Prisons & Probation Ombudsman
Independent Investigations

# Independent investigation into the death of Mr Duncan MacNeil, a prisoner at HMP Isle of Wight, on 24 October 2019

**A report by the Prisons and Probation Ombudsman**

Third Floor, 10 South Colonnade
Canary Wharf, London E14 4PU
Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk
T I 020 7633 4100
F I 020 7633 4141

## 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 Duncan MacNeil died on 24 October 2019, at HMP Isle of Wight, after taking an overdose of amitriptyline and codeine (which he had been prescribed). He was 54 years old. I offer my condolences to Mr MacNeil's family and friends.

Mr MacNeil had longstanding thoughts of suicide. He was well supported in his first few months at Isle of Wight and settled well. However, operational and healthcare staff did not share information, or review his risk after a series of negative events (including the Parole Board's decision not to release him; his consequent refusal to engage in the regime or receive healthcare; the breakdown of his relationship; and several worrying statements referring to his death).

The failure to share important information and failures in clinical procedures enabled Mr MacNeil to stockpile his prescribed medication. After a previous death at Isle of Wight in similar circumstances, the prison had reviewed all prisoners who had been prescribed potentially toxic prescription drugs. Given that Mr MacNeil was still able to stockpile his medication, the measures put in place since our previous recommendation are clearly inadequate and need to be more robust.

As we have found previously at Isle of Wight, staff did not comply with the requirement to check the welfare of prisoners when their cells are unlocked. I am also concerned that Mr MacNeil did not have meetings with his key worker for around six months, during a particularly difficult period.

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** **November 2020**

## Contents

# Summary

## Events

1. Mr Duncan MacNeil was a life-sentenced prisoner. He was recalled to prison on 20 December 2017 and taken to HMP Isle of Wight.

2. Mr MacNeil had had lifelong thoughts of ending his life and had previously attempted suicide. At mental health assessments shortly after his arrival he said that he planned to kill himself. For the first three months at Isle of Wight, Mr MacNeil was managed under the ACCT suicide and self-harm prevention procedures. During that time, he tried to hang himself and cut his arm. A mental health care plan was created and he was regularly reviewed by a mental health nurse.

3. After a settled period, Mr MacNeil hoped the Parole Board would approve his release. However, after two hearings in December 2018 and May 2019, he was informed in July that the Board had not recommended his release. Mr MacNeil's attitude immediately changed. Although he remained courteous to staff, he decided not to work or participate in activities, disengaged from substance misuse support and later refused both mental and physical healthcare appointments.

4. At mental health reviews on 12 and 15 August, Mr MacNeil said that his position was "passive non-compliance" and he would not engage with his sentence plan, or the recommendations of the Parole Board. He also made several comments referring to his death and funeral which the mental health nurse did not share with other staff. Due to his disengagement, there were no further mental health reviews.

5. At a meeting with his key worker on 15 October, Mr MacNeil said that his relationship with his partner had ended and it was agreed that he would seek a transfer to a prison with a lifer unit.

6. On 24 October, Mr MacNeil did not collect his lunch and no one checked the reason for this. At 1.57pm, an officer found Mr MacNeil unresponsive in his cell. Resuscitation was not attempted as rigor mortis had set in (meaning he had been dead for some hours) and a prison GP confirmed his death at 2.05pm.

7. A post-mortem examination concluded that the cause of Mr MacNeil's death was an overdose of amitriptyline and codeine (both of which he was prescribed).

## Findings

8. Mr MacNeil's risk of suicide and self-harm was managed well when he first arrived at Isle of Wight. However, neither operational, nor mental health staff reviewed his risk following events such as the Parole Board's decision not to approve his release; his non-compliance with the prison regime; the breakdown of his relationship; and expressions of hopelessness and references to death during mental health reviews. These factors can indicate increased risk and be potential triggers for self-harm.

9. In addition, Mr MacNeil's mental health nurse overlooked the increased risk factors and failed to act on or share his worrying statements with the healthcare team. This was a missed opportunity for a more detailed assessment and to consider opening ACCT procedures.

10. The clinical reviewer identified several other concerns about the management of Mr MacNeil's clinical care. In particular, Mr MacNeil was assessed as suitable to keep his medication in his possession in his cell to take as required, to be reviewed annually. The clinical reviewer considered that the review should have been sooner, particularly as Mr MacNeil had a history of attempted suicide.

11. Following a death at Isle of Wight, in similar circumstances, we recommended that the Head of Healthcare should ensure that healthcare staff consider all relevant information, including information about recent self-harm, when completing risks assessments for in-possession medication. Mr MacNeil's medication was reviewed as a result and it decided it was safe for him to continue holding his medication in possession.

12. We are concerned that in spite of the steps taken, it is still possible to prisoners to stockpile sufficient toxic drugs to overdose.

13. We consider that if the bad news about Mr MacNeil's release and his worrying statements about death and hopelessness had been shared, this should have also prompted a review of his medication risk assessment. The failure to communicate known risk factors also meant that Mr MacNeil was not reviewed at a multidisciplinary meeting and there was no assessment of his mental capacity when he decided to withdraw from receiving healthcare.

14. We agree with the clinical reviewer that Mr MacNeil's care did not meet the expected standard and was not equivalent to that he could have expected to receive in the community.

15. Isle of Wight's local policy is that the welfare of prisoners should be checked at each roll check, including the one during the lunch period. It is unlikely that Mr MacNeil received a welfare check, given that rigor mortis was evident when he was found just before 2.00pm.

16. The investigation also found that there were no key worker sessions between April and October 2019, at a time of particular turbulence for Mr MacNeil.

## Recommendations

- The Governor and Head of Healthcare should ensure that all staff have a clear understanding of their responsibilities in identifying, managing and supporting prisoners at risk of suicide or self-harm, including:
    - an awareness of the potential risk factors and triggers that might increase a prisoner's risk;
    - recording, acting on and sharing all relevant information on increased risk; and
    - opening ACCT procedures when appropriate.

- The Head of Healthcare should:
    - conduct a fresh review of in-possession medication risk assessments; and
    - ensure that staff know what events and triggers should prompt additional reviews.
- The Head of Healthcare should ensure that healthcare staff assess the mental capacity of prisoners who refuse care against medical advice and repeat capacity assessments regularly to ensure that their wishes have not changed.
- The Governor should:
    - ensure that staff responsible for completing roll checks satisfy themselves that each prisoner is alive and well; and
    - consider how best to ensure that staff understand what is required (as repeated written reminders do not seem to have been effective).
- The Governor should ensure that:
    - key workers are allocated sufficient time to fulfil their role;
    - key workers have regular contact with the prisoners allocated to them;
    - all interactions are recorded in prisoners' case notes; and
    - managers check compliance.

## The Investigation Process

17. The initial 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 her.

18. The initial investigator obtained copies of relevant extracts from Mr MacNeil's prison and medical records.

19. NHS England commissioned an independent clinical reviewer to review Mr MacNeil's clinical care at the prison.

20. Our investigation was suspended for several months while waiting for the cause of death. This has delayed the initial report.

21. Another investigator took over the investigation in June 2020. The investigator and clinical reviewer jointly interviewed two healthcare staff on 8 July. The investigator conducted four further interviews with operational staff on 8 and 15 July, and 5 August. All the interviews were conducted by telephone because of the restrictions imposed by the COVID-19 pandemic.

22. We informed HM Coroner for Isle of Wight of the investigation. She gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.

23. One of the Ombudsman's family liaison officers contacted both Mr MacNeil's partner and his daughter to explain the investigation and to ask if they had any matters they wanted the investigation to consider. Neither had any specific questions but wanted to receive copies of our report.

24. Mr MacNeil's partner and daughter received a copy of our initial report. They made no comments.

25. The initial report was shared with HM Prison and Probation Service (HMPPS). They found no factual inaccuracies and accepted our recommendations. The HMPPS action plan is annexed to this report.

# Background Information

### HMP Isle of Wight

26. 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.

### HM Inspectorate of Prisons

27. The most recent full inspection of HMP Isle of Wight was in April and May 2019. Inspectors found that relationships between staff and prisoners were good; prisoners had reasonable time out of their cells; and they engaged in purposeful activity. Inspectors reported that there had been a deterioration in the areas of safety, rehabilitation and release planning and levels of self-harm were high.

28. The inspectorate conducted an Independent Review of Progress in January 2020 to assess the prison's progress towards meeting the key recommendations. Generally, progress had not been good enough in the majority of areas. However, they found a significant difference between how work had progressed in areas for which local managers had responsibility and those that required national support from HMPPS. Local managers had made reasonable or better progress in five out of seven recommendations.

### Independent Monitoring Board

29. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report, for the year to December 2019, the IMB reported that the significant increase in self-harm was a major concern and the prison was developing a welfare review questionnaire, linked to practical support guidelines.

### Previous deaths at HMP Isle of Wight

30. Mr MacNeil's death was the 16th at Isle of Wight since October 2017. Of those previously investigated, 13 were from natural causes and two were self-inflicted. There have been three further deaths, two self-inflicted and one natural causes.

31. We have previously raised the issues of medication risk assessments and checking the wellbeing of prisoners when they are unlocked.

### Assessment, Care in Custody and Teamwork

32. 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.

## The key worker scheme

33. HMPPS's policy document, Manage the Custodial Sentence Policy Framework, sets out the minimum requirements needed to case manage those in custody from reception to the end of post-release supervision. This included the gradual introduction of the key worker role from September 2018, replacing the previous system of personal officers. Requirements of the scheme include:

- All prisoners in the male closed estate must be allocated to a key worker whose responsibility is to engage, motivate and support them throughout the custodial period.
- All prison officers who work on a residential unit will be allocated a maximum of six prisoners. Governors must ensure that time is made available for an average of 45 minutes per prisoner per week for delivery of the key worker role which includes individual time with each prisoner'.
- Key workers will record meetings, discussions and any progress that has been made on NOMIS in a detailed manner. These notes will be regularly checked as part of on-going quality assurance so it is important that they are sufficient.
- The Governor should ensure that key workers have regular contact with the prisoners allocated to them; that all interactions are recorded in prisoners' case notes; and that managers check compliance.

# Key Events

34. Mr Duncan MacNeil was convicted of murder on 8 October 1982 and sentenced to life imprisonment, with a minimum period to serve of ten years. Between 1992 and 2017, he was released and recalled several times. He also absconded three times from open prisons and spent over seven years at large in the community.

35. On 20 December 2017, Mr MacNeil was arrested for assault and threats to kill and remanded to HMP Isle of Wight. He was later convicted.

36. Mr MacNeil had had lifelong thoughts of ending his life and had previously attempted suicide. At initial and secondary health screens, it was noted that Mr MacNeil was an ex-heroin user, who had been drug-free since 2007. He denied any thoughts of suicide, or self-harm and said he had not harmed himself in the previous 12 months. Mr MacNeil showed clear signs of alcohol withdrawal and was referred to the GP, mental health team and the substance misuse service. A prison GP, then assessed Mr MacNeil and approved alcohol detoxification as an inpatient.

37. Reception staff opened the ACCT procedures because of Mr MacNeil's state of mind and previous self-harm. At his initial ACCT review that evening, Mr MacNeil said that he had tried to kill himself three times in the past and he admitted to active thoughts of suicide. Several multidisciplinary ACCT reviews were held over the following days. Mr MacNeil felt he had nothing to live for and repeatedly said that he would take his own life once he had decided on the means.

38. On 24 December, Mr MacNeil was found unconscious with a ligature around his neck. He was taken to hospital and placed on constant supervision on his return.

39. At mental health assessments on 28 and 29 December, Mr MacNeil spoke about his upbringing and suicidal thoughts that had started at the age of ten and lasted throughout his adult life. He said he was determined to kill himself by hanging or cutting and would wait for the opportunity to do so. A mental health care plan was created and Mr MacNeil saw the mental health team regularly. He also had meetings with the substance misuse service every three months.

40. On 21 February, Mr MacNeil told staff that he had cut his wrist the previous evening due to concerns about plans to transfer him. His partner lived on the island and she could not afford to visit him elsewhere. Staff temporarily removed Mr MacNeil from the transfer list.

41. The ACCT was closed on 15 March. Mr MacNeil then seemed to settle well and had a good rapport with staff and other prisoners. Following investigations by a neurologist in late 2018/early 2019, he was diagnosed with epilepsy (probably caused by alcohol abuse) and a vascular aneurysm (swollen blood vessel) in his brain.

42. After a hearing on 6 December, the Parole Board deferred their decision for five months, to obtain a full psychiatric report and other information. Mr MacNeil's offender supervisor thought that Mr MacNeil understood the rationale for the decision and had accepted that it might have been the best outcome.

43. At a mental health review on 11 February 2019, Mr MacNeil said that he had stopped taking his antidepressants and he had noticed no difference. He added that he did not feel particularly suicidal on that day, but it was always on his mind. The mental health nurse noted no signs of depression.

44. An officer was allocated as Mr MacNeil's key worker. They had an initial meeting on 3 April and an informal chat on 16 May. The key worker recorded no concerns.

45. The second Parole Board hearing was held on 20 May. Mr MacNeil believed the Board would recommend his release.

46. At a substance misuse meeting on 10 July, Mr MacNeil said he was still waiting for the Parole Board decision and hoped to get the result that week. He said, "The longer I stay in prison, the less I give a monkey's."

47. The Parole Board did not recommend Mr MacNeil's release. On 17 July, the offender supervisor spoke to Mr MacNeil about the decision. They also discussed re-categorisation and a transfer to another prison.

48. Following the Parole Board's decision, Mr MacNeil became demotivated, refused to cooperate with the prison regime and spent most of his days sleeping. On 30 July, he refused to sign a drug testing compact and said he was "passively non-complying" with his sentence plan/Parole Board recommendations. He explained to a substance misuse worker that the Parole Board felt that his continuing relationship with his ex-partner placed him at high risk of re-offending. He said he had two options – if released, he would be excluded from the island and prohibited from seeing his stepson, ex-partner and members of her family. Alternatively, he could remain in prison for another 12/18 months, by which time the relationship would be over.

49. Mr MacNeil said he was unhappy with both options and had decided that he would spend the rest of his life in custody as, even if he was released one day, he would be on very restrictive licence conditions. He had refused to see his new offender manager (probation officer) and had no intention of engaging with her in the future. Mr MacNeil said that his passive non-compliance included not attending work or mandatory drug tests and he withdrew from the substance misuse support.

50. On 12 August, a Community Mental Health Nurse held a mental health review. The nurse noted objectives of encouraging Mr MacNeil to comply with his epilepsy medication, discouraging him from negative thoughts of killing himself and discussing the way forward at a multidisciplinary meeting. He described Mr MacNeil's demeanour as reserved and unhappy, but he was polite and held meaningful conversation. During the review, Mr MacNeil said, "I am a lifer and already spent 32 years in prisons…I have tried all sorts of prisons, respect staff and regimes, but I cannot anymore. I just decided not to play their game anymore." He said parole had been refused nine times and he had been asked to do more work for two years. When asked about the grounds for refusal, he said, "They offer loads of reasons for saying no."

51. Mr MacNeil told the nurse that his current position was “passive non-compliance” and that he had stopped working and would not engage with the mental health or substance misuse services as directed by the Parole Board. He had received 28 days cellular confinement for refusing a drug test, with loss of exercise, canteen, television and gym. The nurse noted that Mr MacNeil showed frustration throughout the conversation, particularly when his key worker, or probation officer was mentioned. He said that he could not “see a light at the end of the tunnel” and that he would “surrender” himself because “they own my body and will be paying for my funeral, I will just wait for my time to come and die”.

52. On 15 August, the Community Mental Health Nurse held a follow-up mental health review with Mr MacNeil, noting objectives of discouraging self-destructive or damaging plans; and liaising with wing staff on the need to engage him in conversation and update mental health staff on any “strange behaviour or utterances”. The nurse noted that Mr MacNeil appeared more cheerful, but had started by saying, “Please do not fight my course (sic) as there are other residents that will benefit from your precious time.” He added, “I have detached myself, as I don’t want anything from them and neither do they have anything to offer me.”

53. Mr MacNeil told the nurse that after his recent 28 days on basic and cellular confinement, he had just started another 28 days and said:

> “What I have learnt most in my 32 years prison experience is the ability to absorb things. I have passed the level of depression, anger, violence, or causing self-destruction, to accept my faith (sic) and wait for them to do my funeral when the time comes.”

Mr MacNeil said he took his medication daily. He rejected attempts by the nurse to persuade him to try again for parole. There is no evidence that the nurse liaised with wing staff as intended or shared this information.

54. At meetings on 6 and 15 October, Mr MacNeil’s key worker noted Mr MacNeil continued to say that he saw no point in attending work, or any other wing activity. They agreed that he should move to a prison with a lifer unit, as his relationship had ended so there was no longer a reason for him to stay at Isle of Wight. The key worker said he thought that Mr MacNeil seemed happy about the move and saw it as a way forward.

### Events of 24 October 2019

55. At 1.57pm, an officer opened Mr MacNeil’s cell door, told him that he was locking up and asked if he was okay. He initially thought Mr MacNeil was asleep. After repeating himself three or four times, he nudged Mr MacNeil’s left knee, which was stiff. The officer called to another officer, who also nudged MacNeil, with no response. The officers knew from his condition that he was dead and they should not attempt resuscitation and an officer called a code blue emergency.

56. Healthcare staff arrived and checked Mr MacNeil. There were signs that he had been dead for some time as rigor mortis was present. A prison GP examined Mr MacNeil and certified him dead at 2.05pm.

### Contact with Mr MacNeil's family

57. The prison's family liaison officer, accompanied by an operational support grade staff member, visited Mr MacNeil's nominated next of kin, his ex-partner. They broke the news of Mr MacNeil's death, offered support and kept in touch with her. The family liaison officer and his deputy later spoke to other members of Mr MacNeil's family.

58. In line with national policy, the prison contributed to the costs of Mr MacNeil's funeral, which was held on 26 November 2019.

### Support for prisoners and staff

59. After Mr MacNeil'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 and staff were signposted to the Employee Assistance Programme.

60. The prison posted notices informing other staff and prisoners of Mr MacNeil'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 MacNeil's death.

### Post-mortem report

61. A post-mortem examination concluded that the cause of Mr MacNeil's death was an overdose of amitriptyline and codeine.

62. The findings from blood samples indicated amitriptyline at a level of 3.6mg/L. Therapeutic levels are less than 0.2mg/L and fatalities can occur at levels greater than 2mg/L. Codeine was detected at 6.6mg/L, therapeutic levels being less than 0.5mg/L and fatalities at 2mg/L.

# Findings

### Management of Mr MacNeil's risk of suicide and self-harm

63. Prison Service Instruction (PSI) 64/2011, which covers safer custody, requires staff to be aware of the risk factors and triggers that might increase a prisoner's risk of suicide and self-harm. Although such factors might not increase risk in every case, they should be alert to possible changes in risk. Staff are expected to speak to the prisoner and use their judgement, with all available evidence, to inform their decision about risk and act appropriately to address any concerns, including opening an ACCT if necessary.

64. Mr MacNeil had a history of self-harm and lifelong suicidal thoughts. Reception staff identified his raised risk and he was closely and appropriately managed under the ACCT procedures for his first three months at Isle of Wight. Mr MacNeil self-harmed twice during this period.

#### *Assessment of risk after adverse parole decision and disengagement with regime*

65. Following Parole Board hearings in December 2018 and May 2019, Mr MacNeil believed that he would be released from prison. However, after being notified in July that the Parole Board had decided he should not be released, his attitude immediately changed. He became demotivated, disengaged from work and activities and spent most of his time asleep.

66. Mr MacNeil's key worker could not remember the detail of any conversation about the decision, but said he felt that Mr MacNeil was not surprised and that he had noticed no change in his demeanour. Mr MacNeil's offender supervisor said that Mr MacNeil's reaction to the decision was incredulity as they were both convinced that he would have been successful, but he appeared to be stoical and there was no hint of suicide or self-harm.

67. Mental health reviews with the Community Mental Health Nurse in August 2019 were intended to help prevent negative thoughts of suicide/self-destruction. Mr MacNeil made several worrying statements about hopelessness and death, but there is no evidence that the nurse assessed his risk of suicide and self-harm, or took any other action as a result of this.

68. Mr MacNeil had recently experienced several of the potential triggers listed in PSI 64/2011, including relationship problems, parole refusal, chronic illnesses, hopelessness and a lack of social support. In a PPO thematic report about self-inflicted deaths, published in April 2014, we found that staff conducting risk assessments often placed insufficient weight on known risk factors and too much on perceptions of the prisoner's behaviour and demeanour.

69. Assessment of risk is not an exact science. While we do not wish to second-guess the judgements of the offender supervisor and key worker on the impact of the parole decision, it is possible that they placed more importance on Mr MacNeil's presentation and did not give sufficient consideration to his known risk factors and potential triggers. We recognise, however, that Mr MacNeil may have masked his true feelings during his meetings with them and that a considerable time had elapsed since his previous acts of self-harm. We are

satisfied that there were no clear signs to merit starting ACCT monitoring, but we consider that both the key worker and the offender supervisor should have documented their discussions around risk in more detail after the parole decision.

70. Of greater concern are the actions of the Community Mental Health Nurse, whose remit was to help deter Mr MacNeil's thoughts of suicide. The nurse was fully aware of Mr MacNeil's disengagement from the regime and had noted his explicit statements about death in their discussions. At interview, both a prison GP and the Head of Healthcare said that these remarks should have led the Community Mental Health Nurse to consider opening the ACCT process and taking other action. (The Community Mental Health Nurse is an agency nurse. He had left the prison and was unavailable for interview.)

71. We are concerned that the Community Mental Health Nurse apparently overlooked Mr MacNeil's increased risk factors and failed to share, or act on comments which suggested he might be at increased risk. This was a missed opportunity to formally review his risk and consider how best to further support him and address any needs. We make the following recommendation:

**The Governor and Head of Healthcare should ensure that staff, including agency staff, have a clear understanding of their responsibilities in identifying, managing and supporting prisoners at risk of suicide or self-harm, including:**

- **an awareness of the potential risk factors and triggers that might increase a prisoner's risk;**
- **recording, acting on and sharing all relevant information on increased risk; and**
- **opening ACCT procedures when appropriate.**

## Clinical care

72. The clinical reviewer identified several shortcomings in Mr MacNeil's clinical care. Those linked to Mr MacNeil's death are discussed below.

### *Medication risk assessments and stockpiling*

73. Mr MacNeil had been prescribed several medications, including amitriptyline (an antidepressant which he used for pain relief). From 23 October 2018, his medication was dispensed daily in-possession, meaning he collected it daily and took the doses in his cell at the relevant time. This level of dispensing did not require Mr MacNeil to take the medication in front of healthcare staff at the medication hatch. A medication risk assessment was completed, with the default setting of an annual review. The clinical reviewer was concerned that daily prescribing should have been reviewed more frequently than annually, especially as Mr MacNeil had a history of attempted suicide.

74. We had previously investigated a suicide at Isle of Wight in 2018 in which the prisoner knowingly took an overdose of amitriptyline which he had stockpiled in his cell. Following that investigation, we recommended that the Head of Healthcare should ensure that staff completing medication in-possession risk

assessments considered all relevant information, including information about recent self-harm.

75. A prison GP said that healthcare staff had implemented the PPO recommendation and every prisoner who had been prescribed amitriptyline, including Mr MacNeil, had been reviewed. He said they considered it appropriate to continue Mr MacNeil's prescription.

76. We consider that any significant change in a prisoner's status or behaviour should also lead to a review of in-possession medication. We agree with the clinical reviewer that the adverse outcome of Mr MacNeil's parole hearing potentially increased his risk, and that this information should have prompted a review.

### *Mental healthcare*

77. Mr MacNeil was diagnosed with depression and prescribed antidepressants when he arrived at Isle of Wight. A mental health care plan was in place and he was regularly reviewed. Mental health staff also attended his ACCT reviews.

78. After the parole decision in July 2019, Mr MacNeil made some worrying remarks about death to the Community Mental Health Nurse and later refused both physical and mental healthcare. A prison GP and the Head of Healthcare said that, as well as prompting consideration of ACCT, these remarks should have been reported to the mental health team and discussed at a multidisciplinary meeting, which, in turn, should have prompted a medication review. The clinical reviewer was also concerned that after refusing all healthcare, Mr MacNeil's mental capacity to make an informed decision was not formally assessed and there was no follow up to find out if his wishes remained the same.

79. We share the clinical reviewer's concern that these shortcomings made it possible for Mr MacNeil to continue receiving his medication in-possession and stockpile enough to take an overdose. It seems that our recommendations after the previous death in very similar circumstances did not lead to the robust changes required to prevent such stockpiling. The clinical reviewer believes that more effective action might have prevented Mr MacNeil's death.

80. We agree with the clinical reviewer that Mr MacNeil's care was not of the required standard and therefore not equivalent to that which he could have expected to receive in the community. We make the following recommendations:

**The Head of Healthcare should conduct a fresh review of in-possession medication risk assessments to determine how and when planned reviews of risk should take place; and ensure that staff know what events and triggers should prompt additional reviews.**

**The Head of Healthcare should ensure that healthcare staff assess the mental capacity of prisoners who refuse care against medical advice and repeat capacity assessments regularly to ensure that their wishes have not changed.**

81. The clinical reviewer also made recommendations on aspects of Mr MacNeil's care unrelated to his death the Head of Healthcare will need to consider.

### Welfare checks

82. In response to recommendations after a previous PPO investigation, the Governor issued guidance to staff in May and October 2019, reminding them of the importance of welfare checks. Further guidance, Notice to Staff (NTS) 200/2019 Roll Checks and Welfare Checks, was issued on 13 November 2019. The aim was to clarify misunderstandings among staff about the purpose and timings of such checks. The notice explicitly states that a roll check is both a count of prisoners and a welfare check in which a response should be obtained. These should take place at 6.30am, 12.15pm, 5.15pm and 7.15pm. In addition, there should be a welfare check during morning unlock at 7.45am

83. Cell doors at Isle of Wight are electronically unlocked in the morning and at lunchtime. We do not know when Mr MacNeil was last seen alive, but two prisoners thought they saw him at around 9.00am. Prisoners are checked off a list when they collect their meals. Mr MacNeil did not collect his lunch and no one appears to have asked why.

84. An officer was responsible for the lunchtime roll check after cells were unlocked. At interview, he could not recall anything in particular about the task that day. He said that, at that time, there was no requirement for a welfare check in the morning or at lunchtime and that prisoners had complained about being woken up, but since Mr MacNeil's death, welfare checks are routinely completed.

85. We are concerned that despite repeated written reminders, staff are either still unclear about, or wilfully ignoring the requirement to check the wellbeing of prisoners at key times. It is essential for prisoners' welfare that Isle of Wight achieves compliance with this instruction. We therefore repeat the following recommendation:

**The Governor should:**

- **ensure that staff responsible for completing roll checks satisfy themselves that each prisoner is alive and well; and**
- **consider how best to ensure that staff understand what is required (as repeated written reminders do not seem to have been effective).**

### Key worker meetings

86. Mr MacNeil had an introductory meeting with his initial key worker, on 3 April 2019 and they spoke briefly and informally on 16 May. The date that another officer took over as his key worker was not recorded in Mr MacNeil's personal records. There is no evidence of any further key worker meetings until 15 October, nine days before his death.

87. We are concerned that Mr MacNeil did not have the benefit of consistent support when he had clearly become demotivated due to his relationship problems and the decision about his release. We cannot say whether the additional support of a key worker during this period would have made a difference to him, but it is clear that he did not get the level of support expected from the process at a critical time. We make the following recommendation:

**The Governor should ensure that:**

- **key workers are allocated sufficient time to fulfil their role;**
- **key workers have regular contact with the prisoners allocated to them;**
- **all interactions are recorded in prisoners' case notes; and**
- **managers check compliance.**

Prisons & Probation Ombudsman
Independent Investigations

Third Floor, 10 South Colonnade
Canary Wharf, London E14 4PU

Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk

T I 020 7633 4100
F I 020 7633 4141