Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Louis Thomas a prisoner at HMP Isle of Wight on 12 January 2018

A report by the Prisons and Probation Ombudsman

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Our Vision

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

Our Values

We are:

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

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

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

Mr Louis Thomas died on 12 January 2018, after he was found hanged in his cell at HMP Isle of Wight. He was 38 years old. I offer my condolences to his family and friends.

I am satisfied that there were no indications that Mr Thomas was at imminent risk of suicide or self-harm in the days leading up to his death. We do not therefore consider that staff could reasonably have predicted his actions or prevented his death. Mr Thomas left notes in his cell which said that he was being bullied by other prisoners, and it was alleged that he was assaulted the day before his death. However, we found no evidence that staff were aware of this at the time, and we are satisfied that staff had no reason to have considered monitoring him as a potential victim under anti-bullying procedures.

There were a number of deficiencies in the emergency response, and we are concerned that prison staff tried to resuscitate Mr Thomas when there were clear signs that he was dead.

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

Elizabeth Moody
Acting Prisons and Probation Ombudsman **April 2019**

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Summary

Events

1. On 9 July 2013, Mr Louis Thomas was remanded to HMP Lewes, charged with rape and robbery. It was not his first time in prison. On 28 May 2015, Mr Thomas was transferred to HMP Isle of Wight. He had a history of self-harm and illicit drug use, and he attributed much of his offending behaviour to substance misuse.

2. On four occasions at Isle of Wight, Mr Thomas was monitored under suicide and self-harm monitoring procedures, known as ACCT. His last period of ACCT monitoring ended on 24 November 2017. During his time at Isle of Wight, Mr Thomas worked and, for the most part, interacted appropriately with staff.

3. At around 5.26am on 12 January, an officer found Mr Thomas hanged in his cell. Although Mr Thomas showed no signs of life, officers tried to resuscitate him. Paramedics pronounced him dead. Mr Thomas left a note in his cell which said that he had been bullied by other prisoners.

Findings

4. We found nothing to indicate to staff that Mr Thomas was at risk of suicide, and we do not consider that staff could reasonably have predicted his actions or prevented his death.

5. The officer who found Mr Thomas did not call an emergency code blue, as he should have, and it was seven minutes before the control room called an ambulance.

6. Despite Mr Thomas showing no signs of life, officers tried to resuscitate him, contrary to national guidelines.

7. The clinical reviewer concluded that the healthcare that Mr Thomas received at the prison was equivalent to that which he could have expected to receive in the community.

Recommendations

- **The Governor should ensure that all prison staff are made aware of and understand their responsibilities during medical emergencies, including that the correct medical code is communicated and that an ambulance is called immediately.**
- **The Governor should ensure that all staff are reminded that when a prisoner's life is in danger, they should enter the cell as quickly as possible, especially when the prisoner has a history of attempted suicide and self-harm.**
- **The Governor and Head of Healthcare should ensure that staff are given clear guidance and check their understanding about the circumstances in which resuscitation is inappropriate in accordance with European Resuscitation Council Guidelines.**

The Investigation Process

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

9. The investigator obtained copies of relevant extracts from Mr Thomas's prison and medical records.

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

11. The investigator interviewed 14 members of staff and two prisoners, some jointly with the clinical reviewer.

12. We informed HM Coroner for Isle of Wight of the investigation and have sent her a copy of this report.

13. One of the Ombudsman's family liaison officers contacted Mr Thomas's family to explain the investigation and to ask if she had any matters she wanted the investigation to consider. Mr Thomas's family asked if there was evidence that Mr Thomas was being bullied. They said that in the week before he died, he seemed in a good frame of mind. Mr Thomas's family asked whether the medical care he received was appropriate, including whether he had access to pain relief.

Background Information

HMP Isle of Wight

14. HMP Isle of Wight is an amalgamation of two former prisons, Parkhurst and Albany, and holds approximately 1,100 men. Care UK provides healthcare services at the prison. There is a healthcare inpatient unit at the former Albany site, providing 24-hour care for prisoners. There is no healthcare cover during the night at the Parkhurst site.

HM Inspectorate of Prisons

15. The most recent inspection of HMP Isle of Wight was in May to June 2015. Inspectors reported that although the number of men at risk of suicide or self-harm was higher than in similar prisons, their care was generally good.

16. Inspectors reported that the prison's personal officer scheme provided effective support. They found that although the level of assaults and fights was relatively low, many prisoners reported victimisation by other prisoners and staff. Inspectors reported that the prison's procedures to manage violent prisoners and bullies, known as Challenging Anti-Social Thinking (CAST), were not well embedded and some staff did not fully understand their purpose. Inspectors reported that healthcare commissioners, prison and healthcare providers worked together effectively.

Independent Monitoring Board

17. 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 ending December 2016, the IMB said that the safer custody team operated efficiently and effectively. The IMB reported that healthcare at the Isle of Wight was well-led, dedicated and professional.

Previous deaths at HMP Isle of Wight

18. There has been one previous self-inflicted death at HMP Isle of Wight since 2014. There have also been ten deaths from natural causes at the prison since 2015. In our investigation report into a death in August 2017, we reported on the delay in entering a cell.

Assessment, Care in Custody and Teamwork

19. ACCT is the Prison Service care-planning system used to support prisoners at risk of suicide or self-harm. The purpose of ACCT is to try to determine the level of risk, how to reduce the risk and how best to monitor and supervise the prisoner. All decisions made as part of the ACCT process and any relevant observations about the prisoner should be written in the ACCT booklet, which accompanies the prisoner as they move around the prison. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011.

Key Events

20. Mr Louis Thomas had previously spent time in prison. He had a history of self-harm and illicit drug use in the community, and he attributed much of his offending behaviour to substance misuse.

HMP Lewes

21. On 2 January 2013, Mr Thomas was remanded to HMP Lewes, charged with rape and robbery. Healthcare staff identified several health issues, including a history of drug and alcohol misuse and noted that he experienced chronic pain from an old injury to his ankle.

22. Mr Thomas had also been diagnosed with a personality disorder and depression, and had been prescribed quetiapine, an antipsychotic. Soon after he arrived in prison, GPs and psychiatrists reviewed his antipsychotic medication. His dose was initially reduced but subsequently increased by a nurse.

23. In September 2014, Mr Thomas was convicted, and in October, was sentenced to 20 years in prison. During his first three and a half years in prison, staff monitored him four times under suicide and self-harm procedures, known as ACCT. Mr Thomas described his self-harm as a "release" from frustration. He was often distressed when he did not get what he wanted, including medication on occasions, and this manifested itself in threats to self-harm.

HMP Isle of Wight

24. On 28 May 2015, Mr Thomas was transferred to HMP Isle of Wight. The next day a GP assessed him. He noted that Mr Thomas had been diagnosed with borderline personality disorder and had been prescribed tramadol (an opiate-based painkiller) and codeine for the relief of his chronic ankle pain. The GP noted Mr Thomas's history of alcohol and drug misuse.

25. On 5 June 2015, Mr Thomas was asked whether he wanted to be admitted to the prison's healthcare unit to reduce his reliance on tramadol. He declined.

26. In February 2016, a consultant forensic psychiatrist, re-confirmed Mr Thomas's diagnosis of personality disorder and noted that he should continue with quetiapine. He also noted that Mr Thomas should consider other interventions to develop skills in managing his emotions.

27. Over the following 18 months, Mr Thomas appeared to have settled well at Isle of Wight. Officers noted that he was generally polite and respectful, worked in the prison gardens and adhered to the prison's rules and regimes. Mr Thomas retained regular contact with his family in the community.

28. In April 2016, healthcare staff were told that Mr Thomas was suspected of passing his quetiapine to another prisoner.

29. On 30 August, Mr Thomas told a member of staff from the substance misuse team that he had been using illicitly obtained pregabalin, from which he said he had "self-detoxed". (Pregabalin is used to treat epilepsy, anxiety and nerve pain, and is used illicitly to enhance the euphoric effects of other drugs, such as

opiates.) He said that he wanted to re-engage with the substance misuse team. A week later, Mr Thomas told her that he had only stopped taking illicit pregabalin because it was no longer available in the prison. She planned several one-to-one sessions with Mr Thomas on drug relapse prevention. During a session on 11 October, Mr Thomas told her that he had taken illicit drugs as a form of escapism and to relieve boredom. He said that he did not have any alternative coping strategies in place and felt suicidal most days. Mr Thomas was monitored under ACCT procedures for less than 24 hours. In April 2017, he asked not to see the substance misuse team again.

30. On 9 January 2017, Mr Thomas tested negative during a random drug test, and over the following months, an officer noted that he remained respectful to staff, was motivated and helped other prisoners on the wing. He remained in contact with his friends and family (though it was noted that they had difficulty visiting due to the long journey to the prison).

31. On 28 February, healthcare staff discussed Mr Thomas at a multidisciplinary healthcare meeting. They concluded that there was no objective evidence that he had significant pain but that his reliance on tramadol was likely to reflect his dependence on opiate-type medication. They noted that Mr Thomas should be encouraged to wean himself off tramadol or take part in an opiate addiction treatment programme (in which methadone, a synthetic opiate, is prescribed as a substitute).

32. On 7 March, a GP reviewed Mr Thomas. He noted that he presented with no evidence of mental illness and that a recent assessment had concluded that he did not have ADHD. The GP reconfirmed Mr Thomas's diagnosis of personality disorder.

33. On 26 April, Mr Thomas's tramadol dose was reduced. During a review on 4 May, a GP noted that Mr Thomas was extremely unhappy about this. He explained to Mr Thomas the long-term side effects of opiate addiction.

34. On 6 June, Mr Thomas's tramadol dose was further reduced. That day, an officer noticed that Mr Thomas looked "high". Mr Thomas told the officer that he had started to self-medicate by taking tramadol and gabapentin obtained from other prisoners due to "issues" with healthcare. (Gabapentin is used to treat epilepsy and nerve pain, and is used illicitly to enhance the euphoric effects of opiates.) The next day, Mr Thomas attended the fracture clinic at a hospital about his ankle.

35. On 8 June, the member of staff from the substance misuse team reviewed Mr Thomas. He admitted to using illicit drugs but said that he did not want to engage with the substance misuse team to address his drug-seeking behaviour. The next day, a GP noted that Mr Thomas continued to be very unhappy that his tramadol dose had been reduced and that he again refused to be admitted to the healthcare unit for a pain assessment.

36. On 13 June, Mr Thomas told a prison GP, that he was angry at the decision to reduce his reliance on tramadol, and declined the offer of a methadone detoxification. Mr Thomas told the GP that he had been taking illicit gabapentin, obtained from other prisoners, to "top up" his reducing levels of tramadol.

37. On 23 June, an intelligence report noted that Mr Thomas might be involved in the "running" of drugs between prisoners.

38. On 3 July, an officer noted that Mr Thomas had had a "turbulent" month with his medication issues but remained polite to staff, continued to work and help others on the wing, mixed with other prisoners and complied with the prison's regime.

39. On 18 July, Mr Thomas cut his ankle because he said he was frustrated that he did not have the medication he wanted and about the way he was being treated. He said that he was receiving mixed messages from healthcare staff, which made him angry and depressed. Staff began ACCT procedures. Mr Thomas later told staff that his actions were not a suicide attempt and he did not want to die. He told them that he did not want to be in pain and was just angry with the prison's GPs. On 28 July, ACCT monitoring was stopped.

40. On 19 July, Mr Thomas was involved in a fight with another prisoner. Both said that they were victims. Both men were charged with breaking prison rules and anti-bullying monitoring was started. Mr Thomas was moved to another house block. Charges against both prisoners were later dropped, and anti-bullying procedures were stopped for Mr Thomas.

41. On 20 July, a GP reviewed Mr Thomas, and the GP reiterated to him the dangers of his opiate drug dependence. Mr Thomas agreed to start an opiate withdrawal programme, starting on methadone.

42. Mr Thomas applied for therapy for his borderline personality. On 3 August, his application was acknowledged.

43. On 13 August, an intelligence report noted the suspicion that Mr Thomas was involved in selling and distributing psychoactive substances (PS) and prescription drugs on the wing.

44. On 21 August, Mr Thomas started working in the prison gardens again. On 13 September, the gardens instructor noted that he had been aggressive and agitated and questioned whether he was suited to working in the gardens. Between 16 October and 22 November, Mr Thomas took a break from his gardening job, and completed a cleaning course. He then returned to work in the prison gardens. The British Institute of Cleaning Science, instructional officer, said Mr Thomas was a confident prisoner who was polite and got on well with other prisoners. He said that he did not see Mr Thomas being bullied.

45. On 5 September, a nurse from the substance misuse team reviewed Mr Thomas. Mr Thomas said that, when it was available, he had sourced illicit tramadol and co-codamol (an opiate-based pain killer) for recreational use once or twice a week from the wing. He admitted to previous illicit use of buprenorphine before he started his methadone withdrawal programme. Mr Thomas tested positive for methadone and tramadol, which had not been prescribed to him.

46. On 8 September, Mr Thomas agreed to switch from his methadone withdrawal programme to a buprenorphine-based programme as he said methadone did not agree with him. On 15 September, Mr Thomas admitted to a nurse that he had taken illicit tramadol the night before because his ankle pain had increased.

47. On 28 September, Mr Thomas stopped the substance misuse team staff member in the prison gardens to say that he had withdrawal symptoms. She later noted that Mr Thomas appeared to refer to his opiate withdrawal. On 3 October, during a routine screen, Mr Thomas tested positive for buprenorphine (which was prescribed) but tested negative for other opiates.

48. On 9 October, a prison GP saw Mr Thomas, and noted that he was confrontational and aggressive. Mr Thomas told the doctor that he should have remained on tramadol and was obtaining it illicitly daily on the wing. The GP agreed to refer Mr Thomas again to the pain clinic, and noted that at the end of the consultation, Mr Thomas "jumped up briskly" and strode out of the room. He concluded that Mr Thomas's behaviour appeared to be that of a person seeking drugs rather than someone in pain.

49. On 21 November, a GP reviewed Mr Thomas, and noted that he was hostile and angry during the review. It was explained that the only acceptable solution to Mr Thomas's dependence was an opiate withdrawal. Mr Thomas threatened to self-harm if the GP did not prescribe him gabapentin, but he said that he did not want to be monitored under ACCT procedures. The GP noted that it was unlikely that Mr Thomas would self-harm.

50. On 3 November, Mr Thomas was referred to the pain clinic at a hospital.

51. On 23 November, Mr Thomas told an officer that he felt like "topping himself" but could not understand why. He said that he was worried about his cousin and had applied for a compassionate move to a prison nearer his mother. The officer referred Mr Thomas to the mental health team after he told him that he wanted to speak to a mental health nurse. Staff began ACCT monitoring.

52. At an ACCT review on 24 November, chaired by a custodial manager (CM), and with input from a nurse. Mr Thomas said that he wanted ACCT procedures to end as his comment the previous day was stupid, and he had no thoughts of suicide or self-harm. Mr Thomas was reminded of the staff support available to him, including access to the Samaritans and Listeners (who are trained by the Samaritans to offer confidential support to other prisoners). ACCT monitoring was stopped, and a post-closure review was scheduled for 1 December. On 28 November, Mr Thomas started work in the prison gardens again.

53. On 29 November, a nurse reviewed Mr Thomas, and noted that he was settled but irritable and had increased intrusive thoughts. Mr Thomas denied thoughts of self-harm. The nurse prescribed a low dose of antidepressants.

54. On 2 December, a Supervising Officer (SO) completed Mr Thomas's post-closure ACCT review. He told Mr Thomas that he had endorsed his application for therapy and noted that Mr Thomas seemed upbeat.

55. On 11 December, Mr Thomas attended the orthopaedic clinic at a hospital, and officers noted that he was polite and respectful throughout the visit.

56. On 15 December, Mr Thomas was involved in a sit-down protest with other prisoners about the amount of time that prisoners were locked in their cells and that staff were not adhering to the published core day. Mr Thomas and the other prisoners later returned peacefully to their cells.

57. On 19 December, a GP reviewed Mr Thomas after he attended the orthopaedic clinic. The GP noted that the consultant at the hospital had advised against surgery to Mr Thomas's ankle and that Mr Thomas was awaiting an assessment with the pain clinic. (An appointment was subsequently made for 12 January 2018.) Mr Thomas told the GP that his antidepressants were helping.

58. On 21 December, a nurse reviewed Mr Thomas who said that he had not "been down" or thought about self-harm so much. The nurse agreed to increase Mr Thomas's dose of antidepressants and he asked if he could hold his medication in possession. The nurse told him that he would discuss this with his colleagues. He arranged to review Mr Thomas again in four weeks.

59. On 27 December, the gardens instructor noted that Mr Thomas had settled back at work in the prison gardens and mixed well with other prisoners.

60. On 1 January 2018, Mr Thomas telephoned his family to wish them a happy New Year. They talked about a number of matters, including his access to medications, issues about a possible prison move and how he should have a mental health worker in court. He also telephoned a friend to wish him a happy New Year.

61. In a telephone call to his friends on 4 January, Mr Thomas discussed how he and other prisoners had sometimes been locked in their cells due to incidents on the wing, and that he might move to a prison on the mainland in the next couple of months.

62. On 5 January, a GP saw Mr Thomas who complained of stomach pain and asked for white bread, as opposed to brown, at meal times. The GP noted that he would follow up Mr Thomas's request. The GP prescribed Mr Thomas co-codamol until he had been assessed by the pain clinic.

63. On 6 January, Mr Thomas thanked his friend by telephone for sending him money. In a further short call on 9 January, Mr Thomas said the prison might move him to HMP Bullingdon.

64. On 10 January, Mr Thomas told his friend by telephone that everything was "hunky dory". He asked his friend to contact an off-licence in Brighton to see if they still had CCTV from 2013, which it is presumed he thought might help a legal appeal against his conviction. He told his friend that he looked forward to his upcoming visit.

65. During the day, Mr Thomas stopped the member of staff from the substance misuse team in the prison gardens and asked her to visit him. He told her that he was finally being listened to about his medications, which he said had been changed and were helping with his pain. She told him that she would make an appointment to see him on 12 January.

66. Officers told the investigator that they never saw any signs that Mr Thomas was being bullied and were shocked by his subsequent death. Many described him as polite and upbeat. They said that he mixed well with other prisoners.

67. An Officer, who knew Mr Thomas well, said that Mr Thomas had never told him he was being bullied and he saw no evidence that he was. However, the officer

told the investigator that Mr Thomas, and other prisoners, had commented that the wing was "going downhill" and had turned "shit" since some new prisoners had arrived.

68. Officers said that Mr Thomas was often found near the medication hatch. A SO said that he never saw Mr Thomas under the influence of drugs but suspected that he might have been involved in the prison's drug culture. A CM said that he thought that Mr Thomas was more likely to have sought drugs for himself than to have traded them.

69. A prisoner, said that although he was not close to him, he saw Mr Thomas on most days. He said that Mr Thomas appeared to get on well with other prisoners and he heard that he was trying to move on compassionate grounds to be closer to his home. He said that Mr Thomas did not want to be on the Isle of Wight. He said that he never heard Mr Thomas talk about self-harm and that Mr Thomas's behaviour did not change in the days leading to his death.

70. Another prisoner said that Mr Thomas had a drug problem and would take whatever prescription drugs he could get. He said that he was in debt with other prisoners and traded what little he had to get hold of them.

11-12 January 2018

71. At around 8.30am on 11 January, the gardens instructor warned Mr Thomas about arriving for work without his prisoner identification (ID) card. Mr Thomas was later overheard talking to another prisoner. He said that he forgot his ID card so that he would be sent back to the wing and would not have to work. He noted that Mr Thomas's attendance would be closely monitored.

72. In the afternoon, a prisoner said that he told the instructional worker that Mr Thomas had been assaulted as he could not pay his drug debts and had also had a sharp object poked in his chest. (A prisoner said that Mr Thomas was bullied regularly but would not have reported this to staff as he would not have wanted to have been seen as a "grass".)

73. A CM said he locked Mr Thomas's cell, and saw Mr Thomas lying on his bed in the dark. He said that Mr Thomas complained of a headache. He told Mr Thomas that he would see him in the morning and locked his cell. An officer carried out a roll check at around 5.15pm but noted no concerns.

74. At around 7.40pm, an operational support grade (OSG) relieved the officers who had been on day duty. The OSG said that staff raised no concerns about Mr Thomas during an officer's handover to him. At around 7.45pm, the OSG completed his roll check. He said that he could not recall speaking to Mr Thomas during the check.

75. That night, the OSG said that an officer was on the wing with him. The OSG said it was an uneventful night, and no cell bells were rung.

76. On 12 January, the OSG conducted an early morning roll check, and checked on Mr Thomas at 5.26am. He told the investigator,

> "I shone my torch into the cell, and I could see Mr Thomas stood at the

> back of his cell. I moved the torch around Mr Thomas, but became aware that he was extremely still, very still. I shone the torch up into his face, which I was less inclined to do at the start in case I alarmed him and noticed that he wasn't moving, and I could see a ligature which was around his neck attaching him to the bars of the window in his cell."

77. He said in his incident statement that Mr Thomas "…was standing at the back of the cell motionless by looking at the cell door." He said, "I tried to raise any response by banging on his door and calling out to Mr Thomas, but I could not get a response."

78. After the OSG had turned on the cell light, he said he could see that the ligature was "…around [Mr Thomas'] neck, where it appeared it had sunken quite underneath his jaw."

79. He tried to obtain a response from Mr Thomas by shouting out and banging on his cell door. When he turned on the cell light, he said, "He did look very grey, very grey."

Emergency response

80. At 5.27am, the OSG radioed for assistance for the night manager to attend the house block as soon as possible. He said that the night manager had passed through the wing a short time earlier, so he knew he was close by. He said that although he was aware of emergency codes, he did not call an emergency code blue (indicating that a prisoner is unconscious or having difficulties breathing) as he had "panicked".

81. The night manager arrived at the cell within a minute of the request for him to attend. He said that when he arrived, the OSG asked Mr Thomas what "he was doing". The night manager said that he looked in the cell and saw that Mr Thomas appeared to be standing at the back of the cell with his eyes open, but he could not see a ligature. The officers opened the cell door and went in. They tried to get a response from Mr Thomas.

82. An officer arrived and went into the cell with the OSG. The officer supported Mr Thomas while the OSG cut the ligature, made of strips of material. The officer said that rigor mortis had set in and believed that Mr Thomas was already dead when he cut him down. The OSG said that Mr Thomas was very stiff and believed him to be dead.

83. The officer asked the OSG to collect the defibrillator from the wing office. He returned within a minute. The officer then attached the defibrillator and started cardiopulmonary resuscitation (CPR). The officer stopped trying to resuscitate Mr Thomas after around ten minutes when he said it was clear that there was no chance of recovery.

84. When Mr Thomas had been cut down, the night manager went to the wing office, approximately 10 metres away, and telephoned the control room operator at 5.32am to tell him that they had just found Mr Thomas, suspended from a ligature. He told the control room operator that from his initial assessment, Mr Thomas showed no signs of life and was dead. He asked for an ambulance to be called, and for him to start the death in custody contingency plans. The

control room operator said that he called for an ambulance as soon as he had gathered basic information, as he knew the ambulance service required. The control room logs noted that the ambulance was called at 5.39am.

85. Paramedics arrived at the cell at 6.00am. They assessed that rigor mortis was present and there were no signs of life. They pronounced him dead at 6.12am.

Events after Mr Thomas's death

86. Mr Thomas left several notes of intent in his cell. In one addressed to the authorities, he said that he was being bullied by two other prisoners and could no longer cope. In notes to his family and friends, Mr Thomas said that he was innocent but had no "more fight" in him.

87. In an anonymous note to staff, a prisoner said, "I don't know if this has any relevance, but Louis Thomas was deeply "debted up" and had been using PS over the previous few weeks.

88. After Mr Thomas' death, intelligence reports were submitted which said that he was in debt with other prisoners on the wing after buying prescription medications, spice (a form of PS) and vape cartridges, and that he had been the victim of bullying by other prisoners on the wing who had recently arrived from another prison. Other reports alleged that Mr Thomas had been assaulted by two other prisoners on the wing the day before his death, as he was unable to pay his drug debt.

Contact with Mr Thomas's family

89. On 12 January, after initially making contact with Mr Thomas's ex-partner who was his named next of kin, a family liaison officer (FLO) from HMP Lewes, broke the news of Mr Thomas' death to his family early that afternoon. Isle of Wight offered to contribute to the cost of Mr Thomas' funeral in line with national policy.

Support for prisoners and staff

90. The duty governor debriefed the staff involved in the emergency response and offered support. Other prisoners were told of Mr Thomas's death and were offered support. Officers checked on prisoners assessed as at risk of suicide and self-harm in case they had been affected by the news of his death.

Post-mortem report

91. The post-mortem examination concluded that Mr Thomas died from hanging. The pathologist concluded that there were no features to suggest that Mr Thomas had been the victim of an attack or restraint in the period leading to his death.

92. A toxicology examination found the presence of therapeutic drugs but no illicit drugs in Mr Thomas' bloodstream when he died.

Findings

Assessment of risk

93. PSI 64/2011 on safer custody requires all staff in contact with prisoners to be aware of the risk factors and triggers that might increase prisoners' risk of suicide and self-harm, and to take appropriate action. Any prisoner identified as at risk of suicide or self-harm must be managed under ACCT procedures.

94. Mr Thomas had been monitored under ACCT procedures six times between his remand in July 2013 and his death. His risk factors included personality disorder, depression, issues with prescribed medications and possible substance misuse. Mr Thomas may have also been bullied or harassed by other prisoners, but staff were not aware of this before his death. Mr Thomas was last monitored under ACCT procedures in November 2017 when he made what he described as a flippant remark. Mr Thomas otherwise denied thoughts of suicide or self-harm.

95. No one who met Mr Thomas in the weeks before his death had reason to consider that he was at risk. We are therefore satisfied that it was reasonable for staff to have concluded that he did not pose a risk of suicide or self-harm, which warranted ACCT monitoring in the weeks leading to his death. We do not consider that staff could reasonably have predicted his actions or prevented his death.

Allegations of violence and intimidation

96. PSI 64/2011 sets out how violent prisoners should be managed. It says that all verbal and physical acts of violence must be challenged, appropriate sanctions for perpetrators applied robustly, fairly and consistently, and victims supported and protected. Being a victim of intimidation or violence are recognised risk factors for suicide and self-harm. The PPO has published a range of publications, identifying the links between bullying and suicide. In a review of self-inflicted deaths in prisons in 2013/14, we identified the need for staff to record and investigate all reports or suspicions that a prisoner is being threatened or bullied and to consider the potential impact on the victim's risk of suicide.

97. Although Mr Thomas never told staff that he was subject to violence or intimidation and there was no evidence before his death that he was, intelligence reports submitted after his death indicate that he may have been in debt to other prisoners for drugs and that he was assaulted shortly before his death because of this. The post-mortem examination identified no injuries consistent with an attack in the period before his death.

98. Although another prisoner on the wing said he told a member of staff that Mr Thomas had been assaulted, the member of staff said that he could not recall any such conversation. No other members of staff interviewed could recall any instance when Mr Thomas was assaulted in the weeks before he died.

99. We are satisfied that there was no evidence available before Mr Thomas' death to suggest that staff would have had reason to monitor Mr Thomas as a victim under anti-bullying procedures. However, given the content of the notes he left in his cell, it is likely that he was the victim of bullying, and that this was a factor in

him taking his life. Isle of Wight has anti-bullying and victim support policy and procedures which are currently being reviewed. We make no recommendation.

Emergency response

Code blue and calling an ambulance

100. PSI 03/2013 on medical emergency response codes requires Governors to have a protocol to provide guidance on communicating the nature of a medical emergency, the type of equipment to take to the incident and that there are no delays in calling an ambulance. It says that if a medical emergency code is radioed, an ambulance must be called immediately.

101. Isle of Wight's local medical emergency protocol provides guidance to staff on the procedures to follow during a medical emergency. It states that staff should radio a medical emergency code blue when a prisoner has difficulty breathing or is unconscious. When the OSG found Mr Thomas hanging in his cell, he panicked and did not call a code blue, as he should have.

102. We are also concerned that there was a delay of 12 minutes between the OSG radioing for assistance at 5.27 am and an ambulance being called at 5.39am, including a seven-minute delay after the night manager asked the control room to call an ambulance at 5.32am.

103. Isle of Wight's local policy is not in line with the PSI because it does not make it clear that control room operators should call an ambulance immediately that they receive a code blue. While the failure to radio a code blue and the delays in calling an ambulance may not have affected the outcome for Mr Thomas, in another emergency, they may have done.

104. In his telephone conversation with the control room, the night manager suggested that Mr Thomas had already died. The clinical reviewer, listened to the emergency calls, including the dialogue between the prison's control room officer and the 999-emergency call handler. She concluded that the emergency call handler immediately assumed that Mr Thomas had already died and did not need to be resuscitated. Consequently, the call handler despatched an ambulance so that paramedics could pronounce Mr Thomas dead. (While the actions of the Ambulance Trust are beyond the remit of our investigation, we note the clinical reviewer finding that they need a better understand of the constraints of the prison environment when dealing with urgent calls from prisons.)

105. The clinical reviewer recognised that such incidents are upsetting for staff involved but noted that the actions of officers were illogical in that some were trying to resuscitate Mr Thomas while the officer in the control room exchanged information with the emergency call handler that implied Mr Thomas had already died. She noted that it was not clear whether or not this was accurate. We make the following recommendation:

The Governor should ensure that all prison staff are made aware of and understand their responsibilities during medical emergencies, including that the correct medical code is communicated and that an ambulance is called immediately.

Entering a cell in an emergency

106. PSI 24/2011 on management and security at night says that staff have a duty of care to prisoners, to themselves, and to other staff. The preservation of life must take precedence over usual arrangements for opening cells and where there is, or appears to be, immediate danger to life, then cells may be unlocked without the authority of the night manager and staff can enter the cell on their own. However, staff are not expected to take action that they feel would put themselves or others in unnecessary danger. What they observe and any knowledge of the prisoner should be used to make a rapid and dynamic risk assessment. Isle of Wight's local instructions reflect these requirements.

107. The OSG looked into Mr Thomas' cell at around 5.26am but did not go in until around a minute later when the night manager arrived because he feared that it was a ruse. While we understand the need to assess the risk dynamically to ensure that staff do not put themselves in danger or risk the security of the prison, The OSG could see that Mr Thomas was very grey and had a ligature around his neck, which appeared to the OSG as having sunken underneath his jaw and which was attached to the bars of the cell window. Although earlier intervention may not have made a difference in Mr Thomas' case, it is critical that staff act quickly in such situations. We make the following recommendation:

The Governor should ensure that all staff are reminded that when a prisoner's life is in danger, they should enter the cell as quickly as possible, especially when the prisoner has a history of attempted suicide and self-harm.

Resuscitation

108. European Resuscitation Council Guidelines for Resuscitation 2015, which were shared with prison managers in September 2016, introduced new staff guidance about when not to perform CPR. It states that, "Resuscitation is inappropriate and should not be provided when there is clear evidence that it will be futile." The guidelines define examples of futility as including the presence of rigor mortis.

109. The officers who found Mr Thomas tried to resuscitate him, despite the presence of rigor mortis and their belief that Mr Thomas had been dead for some time. An officer told the investigator that regardless of the circumstances, he felt that he had to try and resuscitate him.

110. While we understand the wish to attempt and continue resuscitation until death has been formally recognised, staff are not required to carry out CPR in these circumstances. Trying to resuscitate someone who is clearly dead is distressing for staff and undignified for the deceased. We make the following recommendation:

The Governor and Head of Healthcare should ensure that staff are given clear guidance and check their understanding about the circumstances in which resuscitation is inappropriate in accordance with European Resuscitation Council Guidelines.

Clinical care

111. The clinical reviewer concluded that the care that Mr Thomas received was equivalent to that which he could have expected to receive in the community. She found that Mr Thomas had good access to mental health support, and that his mental health medications were appropriate.

Opiate pain relief

112. The clinical reviewer noted that Mr Thomas's symptoms and signs of pain were not consistent. She concluded that Mr Thomas is likely to have used his injury for several gains, including obtaining special footwear, special accommodation and access to opiate medication.

113. Mr Thomas was prescribed tramadol, which the clinical reviewer noted increased over time and which resulted in him relying on significant opiate-based pain relief medication for a prolonged period. She reported that Mr Thomas's need for opiate relief predictably escalated and that he was extremely resistant to accepting non-opiate based treatments for his pain.

114. The clinical reviewer reported that such opiate prescribing carries significant health risks and that there is scant evidence of the long-term effectiveness of opiates in (non-cancer) chronic pain relief. She reported that there was increasing evidence of their harmfulness in terms of physical health, mental health and cognitive changes and that long-term opiate use could increase the body's sensitivity to pain. She noted that healthcare staff were keen to reduce Mr Thomas' dependency on opiate pain relief and in 2017, he agreed to take part in substitution therapy.

115. The clinical reviewer reported that dealing with chronic pain and opiate dependency is very difficult in prison, as it is in the community. While she noted that teams including pain and orthopaedic specialist services, primary care and addiction services were involved in developing a plan to reduce and cease opiate medication for Mr Thomas, she found that it would have been good practice to develop a multidisciplinary approach, involving pain services at the outset. She said that it would have been ideal to have gained Mr Thomas's ownership of their plans.

116. The clinical reviewer concluded that the healthcare team recognised the dangers of long-term opiate prescribing and planned to reduce and cease Mr Thomas's prescriptions over a period, appropriately offering opiate substitution therapy to help him with his withdrawal. We make no recommendation.

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