

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Ian Miller, a prisoner at HMP Usk, on 21 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 Ian Miller died of severe blood loss on 21 September 2019, after making cuts to his wrists in his cell at HMP Usk. He was 46 years old. I offer my condolences to his family and friends.

Mr Miller was due to be released from prison on 27 October. On the day before he died, Mr Miller had learned that he would not be able to live with his family on his release, and would only be allowed to have supervised contact with his children.

Although there is evidence from prison and probation staff that he had been told this earlier in his sentence, it is apparent that it was only at this meeting that Mr Miller fully understood the ruling. I am concerned that no one at Usk identified that this might significantly increase Mr Miller's risk of self-harm, that the information was not shared with wing staff and that no one considered starting suicide and self-harm prevention procedures.

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
Deputy Prisons and Probation Ombudsman

February 2021

Contents

Summary 1

The Investigation Process 3

Background Information 4

Key Events 5

Findings 10

Summary

Events

1. On 27 February 2018, Mr Ian Miller was convicted of historic sexual offences and sentenced to three years and four months in prison. He arrived at HMP Parc on the same day. Mr Miller told prison healthcare staff that he had previously been diagnosed with schizophrenia. It is unclear from his earlier medical records whether this was the case, although Mr Miller had been diagnosed with anxiety and depression and was prescribed long-term medication for these conditions.
2. On 22 March, Mr Miller was transferred to HMP Usk. He had frequent reviews with a mental health nurse until these stopped in November, seemingly because the nurse omitted to book any further appointments.
3. Mr Miller was settled for much of his time in prison. Staff and prisoners told us that he enjoyed his job in the prison's recycling team and was looking forward to his release in October 2019.
4. From May 2019, Mr Miller had several meetings with his keyworker and prison offender manager about his release arrangements. He was told that he would not be able to live with his partner and children on release, but his prison records indicate that he remained hopeful that this could be overturned.
5. On 20 September, Mr Miller attended a meeting with his community offender manager and prison offender manager. They confirmed to Mr Miller that he would not be able to live with his family on release, that he would not be allowed unsupervised contact with his children, and that if alternative accommodation could not be found, he may be homeless. It appears that it was only at this meeting that Mr Miller understood that these conditions would be in effect on his imminent release.
6. On the afternoon of 21 September, Mr Miller's cellmate found that he had made deep cuts to both wrists. He alerted staff, who began cardiopulmonary resuscitation (CPR). Paramedics arrived and continued CPR, but shortly afterwards confirmed that Mr Miller had died.

Findings

Identifying the risk of suicide and self-harm

7. The outcome of the pre-release meeting was the apparent trigger for Mr Miller's death. He had clearly stated on a number of occasions that his goal was to return home to his family following release. We are concerned that no one identified that his recognition that he could not live with his family or have unsupervised contact with his family might increase his risk of suicide and self-harm and that no one considered starting suicide and self-harm prevention procedures (known as ACCT), particularly as it was so close to his release date. 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 to reduce Mr Miller's risk.

Mental health care

8. We are concerned that apparent flaws in the mental health team's booking system meant that Mr Miller was not reviewed for the last ten months of his life.

Recommendations

- The Governor should ensure that all staff have a clear understanding of their responsibilities to manage and support prisoners at risk of suicide and self-harm in line with national guidelines, including that:
 - All staff record, share and consider all relevant information about risk and start ACCT procedures when indicated.
 - All staff in contact with prisoners are trained in ACCT procedures, in line with the requirements of PSI 64/2011.
- The Head of Healthcare should ensure that there is a rigorous system for booking any follow-up appointments required for patients on the caseload of the Mental Health Inreach Team.
- The Governor should ensure that a copy of this report is shared with a prison offender manager and that a senior manager discusses the Ombudsman's findings with him.

The Investigation Process

9. The investigator issued notices to staff and prisoners at HMP Usk informing them of the investigation and asking anyone with relevant information to contact him/her. No one responded.
10. The investigator visited Usk on 25 September 2019. He obtained copies of relevant extracts from Mr Miller's prison and medical records, and interviewed two prisoners who knew Mr Miller.
11. The investigator interviewed five members of staff at Usk on 6 November. Healthcare Inspectorate Wales commissioned a clinical reviewer to review Mr Miller's clinical care at the prison. The clinical reviewer joined the investigator for the staff interviews.
12. We informed HM Coroner for Gwent of the investigation. She gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.
13. The Ombudsman's family liaison officer contacted Mr Miller's partner to explain the investigation and to ask if she had any matters she wanted us to consider. Mr Miller's sister replied on behalf of the family. She asked whether prison staff should have started ACCT procedures, given the news Mr Miller received the day before his death and his previous mental health diagnosis. Mr Miller's family also asked several questions that we have addressed through separate correspondence.
14. We shared the initial report with HM Prison and Probation Service (HMPPS). They highlighted one factual inaccuracy, and this report has been amended accordingly. The action plan has been annexed to this report. The Aneurin Bevan University Health Board (who deliver healthcare services at Usk) also highlighted some factual inaccuracies, which we have amended in this report.
15. We also shared the initial report with Mr Miller's family. They wrote to us raising a number of questions that do not impact on the factual accuracy of this report and have been addressed through separate correspondence.

Background Information

HMP Usk

16. HMP Usk holds up to 273 convicted men, and is jointly managed with the nearby HMP Prescoed. The Aneurin Bevan University Health Board delivers healthcare services at Usk. Nurses are on duty from 8.00am to 4.30pm on weekdays, and there is a GP surgery on Mondays, Wednesdays and Fridays. Gwent Out of Hours Cover provides a telephone triage service out of hours.

HM Inspectorate of Prisons

17. The most recent inspection of HMP Usk was in October 2017. Inspectors reported that levels of self-harm were very low, and men in crisis received very good care and support. However, they reported that only 61 per cent of staff had received mandatory training in ACCT procedures.

Independent Monitoring Board

18. 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 March 2019, the IMB reported that they had no significant concerns or issues about the prison, and considered it to be well-run. They reported that ACCT procedures were started infrequently.

Previous deaths at HMP Usk

19. Mr Miller is the first prisoner to take his life at Usk since we began investigating deaths in prisons in 2004. In the last two years, two men at Usk have died of natural causes. There were no significant similarities between their deaths and Mr Miller's.

Assessment, Care in Custody and Teamwork (ACCT)

20. 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.
21. 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.

Key Events

22. Mr Ian Miller was convicted of various offences during his life and had served an 18-month sentence in 1990. In 2008, he was diagnosed with anxiety and depression, and prescribed olanzapine (an antipsychotic medication also used to treat anxiety and depression). In December 2012, Mr Miller cut his wrists, causing significant wounds. He was admitted to a psychiatric hospital. In a letter after his admission, a consultant psychiatrist wrote that Mr Miller believed that he had schizophrenia but that this was not the case. It is unclear whether Mr Miller was ever formally given this diagnosis.
23. On 10 August 2017, Mr Miller was remanded in custody to HMP Parc, charged with historic sexual offences. Prison staff started ACCT procedures as Mr Miller was reported to be very tearful and said he had previously tried to take his life. On 30 August, Mr Miller was released on bail.
24. On 27 February 2018, Mr Miller was sentenced to three years and four months in prison. The court also imposed a Sexual Harm Prevention Order (SHPO) which prevented unsupervised contact with his children on release. Mr Miller returned to Parc that day. On arrival, he told prison staff that he had cut his wrists in 2012 and taken an overdose in 2010.
25. A nurse assessed Mr Miller and recorded that he said he was diagnosed with schizophrenia and depression. The nurse noted Mr Miller's current medication as olanzapine and sertraline (an antidepressant). Mr Miller spoke about his previous self-harm and that he had been admitted to a psychiatric hospital in the past. He said he had no current thoughts of self-harm.

HMP Usk

26. On 22 March, Mr Miller was transferred to HMP Usk. On arrival, he told a nurse that he had schizophrenia and depression, and he spoke about his previous self-harm. The nurse referred him to the mental health team.
27. On 3 April, a mental health nurse assessed Mr Miller. He recorded that Mr Miller said that he had paranoid schizophrenia but had been well for a number of years while taking olanzapine. Mr Miller said that he occasionally heard voices but did not respond to or act upon them. The mental health nurse noted that Mr Miller would be monitored throughout his time in prison and handed over to a community team on release.
28. Over the following months, the mental health nurse reviewed Mr Miller around every two to three weeks. Mr Miller sometimes said that he felt anxious or stressed about his work placement in prison.
29. On 30 July, a consultant psychiatrist reviewed Mr Miller. He recorded that Mr Miller said that he heard voices and experienced low mood and anxiety. Mr Miller was reluctant to increase the dose of his current medication, so the consultant psychiatrist added haloperidol (an antipsychotic) to his prescription.
30. On 16 August, the mental health nurse reviewed Mr Miller. He recorded that Mr Miller said that his mental health had "really turned around" as he now had a new

job in prison and had achieved enhanced status on the prison's Incentives and Earned Privileges (IEP) scheme (which aims to encourage and reward responsible behaviour in prisons).

31. On 21 August, an officer, who was Mr Miller's keyworker, recorded that Mr Miller enjoyed his current job and was counting down the days until his release on 27 October 2019. Over the next few months, the keyworker made several positive entries about Mr Miller's contribution to prison life.
32. In October, the mental health nurse twice reviewed Mr Miller. He recorded that Mr Miller reported a low mood and that he was not socialising with other prisoners as he had previously.
33. On 26 November, the mental health nurse recorded that Mr Miller had a new job and was happy to be occupied throughout the day. Mr Miller said that he did not think he needed to be assessed again by the consultant psychiatrist, as he was feeling well. The mental health nurse recorded that he would keep Mr Miller under review, but this was the last consultation they had. The mental health nurse told us that he mistakenly omitted to book Mr Miller's next appointment, after which he dropped off their system.
34. On 23 December, the keyworker recorded that Mr Miller was very happy with his new job in recycling. In 2019, he continued to make positive entries about Mr Miller's progress.
35. On 29 March 2019, a prison offender manager emailed Mr Miller's then community offender manager, to ask whether it would be appropriate to release him to his family home (where Mr Miller had previously lived with his partner and their children). The community offender manager replied on 15 April, and said that Mr Miller's family home would not be suitable release accommodation. The prison offender manager asked the keyworker to speak to Mr Miller about this and to try to identify alternative accommodation.
36. On 13 May 2019, the keyworker spoke to Mr Miller. He recorded that Mr Miller had thought that he was able to return to his family home on release, and said that he did not have anywhere else to go. The keyworker contacted the prison offender manager who subsequently emailed the community offender manager to ask whether Mr Miller would be eligible for a place in a probation approved premises. (Approved premises accommodate offenders released from prison on licence, with the purpose of providing an enhanced level of residential supervision in the community.)
37. On 7 June, Mr Miller attended a sentence planning meeting, chaired by the offender management unit hub manager. Also present were the prison offender manager and the keyworker. The offender management unit hub manager recorded that Mr Miller planned to return to his family home on release but that this was currently deemed unsuitable. She noted that Social Services were due to assess whether any additional support would be required if Mr Miller were to return home.

38. On 9 June, the keyworker spoke to Mr Miller. He recorded that Mr Miller had no issues other than the hope that the issue with his release accommodation was soon resolved, ready for his release.
39. On 21 June, the community offender manager emailed the prison offender manager, and said that Mr Miller was not eligible for a place in an approved premises. The prison offender manager asked the keyworker to discuss this with Mr Miller, and highlighted that it meant that Mr Miller would be homeless on release unless he could identify alternative release accommodation.
40. On 26 June, the keyworker spoke to Mr Miller. He told us that he reiterated that Mr Miller would not be able to move into his family home on release from prison. The keyworker said that Mr Miller already understood that he would not be able to go home and they discussed future steps in finding accommodation.
41. On 22 July, Mr Miller told his keyworker that his partner's mother had died. He said that his partner was waiting for an appointment for a Social Services assessment and he hoped that it would recommend that he could return home. On the same day, a community offender manager recorded that Mr Miller planned to return home on release, and that the Social Services assessment would discuss any safeguarding measures required on release.
42. On 7 August, Mr Miller expressed frustration to his keyworker that the Social Services report had not yet been completed. Mr Miller reiterated that he was very keen to go home to his family.
43. On 9 September, Mr Miller gave his partner's father's address to his keyworker as potential release accommodation. The prison offender manager forwarded the address to the community offender manager to check whether it would be suitable.

20 September 2019

44. In the morning, Mr Miller saw a prison GP for a medication review. The prison GP recorded that Mr Miller said that his mental health was good. She told us that he also said he had a probation meeting in the afternoon and that he was looking forward to going home. The prison GP recorded that Mr Miller required a mental health review to consider reducing his medication. (An appointment was subsequently booked for 24 September.)
45. At around 12.00pm, Mr Miller attended a pre-release probation meeting with his recently assigned new community offender manager, and the prison offender manager. The community offender manager recorded that Mr Miller said that he wanted to be released to his home address and to live with his family. She told us that this was Mr Miller's biggest issue at the meeting. The community offender manager told Mr Miller that this would not be possible because he was subject to the SHPO that prohibited him from living with children. She told us that Mr Miller said he had no knowledge of the SHPO, asked her to "get it lifted" and appeared to have clear expectations that he would be able to live with his family on release. The prison offender manager printed a copy of the SHPO and explained it to Mr Miller. They reiterated that it meant that he could not live with

his family, and also that he would only be able to have supervised contact with his children.

46. The prison offender manager told us that they also explained to Mr Miller that he would not be able to live with his partner's father on release, because his address was too close to the family home. The prison offender manager said that they told Mr Miller that they would have to refer him to local authority housing and to agencies that could help identify release accommodation. He said that if suitable accommodation was not identified, Mr Miller would be released to 'no fixed abode' which meant that he would be homeless. The prison offender manager said that Mr Miller understood this.
47. The prison offender manager told us that Mr Miller displayed little emotion during the meeting, and that he appeared to be "on a very even keel". He said that there was nothing during the meeting that gave him any cause to consider that Mr Miller's risk of suicide and self-harm had increased. The community offender manager also said that the meeting ended amicably and Mr Miller showed no signs of distress. She also highlighted that Mr Miller had indicated that he was looking to the future by discussing a rehabilitation course he planned to undertake.
48. After the meeting, Mr Miller returned to his cell. His cellmate told us that Mr Miller was very quiet when he returned and did not appear to want to talk about the meeting.
49. At 2.00pm, Mr Miller telephoned his partner. Prisoners' telephone calls are recorded and we listened to recordings of Mr Miller's calls. Mr Miller told his partner that he would not be able to move back home or to her father's house, and that he would only be allowed supervised contact with their children. Mr Miller said he was, "Down about it ... I don't know what to think."
50. At 5.35pm, Mr Miller telephoned his partner again. He said that he had been "shaking all afternoon" and was "devastated".
51. At 6.50pm, Mr Miller telephoned his partner for a third time. He apologised several times and again said he was "devastated," and he did not know what to think.

21 September 2019

52. Mr Miller's cellmate told us that Mr Miller spent the morning watching horse racing on television, which was his usual Saturday routine. At around 10.55am, Mr Miller telephoned his partner and discussed which horses they should place bets on.
53. At around 11.30am, prisoners eat lunch. His cellmate said that Mr Miller ate alone, because he [the cellmate] was going to eat during a visit he had booked for the afternoon and the other prisoners with whom they usually ate were working.
54. At 12.00pm, prisoners were locked in their cells. The cellmate said that Mr Miller went to sleep, as he usually did at that time on a Saturday.

55. At 1.30pm, the prisoners were unlocked. Mr Miller telephoned his partner, and discussed the bets she had placed. At around 1.45pm, the cellmate left the cell for his visit.
56. At around 4.05pm, the cellmate returned to the cell. He found Mr Miller sitting on the toilet, having made deep cuts to his wrists. He pressed the cell call bell and gestured to prison staff to attend. Four officers went to the cell immediately, followed by a Supervising Officer (SO).
57. An officer radioed a medical emergency code red, indicating a life-threatening situation. The control room operator telephoned for an ambulance immediately. A second officer began cardiopulmonary resuscitation (CPR), later being relieved by others. Prison staff attached a defibrillator, which advised that there was no shockable rhythm and they should continue CPR.
58. At around 4.22pm, paramedics arrived at Mr Miller's cell. They initially continued resuscitation efforts but, at around 4.55pm, confirmed that Mr Miller had died.
59. Mr Miller left a note in his cell addressed to his partner, in which he said that he could not live without their children.

Contact with Mr Miller's family

60. A prison family liaison officer (FLO), the duty operational manager, and a prison chaplain visited Mr Miller's partner on the evening of 21 September, and informed her of his death. Usk contributed to the costs of Mr Miller's funeral in line with Prison Service instructions.

Support for prisoners and staff

61. After Mr Miller's death, a prison manager debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.
62. The prison posted notices informing other prisoners of Mr Miller's death and offering support. The cellmate told us that he felt well-supported following the death.

Post-mortem report

63. A post-mortem examination identified that Mr Miller died from hypovolaemic shock (severe blood loss, meaning the heart is unable to pump sufficient blood around the body), due to bleeding from the radial artery (the major artery in the forearm) that was caused by lacerated wrists.

Findings

Identifying the risk of suicide and self-harm

64. 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. PSI 64/2011 also states that any information that becomes available which may affect a prisoner's risk of harm to self must be recorded and shared, to inform proper decision making.
65. We have considered whether staff at Usk should have recognised Mr Miller as at risk and begun ACCT procedures to support him.
66. Mr Miller had some risk factors for suicide and self-harm. He had previously harmed himself, he was prescribed long-term medication for depression and anxiety, and he had previously been admitted to a psychiatric hospital. Most significantly, on the day before his death, Mr Miller understood that he would not be able to live with his family on release from prison in six weeks' time, may instead be homeless, and that he would not be allowed unsupervised contact with his children on release.
67. The community offender manager and prison offender manager both told us that Mr Miller should already have known that he would not be able to return home or have unsupervised contact with his children. We appreciate that there is evidence in his prison records that he had been told this in previous months. However, it is also apparent that Mr Miller had remained hopeful that these rulings could be overturned, and both the community offender manager, and the prison offender manager thought he came to the meeting on 20 September with unrealistic expectations given what he had previously been told.
68. It is apparent that it was only at this meeting that Mr Miller realised that he would not be able to overturn the rulings. We consider that this realisation should have been identified as a potential trigger for suicide and self-harm. Both the community offender manager and prison offender manager thought that Mr Miller took the news well at the time, and both said that they did not think that his risk had increased as a result. However, while an individual's presentation is important, as we have said repeatedly the learning from our investigations is that assessments of risk too often place insufficient weight on known risk factors and too much on staff's perceptions of the prisoner's behaviour and demeanour.
69. We consider that the community offender manager and the prison offender manager should have been more alert to Mr Miller's increased risk of suicide and self-harm, shared this information with wing staff, and considered starting ACCT procedures. If staff had started ACCT procedures, it would have allowed them to identify and address Mr Miller'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.

70. We are concerned that the prison offender manager told us that he had not received suicide and self-harm awareness training (a mandatory requirement of PSI 64/2011 for all staff). We make the following recommendations:

The Governor should ensure that all staff have a clear understanding of their responsibilities to manage and support prisoners at risk of suicide and self-harm in line with national guidelines, including that:

- **All staff record, share and consider all relevant information about risk and start ACCT procedures when indicated.**
- **All staff in contact with prisoners are trained in ACCT procedures, in line with the requirements of PSI 64/2011.**

The Governor should ensure that a copy of this report is shared with the prison offender manager and that a senior manager discusses the Ombudsman's findings with him.

Mental health care

71. In his first months at Usk, Mr Miller had frequent reviews with the mental health team, usually with the mental health nurse. These ended in November 2018, seemingly because the mental health nurse omitted to book Mr Miller's next appointment. When this happens, there is no additional prompt to book another review.
72. The clinical reviewer noted that there were clearly flaws in the mental health team's appointments system. She said, however, that there was nothing to suggest that the mental health nurse's omission had any impact on Mr Miller's death, and no evidence that Mr Miller was experiencing any breakthrough mental health symptoms. We make the following recommendation:

The Head of Healthcare should that there is a rigorous system for booking any follow-up appointments required for patients on the caseload of the Mental Health Inreach Team.

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