been no apparent change in his presentation.
143. Nurse B said that staff assessed Mr Piggott as low risk because he had not self-harmed. She said it was very difficult to assess a prisoner's risk when they were not communicating but that as he was in the healthcare unit he would have been more closely observed than if he was living on a standard residential wing.
144. When asked about Mr Piggott being assessed as low risk, the consultant psychiatrist (who was not present at the ACCT reviews) said, "When people's

mental states are abnormal and if they've had a history of self-harm, and you're having difficulty reviewing and understanding their mental state, it's difficult to reassure yourself that they're low risk".

145. On 23 May, the Governor identified that the prison was concerned about Mr Piggott's current presentation and risk to himself. She instructed the acting Deputy Governor to undertake an enhanced ACCT case review with Mr Piggott. The PSI instructs that an enhanced case review is used when a prisoner needs additional case management in order that their "heightened or exceptional risk of harm to self, others and/or from others is managed".
146. We recognise the difficulties in assessing a prisoner's risk to himself if he is not engaging with staff. However, we do not consider that Mr Piggott should have been assessed as a low risk to himself during the last week of his life. Although he had not self-harmed for two weeks, the fact that he was not engaging with staff was, in itself, a cause for concern. If the risk was to be reduced to low, we would have expected a detailed and considered justification to have been recorded as to why this was the case.
147. We are particularly concerned that Mr Piggott's risk was assessed as low at the enhanced case review on 24 May. Mr Piggott's mental health had been deteriorating since the beginning of May. He had recently self-harmed. For the last couple of weeks, he had not been engaging with staff or taking his medication, was intermittently refusing food and was soiling his bed, refusing to shower and neglecting his self-care. He was considered sufficiently mentally unwell to have been referred for a transfer to a psychiatric unit. He was also known to be very stressed about his parole review (which was due in July). In these circumstances we consider that it was not appropriate to have assessed his risk as low.
148. We are also concerned that the notes of the enhanced case review were not put in Mr Piggott's ACCT file. As a result, the notes and plan from this review were not readily available to all those who accessed the ACCT file subsequently. We are aware that the acting Deputy Governor did, however, email the information to all those present at the review and entered the information onto Mr Piggott's electronic record.
149. PSI 64/2011 says that, in addition to planned case reviews, a case review should be held when there are additional concerns. On the morning of 25 May, Mr Piggott's behaviour deteriorated and he banged his head for a couple of hours to the point where it was bleeding. Whether Mr Piggott was doing this to soothe himself or as a deliberate act of self-harm, it amounted to self-harm.
150. Nurse A had sufficient concerns about Mr Piggott's behaviour that morning to contact a GP and another nurse, who suggested to an off-site psychiatrist that Mr Piggott should be considered for constant observation. The psychiatrist agreed to this, assuming that the mental health nurse had assessed Mr Piggott in person. The nurse also contacted the acting Deputy Governor who arranged for Mr Piggott to be seen by the orderly officer.
151. We are concerned that this behaviour and the concerns of staff did not trigger an ACCT case review and that Mr Piggott's assessed risk and level of observations

remained unchanged. We are also concerned that there was confusion between prison and healthcare staff about whose responsibility it was to take the lead in assessing Mr Piggott's risk.

152. By the time the psychiatrist got to the prison in the afternoon and reviewed Mr Piggott himself, he decided that constant supervision was not necessary. However, we are concerned that the psychiatrist made this decision in the belief that an ACCT review had taken place earlier in the day and concluded that Mr Piggott's risk and level of observations did not need to be changed. This had not happened and the acting Deputy Governor said that he was waiting for the psychiatrist's assessment of Mr Piggott's level of risk. The psychiatrist was sufficiently concerned to increase Mr Piggott's nursing observations to two per hour but, again, this did not trigger an ACCT review.

153. We make the following recommendations:

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

- **all known risk factors are considered when determining the level of risk of suicide and self-harm;**
- **ACCT caremap actions are specific and meaningful, aimed at reducing a prisoner's risk and identify who is responsible for them;**
- **observations are carried out at unpredictable intervals;**
- **ACCT reviews are held whenever an event occurs that could mean a prisoner is at increased risk; and**
- **all case reviews are included in the ACCT documentation.**

Clinical care

154. The clinical reviewer concluded that, overall, the range, quantity and quality of the care for Mr Piggott's physical, mental health and social needs was equivalent to that which he could have expected to receive in the community.

155. It is rare that a prisoner has continuity of care between two prisons but Mr Piggott did so with the psychiatrist and the learning disability nurse at Coldingley and High Down. The learning disabilities nurse made continued concerted efforts to engage with Mr Piggott and other agencies on his behalf. Both the psychiatrist and his manager reviewed Mr Piggott regularly, and he was discussed at multidisciplinary team meetings. Generally, we found there to be very good communication both within the mental health team and with other agencies, such as the National Probation Service.

156. However, on 25 May, when Mr Piggott continuously banged his head and made it bleed, we are concerned that his care could have been improved through clearer communication and crisis management. In particular, we are concerned that healthcare staff assumed it was for prison staff to decide whether Mr Piggott's ACCT observations should be increased, although they could and should have made this decision themselves if they thought it necessary.

157. Nurse B said she thought Nurse A should have been more proactive in assessing the situation and acting on suggestions made by herself and the psychiatrist. However, given Nurse B's knowledge of Mr Piggott, we consider that she should have assessed him in person herself before suggesting constant observations to the psychiatrist. The psychiatrist, in turn, assumed that the nurse had completed a face to face assessment before he agreed to her suggestion.
158. In addition, the learning disabilities nurse who had extensive knowledge of Mr Piggott, was working at another prison that day and could have been contacted, although this was not tried. The Head of Healthcare said that he thought the entries in Mr Piggott's medical records on 25 May were "messy" and decisions should not have been made without seeing Mr Piggott in person. He said he thought this had put the psychiatrist in a "difficult position".
159. Both the Head of Healthcare and the consultant psychiatrist said they believed the psychiatrist had made a balanced and reasonable judgment in the end and they did not believe Mr Piggott needed constant supervision at that stage. The Head of Healthcare said that he did not consider that Mr Piggott's head banging necessarily represented an increase in his risk to himself, as this behaviour had occurred before. The clinical reviewer also concluded that the psychiatrist's decision on the level of observation on 25 May was balanced and appropriate.
160. We recognise that Mr Piggott was no longer banging his head continuously when the psychiatrist saw him, and we do not consider that it was unreasonable for him to conclude that constant supervision was not necessary. We also recognise that with two nursing observations an hour and one ACCT observation an hour, Mr Piggott's level of observations had effectively been raised to three per hour. However, we consider that decisions about the necessary level of observations should have been made as part of a considered ACCT review.
161. Central and North-West London (CNWL) NHS Foundation Trust completed an investigation into Mr Piggott's death. They were also concerned that mental health staff made decisions about crisis management without seeing Mr Piggott in person. They recommended that there should be an agreed process for the management of prisoners with complex and/or deteriorating mental health, decisions about constant supervision, crisis management plans and how information about parole hearings is shared with the team to enable timely co-ordinated planning. The clinical reviewer also recommended that there needs to be an improvement in communication between healthcare staff. We make the following recommendation:

The Governor and Head of Healthcare should ensure that there is a clearly agreed protocol for the management of prisoners with complex and/or deteriorating mental health which includes decisions around level of observations and crisis management.

Referral to hospital

162. By 4 May, Mr Piggott's mental health had deteriorated to such an extent that those present at a care plan meeting agreed that he should be referred to a secure psychiatric unit for assessment. Neither the consultant psychiatrist nor the psychiatrist were present at this meeting which took place on a Friday. The

consultant psychiatrist was on annual leave the following week and the psychiatrist reviewed Mr Piggott and noted the change in his behaviour which he planned to discuss with the consultant psychiatrist the following week. On 14 May, the psychiatrist spoke to the consultant psychiatrist and they agreed that Mr Piggott should be referred to a medium secure psychiatric unit as a matter of urgency. The psychiatrist sent this referral the next day.

163. The clinical reviewer commented that, in the circumstances, he believed this was an appropriate point to complete the referral since the psychiatrists had not initially been present at the multidisciplinary meeting, nor had the referral been considered urgent. Healthcare staff subsequently followed up this referral on 21 May and on 25 May updated the secure unit on Mr Piggott's worsening mental state. Mr Piggott's assessment had been booked for 11 June, nearly one month after the initial referral.
164. In January 2016, we published a thematic review of lessons to be learned from our investigations into self-inflicted deaths in prisons where mental health issues were involved. We noted that where a secure hospital had been identified as the best environment to deliver appropriate care for acutely ill prisoners, we would expect all possible steps to be taken by the prison and the hospital to ensure this takes place within the Department of Health's 14-day target. We also noted that prisons need to be especially vigilant about the care of prisoners who are being considered for, or are awaiting, transfer to a secure hospital.
165. Staff at High Down agreed with the Inspectorate's finding that the 14-day transfer target is rarely met. All staff questioned said they thought this target was unrealistic. The consultant psychiatrist could not recall a single prisoner being transferred within this target. The healthcare professionals outlined the difficulties in Mr Piggott's case: that he needed a specialist service for people with learning disabilities, and that his previous behaviour meant that getting him accepted by a psychiatric hospital at all would be more problematic. Delays in persuading a hospital to agree to carry out an assessment, assess the individual, then find a suitable bed, all meant that the process could take months. The Head of Healthcare said that a month between referral and assessment was not unusual.
166. We find this extremely concerning.

IPP Sentence and release

167. Mr Piggott was ten years over his tariff at the time of his death. He had lived all his adult life in prison. The effect of this cannot be overstated. It is well documented that he felt both hopeless about the prospect of his release and also fearful of his ability to cope in the community. His declining mental health and withdrawal from prison life are a stark reminder of the stress that such uncertainty puts prisoners under. Mr Piggott's behaviour typically declined when a parole hearing was imminent. This behaviour and his use of PS then hampered any progress he had made. Tragically, this was a cycle it seems he only felt able to break by taking his own life.
168. However, we recognise the efforts made by staff from different agencies who tried to assist Mr Piggott towards release: the learning disability nurse, mental

health nurses, psychiatrists, his offender manager in the community and offender supervisor in prison, along with other prison and healthcare staff. Individuals made sustained efforts to assist and progress Mr Piggott in very difficult circumstances. All those we spoke to were not only shocked but clearly quite personally affected by Mr Piggott taking his own life.

Management of the healthcare unit

169. At the time of Mr Piggott's death, staff said that the healthcare unit was going through a disruptive period, with several prisoners located in the unit for security reasons or because they were vulnerable themselves. This meant that staff had to run several different unlock regimes for prisoners who could not associate together. This was time-consuming and drew their attention away from more focused, therapeutic work. Sometimes prisoners' association periods were also shortened.
170. Staff also said that they suspected PS was available on the unit. (This is discussed further below.) Some prisoners and staff also said that on the night of 25 May prisoners were talking about how to tie ligatures, but it has not been possible for the investigator to verify this information first-hand. Staff also said that one of the prisoners located near Mr Piggott was being abusive about travellers but that this was not directed at Mr Piggott (who was from a travelling background). Certainly, one prisoner in a neighbouring cell was being very noisy on the night of 25 May and can be seen throwing items from his cell on CCTV.
171. It is difficult to determine how this environment impacted on Mr Piggott's wellbeing. However, if he was aware of the increase in tension on the unit, this may have heightened his anxiety and led him to withdraw further.
172. These findings were supported by CNWL's investigation which concluded that that there was no clear policy for the clinical management of patients in the healthcare unit, including an admission and discharge pathway. CNWL found that the healthcare unit was not "conducive to a therapeutic regime as there were a mixture of clinical and non-clinical occupants, evidence of illegal substances on the unit and verbal aggression and intimidation from some prisoners". They noted that a policy should be developed. We make the following recommendation:

The Governor and Head of Healthcare should ensure that there is a clear protocol for the management of prisoners in the healthcare unit, including an admission and discharge pathway, plans for dealing with disruptive patients and that staff are supported when working in this difficult environment.

Nursing observations, 25/26 May

173. Mr Piggott was subject to two nursing observations and one ACCT observation per hour overnight on 25/26 May. Nurse C was responsible for completing the nursing observations. She did not accurately record the times she completed the checks and only completed 15 checks while documenting 20. Most concerningly, she only checked Mr Piggott once an hour for the last three hours before he was found hanging.

174. Nurse C said she had “let my standard down”. She said that, at the time, she was not aware she had missed checks and was distracted by the disruptive prisoner next door to Mr Piggott. She said that sometimes she signed for more than one of Mr Piggott’s checks at once or would check several prisoners at once. She said she deeply regretted not checking Mr Piggott as required.
175. Nurse C said that she would have expected another nurse to be located with her in the Healthcare Unit to assist with her nursing observations on Mr Piggott. She felt she had too much work that evening. The Head of Healthcare said that there would only be two nurses in the healthcare unit if there was a prisoner subject to constant supervision. He said he believed Nurse C had the capacity to complete all her duties that evening. Nurse C also said she had personal and medical issues but had not informed anyone of these. In hindsight, she realised that she was finding it difficult to cope.
176. The Head of Healthcare reviewed the CCTV footage of that evening within days of Mr Piggott’s death. He suspended Nurse C as a result. He also referred her to the Nursing and Midwifery Council. Their investigation remains ongoing at the time of writing (January 2019).
177. Nurse C said that if a prison officer had just completed an ACCT check and communicated this to her, she would sometimes count this as her nursing observation. The acting Deputy Governor and the Head of Healthcare said that this was entirely inappropriate and that they expected prison and healthcare staff who shared an office to communicate with each other to ensure that they were not doing their checks at the same time. We recognise that the Head of Healthcare took swift, decisive action when he realised that Nurse C had falsified her records. He told the investigator that he was convinced this was not a wider issue and that her suspension had also acted as a reminder to staff of the seriousness of not completing the checks properly. We therefore make no recommendation in this regard.
178. However, we consider that this reinforces the need for the level of observations to be agreed at ACCT reviews. If it had been decided that Mr Piggott should be observed three times an hour as part of the ACCT monitoring, it would have been absolutely clear that it was not acceptable for two observations to be conflated.
179. Nurse C told the investigator that on reflection, when she first checked Mr Piggott at 4.50am, the ligature might have been tied around the light fitting but she did not see it. There was only a dim light in Mr Piggott’s cell at this stage. She was sure that Mr Piggott’s hands had been moving and in a praying position. She said she had no concerns for his welfare at the time and continued to check other prisoners.
180. It is impossible to say with certainty, but it seems likely that at this point Mr Piggott had already tied the ligature around the light fitting on the ceiling since this would have required a sustained effort and would have been difficult to complete before Nurse C returned to the cell one minute later. We therefore make the following recommendation:

The Head of Healthcare should ensure that healthcare staff assure themselves of a prisoner's well-being when completing nursing observations and are alert to behavioural changes.

Entering the cell

181. Once Nurse C had returned to the cell and Officer A arrived to do her ACCT check and saw Mr Piggott hanging, another two and a half minutes elapsed before Officer B unlocked the cell. Both officers told the investigator that they had been trained never to go into a cell unless there were three officers present. In contrast, Nurse D told the staff to open the cell door immediately once he reached the cell. Despite there not being three officers, Officer B did so as he felt that there was a genuinely life-threatening situation.
182. Instructions about night procedures (PSI 24/2011, *Management and Security of Nights*) and about safer custody (PSI 64/2011, *Safer Custody*) are clear that preservation of life takes precedence over the usual arrangements for opening cells. Where there appears to be immediate danger to life, prison staff can unlock cells by themselves without the authority of the night manager, subject to a personal risk assessment.
183. If Nurse C's observations that Mr Piggott was praying, and therefore still alive, when she first went to his cell were accurate, the subsequent delay in entering his cell is a particular concern. These were vital minutes which could have made a difference to Mr Piggott's chances of survival. We make the following recommendation:

The Governor should ensure that all staff are made aware of and understand their responsibilities during medical emergencies, including opening cells when there is an immediate danger to life.

Psychoactive Substances (PS)

184. Mr Piggott had a history of using PS. This adversely impacted on his mental health and, on several occasions, psychiatrists recorded that they suspected that Mr Piggott was suffering from a drug-induced psychosis. One member of staff said that Mr Piggott was used by other prisoners as a 'guinea pig' to test new batches of PS. Mr Piggott himself said he found it hard to say 'no' to other prisoners and was vulnerable to holding illicit items for them or getting into debt as a result. His learning disability seemed to exacerbate this situation and made him more vulnerable to the influence of others.
185. HM Inspectorate of Prisons has expressed concern about the ready availability of drugs at High Down and it is particularly troubling that staff said that PS was being used in the healthcare unit at the time of Mr Piggott's death. The unit is separated from the general population and is home to some of the most mentally unstable prisoners. Mr Piggott had been admitted there to allow for a period of stability and assessment in an environment where drugs were supposedly not available.
186. We cannot say whether Mr Piggott accessed PS in the healthcare unit and, if so, whether drug use contributed to mental deterioration and his decision to kill himself. The evidence is conflicting. On the one hand, there are no records of

him being found under the influence of PS while in the healthcare unit, and the toxicology report did not detect any drugs in Mr Piggott's system after his death. However, the toxicologist noted that there are over 400 types of PS which are rarely detectable as they are so quickly metabolised, so this finding does not necessarily mean that Mr Piggott was not using PS in the weeks before his death. In addition, Mr Piggott had an empty plastic bag hidden in his rectum when he died. The most likely use for this was to conceal PS, as he had been known to do in the past.

187. Mr Piggott was referred to the substance misuse team on numerous occasions during his time at High Down and sometimes engaged with them, although had not done so after February 2018. He was referred for drug tests and staff sometimes submitted intelligence reports in relation to his suspected drug misuse. However, we are concerned that these were not consistently used to document Mr Piggott's substance misuse.
188. The Head of Security told the investigator that only three intelligence reports were submitted relating to drug use in the healthcare unit in 2018. None of these were within the three months preceding Mr Piggott's death. This is clearly of concern given staff's suspicions that PS was available in the healthcare unit at the time of Mr Piggott's death. We make the following recommendation:

The Governor and Head of Healthcare should ensure that signs of drug use are recorded in prisoners' records and all staff should submit intelligence reports when they are aware of suspected drug use.

189. The PPO's Learning Lessons Bulletin on PS, published in July 2015, sets out why PS have become a source of increasing concern in prisons. There is evidence that PS pose dangers to both physical and mental health. In addition, trading these substances can lead to debt, violence and intimidation. In our Annual Report for 2017-2018, we noted that the number of deaths where the use of PS may have played a part continued to rise.
190. High Down has an extensive PS protocol. This sets out the safety, supportive and security measures which should be taken if a prisoner is suspected to be under the influence of PS. It includes a check list to be completed if a prisoner has taken PS which will then be collated and analysed by the drug strategy team. Business card-sized reminders have also been provided to all staff with details of actions they need to take in such situations. Mail coming into High Down is screened by dogs for drugs including PS, and the prison has also started photocopying a proportion of prisoners' mail to stop liquid PS coming into the prison on paper.
191. High Down is not alone in facing the problem of drugs – it is a serious problem across much of the prison estate. Individual prisons are doing their best to tackle the problem by developing their own local drug strategies. However, in the PPO's view, there is an urgent need for national guidance to prisons from HMPPS, providing evidence-based advice on what works.
192. In recent investigations, we recommended that the Chief Executive of HM Prison and Probation Service (HMPPS) should issue detailed national guidance on measures to reduce the supply of and demand for drugs, including PS, in prisons.

The Acting Ombudsman also wrote to the Prisons Minister raising her concerns about the high number of drug-related deaths she was investigating. The Chief Executive told us that HMPPS planned to issue a national drug strategy in the autumn of 2018. At the time of writing (January 2019), this has not been published. We therefore make the following recommendation:

The Chief Executive of HMPPS should provide the Ombudsman with a revised date for issuing detailed national guidance on measures to reduce the supply and demand of drugs in prisons, and an assurance that this new date will be met.

Family Liaison

193. After the family liaison officer had returned some of Mr Piggott's belongings on 4 June, she did not contact Mr Piggott's next of kin again. She was unexpectedly away on sick leave from July onwards. There was no handover and no one else was allocated to this role. Mr Piggott's next of kin had to pay the funeral expenses themselves and the prison did not contribute as they had offered to do, and in line with policy. The next of kin were also concerned that they had not received all of Mr Piggott's possessions.
194. Once our investigator was aware of this, she contacted the prison on 1 August. High Down confirmed a week later that a cheque was being sent to Mr Piggott's next of kin to assist with funeral expenses. A manager telephoned Mr Piggott's sister to apologise. A member of staff also found Mr Piggott's remaining possessions and returned these to Mr Piggott's sister. We make the following recommendation:

The Governor should ensure that, in line with PSI 64/2011, following a death in custody, family liaison is appropriate, including keeping in touch with the family, returning the deceased prisoner's possessions and contributing towards funeral expenses.

Staff debrief

195. A SO said that no debrief had taken place after Mr Piggott's death as the prison was in night state. Mr Piggott was taken to hospital around the time of the morning shift change. We appreciate that this made holding a debrief immediately difficult. However, all staff should have been spoken to before they went home, even if this was individually. A debrief for all staff should then have been held at a later date. Only healthcare staff said they had the opportunity to attend a later debrief.
196. Debriefs provide an opportunity to ensure that those who were involved in a prisoner's care have the opportunity to discuss any issues arising, and to be offered support. We make the following recommendation:

The Governor should ensure that following a death in custody all staff involved have the opportunity to attend a debrief in line with PSI 64/2011,

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