

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr James Devenny, a prisoner at HMP Elmley, on 2 September 2019

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 James Devenny was found hanged in his cell at HMP Elmley on 2 September 2019. He was 34 years old. I offer my condolences to his family and friends.

Mr Devenny's behaviour changed considerably in the five days before he died. He became paranoid about the actions and motivation of staff and prisoners, believed there was a conspiracy among them to kill him, and was frequently aggressive and threatening to staff. Such changes and behaviour often characterise a considerable increase to an individual's risk of self-harm, and I am concerned that no one at Elmley appeared to identify this or consider starting suicide and self-harm prevention procedures.

As a result of this aggressive behaviour, prison staff kept Mr Devenny locked in his cell for the last four days of his life and he was unable to associate with other prisoners. He was effectively segregated during this time, and I am very concerned that this happened without the usual safeguards that would apply when a prisoner is formally segregated.

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

May 2020

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Summary

Events

1. In November 2006, Mr James Devenny was remanded in custody. He was later sentenced to an indeterminate sentence for public protection. During his years in prison, Mr Devenny occasionally harmed himself. Staff started suicide and self-harm prevention procedures, known as ACCT, on five occasions.
2. On 6 February 2019, Mr Devenny was transferred to HMP Elmley, where staff described him as a man who was relatively settled and gave them little cause for concern.
3. On 28 August, Mr Devenny wrote a note to a chaplain in which he accused staff of watching him with sophisticated surveillance equipment, said that there was a conspiracy against him among staff and prisoners, and that he was in fear for his life as someone had paid a lot of money to have him killed. All the prison staff and prisoners we spoke to thought that Mr Devenny's fears were unfounded and that this was evidence of paranoia or deteriorating mental ill health.
4. On 29 August, Mr Devenny repeated his fears that there was a conspiracy to kill him. He was aggressive and threatening to staff, and they therefore restrained him and locked him in his cell. Mr Devenny did not leave his cell for the remainder of his life. He was only offered the opportunity to leave his cell when all other prisoners were locked in theirs but he chose to remain in his cell. Mr Devenny began to block his cell observation panel, as he did not want anyone to look in on him. A wing manager referred him to the mental health team, who booked an assessment for Mr Devenny for 3 September.
5. On 2 September, an officer found that Mr Devenny had blocked his cell observation panel, but did not respond or remove the blockage when he tried to speak to him. The officer left the landing to fetch assistance. After eight minutes, several officers returned, opened the cell, and found Mr Devenny hanging. They began cardiopulmonary resuscitation, assisted by healthcare staff, who later confirmed that Mr Devenny had died.

Findings

Identifying the risk of suicide and self-harm

6. Mr Devenny's behaviour changed considerably in the last four days of his life. While staff completed a timely and appropriate referral to the mental health team, we are concerned that no one appeared to consider that this change in Mr Devenny's behaviour, coupled with his apparent fears and paranoia, might increase his risk of suicide and self-harm. It is always a matter of judgement whether to start ACCT procedures, but had prison staff done so, it would have given them the opportunity to work holistically to reduce Mr Devenny's risk and identify any additional triggers.

Segregation

7. Mr Devenny spent the last four days of his life locked in his cell and unable to socialise with other prisoners. He was not detained under any segregation rule, and we are particularly concerned that he was kept in his cell without any lawful authority and without the proper support and safeguards, including mandatory health visits and assessments of his mental well-being that are required whenever a prisoner is segregated. This amounted to de facto segregation without due process which we regard as a very serious matter.

Use of force

8. Following the restraint on 29 August, no one completed statements or the mandatory health assessment that are required whenever force is used.

Substance misuse

9. When prison staff suspected that Mr Devenny had used psychoactive substances (PS) in June 2019, they did not refer him to the substance misuse team. This was a missed opportunity to address any substance misuse issues he had.

Blocked observation panel

10. The officer who found that Mr Devenny did not respond when requested to remove the blockage, did not radio for assistance. This would have been the quickest way of summoning support.

Recommendations

- The Governor should ensure that all staff have a clear understanding of their responsibilities to manage prisoners at risk of suicide and self-harm in line with national guidelines and, in particular, the need to record, share and consider all relevant information about risk, and start ACCT procedures when indicated.
- The Governor should ensure that prisoners are not subject to de facto segregation without due process.
- The Governor should ensure that the provisions and safeguards of PSO 1700 apply to all segregated prisoners, including any outside the segregation unit.
- The Governor and Head of Healthcare should ensure that all incidents in which force is used are managed in line with national policy, including that:
 - Staff involved in a use of force incident complete a statement within 72 hours, except in exceptional circumstances.
 - An appropriate healthcare professional examines the prisoner as soon as possible and completes an F213.
- The Governor should ensure that any prisoners identified as or suspected of using psychoactive substances are referred to the substance misuse service.
- The Governor should ensure that a local protocol is developed and shared with staff to instruct them on what to do if they find a cell observation panel obscured, including that:

- Staff challenge all prisoners who have blocked their observation panel, ensure the blockage is removed, and seek to identify and address any issues the prisoner has that might have led them to create the blockage.
- Subject to a risk assessment, staff enter cells as quickly as possible if there is reason to consider that the prisoner may be at risk.

The Investigation Process

11. The investigator issued notices to staff and prisoners at HMP Elmley informing them of the investigation and asking anyone with relevant information to contact him. Two prisoners responded.
12. The investigator visited Elmley on 9 September. During the visit, he obtained copies of relevant extracts from Mr Devenny's prison and medical records, and interviewed four prisoners who knew Mr Devenny. He returned to Elmley on 1 and 2 October, and interviewed seven members of staff and the two prisoners who had come forward (one of whom subsequently withdrew his statement). On 28 October, he interviewed four additional members of staff.
13. NHS England commissioned a clinical reviewer to review Mr Devenny's clinical care at the prison. The clinical reviewer joined the investigator for interviews with staff on 28 October.
14. We informed HM Coroner for Mid Kent and Medway of the investigation, who gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.
15. The Ombudsman's family liaison officer contacted Mr Devenny's next of kin to explain the investigation and to ask if she had any matters she wanted us to consider. Mr Devenny's next of kin had no specific questions.
16. We shared the initial report with HM Prison and Probation Service (HMPPS). They pointed out some factual inaccuracies and this report has been amended accordingly.

Background Information

HMP Elmley

17. HMP Elmley holds up to 1,252 men, remanded and sentenced, in six houseblocks with a mixture of single, double and triple cells. Integrated Care 24 Ltd provides 24-hour primary healthcare services, with input from Minster Medical Group. Oxleas NHS Foundation Trust provides mental health services.

HM Inspectorate of Prisons

18. The most recent inspection of HMP Elmley was in April 2019. Inspectors reported that the number of incidents of self-harm had increased but were at a similar level to comparable prisons. They reported significant drug use in the prison, with no effective supply reduction strategy. Inspectors also found that the quality of investigations into violent incidents was inadequate.

Independent Monitoring Board

19. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report for the year to October 2018, the IMB reported that there had been a 25 per cent fall in reported incidents of violence compared to the previous year. They attributed this to staff proactively confronting behaviours that had previously led to violence and highlighted positive decisions taken at the weekly Violence Reduction Forum.

Previous deaths at HMP Elmley

20. Mr Devenny was the ninth prisoner from Elmley to die since September 2017, and the first prisoner in this time to take his own life. There are no significant similarities between these previous deaths and Mr Devenny's.

Assessment, Care in Custody and Teamwork

21. 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. After an initial assessment of the prisoner's main concerns, levels of supervision and interactions are set according to the perceived risk of harm. Checks should be irregular to prevent the prisoner anticipating when they will occur. There should be regular multi-disciplinary review meetings involving the prisoner.
22. As part of the process, a caremap (plan of care, support and intervention) is put in place. The ACCT plan should not be closed until all the actions of the caremap have been completed. 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.

Psychoactive Substances (PS)

23. PS (formerly known as 'new psychoactive substances' (NPS) 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 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 PS to precipitate or exacerbate the deterioration of mental health, and they are linked to suicide or self-harm.
24. In July 2015, we published a Learning Lessons Bulletin about the use of PS (still at that 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.
25. HMPPS now has in place provisions that enable prisoners to be tested for specified non-controlled PS as part of established mandatory drugs testing arrangements.

Key Events

26. On 9 November 2006, Mr James Devenny was remanded in custody, charged with wounding with intent to endanger life. He was later sentenced to an indeterminate sentence for public protection (IPP), with a minimum time to serve of four years and eight months in prison.
27. Prison doctors prescribed antidepressant medication to Mr Devenny throughout his time in custody. In 2014, he was prescribed dihydrocodeine (a strong, opiate based painkiller) for long-term back pain.
28. In 2014, prison staff twice started ACCT procedures when Mr Devenny threatened to harm himself due to his frustration at various issues at HMP Lowdham Grange, where he now lived. In November 2016, they opened ACCT procedures again when Mr Devenny harmed himself due to frustration at a wing move. (The nature of the incident is not recorded.)
29. In January 2017, prison staff opened ACCT procedures when the Parole Board refused Mr Devenny's release on licence. Over the following days, he made a ligature and was admitted to hospital after cutting his arm. He said that he believed that other prisoners were talking about him and that he was under threat. On 8 February, Mr Devenny was transferred to HMP Swaleside. Prison staff ended the ACCT procedures two weeks later.
30. On 11 October, a psychiatrist assessed Mr Devenny due to his ongoing anxiety. Mr Devenny said that he had experienced suicidal thoughts every day for a long time but had not acted on them. The psychiatrist concluded that Mr Devenny had symptoms of anxiety and depression, and that he was not actively suicidal.
31. On 20 February 2018, Mr Devenny attacked a prison officer with a rock. The incident was reported to the police and he was charged with assault.
32. On 5 August, prison staff started ACCT procedures when Mr Devenny exhibited "bizarre" behaviour and was reported to be speaking randomly and making little sense. He denied having taken drugs. On 10 August, a mental health nurse assessed Mr Devenny and recorded that he did not appear to have symptoms of psychosis or thought disorder. On 13 August, prison staff ended the ACCT procedures.
33. On 20 November, prison staff started ACCT procedures after seeing blood in Mr Devenny's cell. Six days later, he cut his arm. At a mental health assessment on 5 December, Mr Devenny said that everyone was against him and he felt under stress. Mr Devenny said that he sometimes harmed himself to relieve stress and did not intend to take his life. On 2 January 2019, prison staff ended the ACCT procedures.

HMP Elmley

34. On 6 February, Mr Devenny was transferred to HMP Elmley to be sentenced for the assault on the officer a year earlier. He received a further six months in prison, in addition to his IPP.

35. A nurse assessed Mr Devenny when he arrived at Elmley. She recorded that he said he had no current thoughts of harming himself and that he did not use illicit drugs. She noted that Mr Devenny had a history of depression, and his current medication included dihydrocodeine and mirtazapine (antidepressant medication).
36. An officer told us that Mr Devenny was an average prisoner, who worked well in his job as a wing cleaner on Houseblock 2. He said that Mr Devenny did not have any significant issues in prison and appeared to be popular with other prisoners. Another officer said that Mr Devenny was originally uneasy when he arrived at Elmley but began to engage better with others when he started working as a cleaner, after which he settled well on the houseblock. A Supervising Officer (SO) agreed that Mr Devenny was a man who appeared settled and did not raise any issues of concern for staff.
37. On 1 March, Mr Devenny told a prison GP that he had recently felt increasing anxiety. The GP prescribed duloxetine (medication to treat depression and anxiety).
38. On 23 April, a prison chaplain told Mr Devenny that his foster mother was ill in hospital and had a poor prognosis. On 29 April, the chaplain told Mr Devenny that his foster mother had died.
39. On 13 June, Mr Devenny was one of several prisoners suspected by staff to be under the influence of drugs. The next day, they again suspected he was under the influence of drugs.
40. On 29 June, Mr Devenny broke his cell observation panel. He said he did this because he did not receive his medication on time. Three days later, he was reportedly aggressive to wing staff.
41. On 22 August, Mr Devenny met his prison offender supervisor to discuss his sentence plan. The offender supervisor recorded that Mr Devenny ended the meeting quickly and said he would not participate in any of the recommended programmes. He recorded that he had told Mr Devenny that he appeared to be doing well on Houseblock 2, to which Mr Devenny replied that it was “a miracle I haven’t killed someone”. He recorded that Mr Devenny would not elaborate on this, stating that he, “Just wanted to get out of this shit-hole”.
42. On 27 August, Mr Devenny telephoned a friend. Prisoners’ telephone calls are recorded and we listened to recordings of Mr Devenny’s calls. Mr Devenny told his friend that he was, “Getting set up ... I can hear ... lads talking shit [about me]”. Mr Devenny told his friend that this was about money and indicated that someone had paid a lot of money to set him up. He also told his friend that others were listening to and repeating what he said in his cell.

28 August 2019

43. On 28 August, Mr Devenny approached a resettlement worker. She recorded that he was “demanding and rude”, said that no one was doing anything to help him move from his wing, and that there was a “hit” on his head. She directed Mr Devenny to the wing manager, and recorded that he responded, “They are all in on it”. She told an SO what Mr Devenny had said.

44. The SO told us that Mr Devenny had begun to make comments to staff such as, “I know something is going on”. He said that Mr Devenny asked to speak to a chaplain, and he therefore asked the chaplain to visit the houseblock.
45. The chaplain met Mr Devenny that afternoon. During the meeting, Mr Devenny gave him a note he had written which said:

“People are watching me with either heat sensitive cameras or infra-red cameras and someone has paid from what I’ve heard £300,000 to kill me and I know the officers are in on it.”
46. The chaplain told us that he tried to talk to Mr Devenny about this, but Mr Devenny took this to indicate that he did not believe him and became angry. At one stage, Mr Devenny thought he could hear someone outside the door of the office in which they were talking. The chaplain said he opened the door and showed Mr Devenny that no one was there, at which point Mr Devenny left the room. The chaplain reported the outcome of the meeting to the SO. He told us that his impression was that Mr Devenny was experiencing a mental health issue.
47. Several prisoners spoke to us about Mr Devenny’s concerns in the last days of his life. His neighbour said that Mr Devenny thought there was a conspiracy against him among other prisoners. He said he thought Mr Devenny was confused and did not think that he was under threat from anyone. He said that he understood that some of Mr Devenny’s friends had told him to stop using ‘Spice’ (a psychoactive substance), as they thought it was playing tricks on his mind.
48. Another prisoner said that Mr Devenny became paranoid that people were out to get him, and that his mental health “went downhill” quickly in the week before he died.
49. A further prisoner said that Mr Devenny struggled with his mental health and with paranoia, and that this paranoia got much worse in the time before his death. He said that Mr Devenny believed that people were talking about him and threatening him. He said that he did not think there was any truth to Mr Devenny’s fears.
50. Another prisoner told us that Mr Devenny smoked ‘Spice’ for much of his time at Elmley. Towards the end of his life, Mr Devenny began to think that a contract had been put on his life and became paranoid and very suspicious of others. He said that he doubted that Mr Devenny’s concerns were true.

29 August 2019

51. The SO recorded that Mr Devenny had shown “many indicators of mental health decline” and was becoming a serious risk to others. He noted that Mr Devenny believed that everyone, including staff, was going to kill him. He told us that Mr Devenny said that he was going to seriously hurt or kill an officer, as he believed that he needed to take pre-emptive action to prevent himself from being killed.
52. Mr Devenny asked to speak to a chaplain again, and said that he would not move from the landing until this was arranged. Due to his aggressive behaviour and threats, prison staff restrained Mr Devenny and moved him back into his cell.

None of the staff involved completed use of force statements, as Prison Service policy requires when force is used.

53. A prison chaplain then visited Mr Devenny and spoke to him at his cell door. He recorded that Mr Devenny said he thought other prisoners were talking about him. Mr Devenny said that he did not feel safe at Elmley and wanted to transfer to another prison.
54. The SO completed a referral to the mental health team. In the referral, he stated that Mr Devenny's behaviour had declined rapidly, that he was constantly paranoid and that he had told a chaplain and written a note which stated that he thought everyone, including staff, planned to kill him.
55. Mr Devenny remained in his cell for the rest of his life. The SO told us that a manager decided to keep him in his cell to ensure the safety of staff, although he could not remember who told him this and no one made an entry in Mr Devenny's records to this effect. Some members of Houseblock 2 staff told us that a note on the board in the staff office indicated that Mr Devenny was segregated under Prison Rule 53, which allows prisoners to be segregated before a prison disciplinary hearing when they have been charged with an offence against prison discipline. However, no one had charged Mr Devenny with an offence. The then Head of Residence with responsibility for Houseblock 2, told us that she understood that Mr Devenny had chosen to remain in his cell and was therefore "self-isolating".
56. The SO told us that he arranged with staff in the segregation unit that Mr Devenny could go there under escort for a shower, to use the telephone or for other aspects of the regime. However, Mr Devenny always declined and remained in his cell. The SO instructed staff only to open Mr Devenny's cell when there was a minimum of four officers present.
57. An officer told us that Mr Devenny began to block his cell observation panel. Mr Devenny said that he did this because he did not want other prisoners looking in on him. He said that they agreed with Mr Devenny that staff would knock on his door if they wished to speak to him, at which point he would remove the blockage.

30 August 2019

58. An officer recorded that he heard Mr Devenny kicking his door and threatening staff.
59. The operational manager for mental health and a mental health nurse met to discuss new referrals. They concluded that it was appropriate to assess Mr Devenny, and that he should be booked for a non-urgent mental health assessment, which meant that he would be seen within ten working days. (A prisoner judged to require an urgent mental health assessment should be seen within 48 hours.) Mr Devenny was subsequently booked for an assessment on 3 September.
60. Every week there is a Safety Intervention Meeting at Elmley which managers, including the Head of Safety, attend. The aims of the meeting include identifying prisoners who require engagement and support, and to discuss how that support might be provided. The then Head of Residence and the then Head of Safety

discussed Mr Devenny at the meeting on 30 August. They recorded that he had been kicking his door and threatening staff. The meeting minutes noted that they would take unspecified action. The then Head of Safety told us that this meant monitoring and discussing Mr Devenny's behaviour with wing staff over the following week and considering what action to take.

31 August 2019

61. An officer recorded that Mr Devenny continued to be very aggressive towards staff, and that his behaviour had declined.
62. The then Head of Residence referred Mr Devenny to the mental health team. She recorded that Mr Devenny had displayed very threatening behaviour towards staff, that his behaviour had changed to the extreme, and they were unsure whether this change was related to deteriorating mental health.

2 September 2019

63. A nurse considered the Head of Residence's mental health referral and noted that Mr Devenny already had an assessment booked for the next day. She marked it as a duplicate referral with no further action required.
64. Officer A told us that Mr Devenny appeared relaxed in the morning. He said that Mr Devenny spoke to him about cleaning his cell, and his conduct was considerably improved compared to recent days.
65. A prisoner told us that he spoke to Mr Devenny through his cell door. He said that Mr Devenny seemed normal but asked him to get some 'Spice'. He said that he told Mr Devenny that he did not know where to obtain this.
66. At around 1.48pm, Mr Devenny pressed his cell bell. Officer A responded promptly. He told us that Mr Devenny asked him to contact the chaplaincy and ask someone to see him. He said that he telephoned the chaplaincy and spoke to someone who told him that they could not come that day but would try to see him the next day. He said that he could not remember which chaplain he spoke to. We spoke to all three chaplains who worked on 2 September, none of whom could remember speaking to him.
67. Officer A returned to Mr Devenny's cell and told him that a chaplain would try to see him tomorrow. He told us that Mr Devenny did not say why he wanted to speak to a chaplain and appeared agitated that he could not see one that day. Mr Devenny asked for a portable telephone to use in his cell, but he said there were none available on the houseblock.
68. Mr Devenny pressed his cell bell twice more at around 2.06pm and 2.21pm. Officer B responded on both occasions. He has since left the Prison Service and we have not been able to interview him. Officer A told us that he understood that Mr Devenny had also asked Officer B for a telephone.
69. At 3.15pm, Officer B delivered post to Mr Devenny. In his statement, Officer B wrote that the observation panel was blocked. He wrote that he called to Mr Devenny and banged on the door, but Mr Devenny did not respond. CCTV

footage shows that the officer spent 11 seconds at the cell before leaving the landing.

70. Officer B then went to the staff office and told Office A what he had found at Mr Devenny's cell. They agreed to find additional staff so that they could open the cell.
71. At 3.23pm, both officers and three other staff returned to Mr Devenny's cell. Officer A opened the cell and found Mr Devenny hanging from a ligature that he had tied to the light fitting. He cut the ligature and another officer radioed a medical emergency code blue, indicating a life-threatening situation. The control room operator telephoned for an ambulance immediately.
72. An officer began cardiopulmonary resuscitation (CPR). At 3.28pm, a nurse arrived. She attached a defibrillator, which advised that there was no shockable rhythm and they should continue with CPR. After around 15 minutes, she concluded that Mr Devenny had died.

Contact with Mr Devenny's family

73. Mr Devenny had a nominated next of kin, but did not nominate an alternative when she died. Prison staff checked his records and could only identify that he had another next of kin who lived in the West Midlands. They asked West Midlands Police for help in locating him. On 7 September, the police found him and told him of Mr Devenny's death.
74. A family liaison officer then contacted Mr Devenny's next of kin. Elmley contributed to the costs of the funeral in line with national instructions.

Support for prisoners and staff

75. After Mr Devenny's death, the deputy governor debriefed the staff involved in the emergency response to ensure that they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.
76. The prison posted notices informing other prisoners of Mr Devenny'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 Devenny's death.

Post-mortem report

77. A post-mortem examination identified the cause of death as hanging. The toxicology examination did not identify any illicit drugs or medication although it did not test for synthetic cannabinoids (PS) such as 'Spice'.

Findings

Identifying the risk of suicide and self-harm

78. Prison Service Instruction (PSI) 64/2011, which governs ACCT suicide and self-harm prevention procedures, requires all staff who have contact with prisoners to be aware of the risk factors and triggers that might increase the risk of suicide and self-harm and take appropriate action. Any prisoner identified as at risk of suicide or self-harm must be managed under ACCT procedures. We have considered whether staff at Elmley should have recognised Mr Devenny as at risk and begun ACCT procedures to support him.
79. Mr Devenny had some risk factors for suicide and self-harm. He had previously harmed himself, he was prescribed long-term anti-depressant medication, he had suffered a recent bereavement, had little contact with his family and he was serving an indeterminate sentence with little likelihood of imminent release. There was also evidence from his friends that Mr Devenny used PS in prison, and there are concerns that use of these substances might increase the risk of suicide and self-harm.
80. Most significantly, Mr Devenny's behaviour changed considerably in the days before his death. He became convinced that there was a conspiracy among staff and prisoners to assault or kill him, and he chose to remain in his cell as a result. All the staff and prisoners we spoke to agreed that Mr Devenny's fears were unfounded, and many described his thoughts as evidence of paranoia or worsening mental ill-health.
81. PSI 64/2011 highlights that being a victim of violence or intimidation, or being in fear of such, is a risk factor and potential trigger for suicide and self-harm. Mental ill-health is also identified as a risk factor, and a deterioration in this is a potential trigger.
82. It is apparent that staff at Elmley were concerned for Mr Devenny's wellbeing, and they made a prompt and appropriate referral to the mental health team. However, we are concerned that no one appeared to consider that this change in Mr Devenny's behaviour, and his apparent fears and paranoia, might increase his risk of suicide and self-harm, and no one considered starting ACCT procedures. If staff had started ACCT procedures, it would have allowed them to identify and address Mr Devenny's issues and triggers, and work to reduce the impact of these. While we cannot say that this would have led to a different outcome, it would have given prison staff more chance of preventing his death. We make the following recommendation:

The Governor should ensure that all staff have a clear understanding of their responsibilities to manage prisoners at risk of suicide and self-harm in line with national guidelines and, in particular, the need to record, share and consider all relevant information about risk, and start ACCT procedures when indicated.

Segregation

83. Following a restraint on 29 August, Mr Devenny spent the last four days of his life locked in his cell and unable to socialise with other prisoners. It is unclear what the authority for this was. Some members of Houseblock 2 staff told us that Mr Devenny was segregated under Prison Rule 53 (which allows prisoners who have been charged with a disciplinary offence to be held away from others before the adjudication hearing to prevent collusion or intimidation) and that this had been written on a board in the staff office. However, Mr Devenny had not been charged with an offence against prison discipline, and could not therefore have lawfully been segregated under Rule 53.
84. We were also told by the then Head of Residence that Mr Devenny was voluntarily 'self-isolating' in his cell. While it is apparent that he chose not to leave the cell when offered the opportunity, any time out of his cell would have been away from other prisoners and under the supervision of at least four members of staff. We do not consider, therefore, that his isolation could be described as voluntary.
85. Mr Devenny was, therefore, effectively segregated from other prisoners. We understand that his threatening behaviour meant that segregation – potentially under Prison Rule 45, which allows prisoners to be segregated for the good order of the establishment – might have been justified. However, we are very concerned that there was no proper written authority justifying the decision to isolate him from other prisoners, and that important safeguards for segregated prisoners were not therefore followed.
86. As the proper segregation process was not followed, this meant that none of the mandatory requirements of Prison Service Order (PSO) 1700, which are designed as safeguards to counter some of the negative effects of segregation, were completed. A qualified healthcare professional should complete a safety algorithm for all segregated prisoners, the purpose of which is to take a snapshot assessment of a prisoner's mental health when deciding whether to segregate them. A healthcare professional should also visit segregated prisoners every day to assess their physical, emotional and mental wellbeing. Prisoners segregated under Rule 45 should have their segregation reviewed by a multi-disciplinary board within 72 hours, with the aim of addressing the underlying issues that led to the segregation.
87. It is extremely worrying that Mr Devenny spent the last four days of his life effectively segregated and without proper support. We make the following recommendations:

The Governor should ensure that prisoners are not subject to de facto segregation without due process.

The Governor should ensure that the provisions and safeguards of PSO 1700 apply to all segregated prisoners, including any outside the segregation unit.

Use of force

88. PSO 1600 sets out Prison Service policy on the Use of Force. PSI 30/2015 provides amendments to this policy and instructs that all staff involved in any use of force must complete statements describing and justifying their actions within 72 hours of the incident (unless there are exceptional circumstances preventing this). PSO 1600 states that an appropriate healthcare professional must be informed whenever force has been used to restrain a prisoner, and in all cases, they must examine the prisoner as soon as possible and complete the appropriate form (known as an F213). No-one completed any statements after the use of force on 29 August, and healthcare staff were not informed. We make the following recommendation:

The Governor and Head of Healthcare should ensure that all incidents in which force is used are managed in line with national policy, including that:

- **Staff involved in a use of force incident complete a statement within 72 hours, except in exceptional circumstances.**
- **An appropriate healthcare professional examines the prisoner as soon as possible and completes an F213.**

Mental health referral

89. Prison staff appropriately referred Mr Devenny to the mental health team on 29 August. The mental health team considered the referral promptly at their daily referral meeting, and concluded that Mr Devenny should be booked for a non-urgent assessment. A mental health nurse told us that this meant that he should be assessed within ten working days, rather than within 48 hours for an urgent assessment. (An appointment was subsequently booked for three working days.)
90. The mental health nurse explained that the criteria for a referral to be considered urgent included current self-harming behaviour or explicitly stated suicidal intent. Other criteria were a history of contact with community mental health services or previous hospital admission under the Mental Health Act.
91. Mr Devenny did not meet any of these criteria. The clinical reviewer concluded that Mr Devenny's referral was appropriately considered by the mental health team at Elmley. We agree.

Substance misuse

92. Several of Mr Devenny's friends on Houseblock 2 told us that he used PS in prison, and one said that Mr Devenny asked for it a few hours before his death. (We do not know whether Mr Devenny obtained or used PS in the time before his death.) In June 2019, prison staff twice identified that Mr Devenny was under the influence of drugs. No one referred Mr Devenny to the substance misuse service, which was a missed opportunity to identify and address any substance misuse issues he had. We make the following recommendation:

The Governor should ensure that any prisoners identified as or suspected of using psychoactive substances are referred to the substance misuse service.

Blocked cell observation panel

93. Mr Devenny spent the last few days of his life with material covering the observation panel of his cell door. Officer A told us that Mr Devenny did this because his paranoia meant that he did not want other prisoners to look at him. He said that staff agreed to this on the condition that Mr Devenny removed the obstruction when they knocked on his door.
94. We appreciate that prison staff were trying to help Mr Devenny when they allowed him to cover his observation panel. However, it is important that staff are able to see into cells whenever they require to ensure the welfare and safety of prisoners and that they are not engaging in activities against prison rules. Staff should always challenge prisoners who block their panels, and consider ways of addressing the issues that have led to this.
95. Officer B was unable to check on Mr Devenny's welfare when he did not respond on 2 September. Elmley does not have a local policy to tell staff what to do if they find a cell observation panel obscured. In such circumstances, we would usually expect staff who cannot see or speak to a prisoner to radio for help from other staff and remain at the cell door. If they believe the prisoner may be at risk, they should assess the risk of opening the cell door before help arrives.
96. When Officer B found that Mr Devenny had blocked his observation panel and could not get a response from him, he left the landing to fetch assistance from colleagues. In his statement, he wrote that Mr Devenny had made multiple threats to staff and that he had been instructed not to unlock the door by himself. Given Mr Devenny's unpredictable behaviour over the preceding days, we agree that it was reasonable that he did not go into the cell alone when he could not see what he would face on opening the door. Nevertheless, eight minutes passed before he returned to the cell with support and the door was opened, which is too long given the potential implications of Mr Devenny not responding to contact. Our view is that he should have radioed for more urgent assistance. We make the following recommendations:

The Governor should ensure that a local protocol is developed and shared with staff to instruct them on what to do if they find a cell observation panel obscured, including that:

- **Staff challenge all prisoners who have blocked their observation panel, ensure the blockage is removed, and seek to identify and address any issues the prisoner has that might have led them to create the blockage.**
- **Subject to a risk assessment, staff enter cells as quickly as possible if there is reason to consider that the prisoner may be at risk.**

**Prisons &
Probation**

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