Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Dwayne Sunderland, a prisoner at HMP Isle of Wight, on 10 November 2019

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Our vision

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

Our values

We are:

Impartial: we do not take sides

Respectful: we are considerate and courteous

Inclusive: we value diversity

Dedicated: we are determined and focused

Fair: we are honest and act with integrity

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

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

Mr Dwayne Sunderland was found hanged in his cell at HMP Isle of Wight on 10 November 2019. He was 36 years old. I offer my condolences to Mr Sunderland's family and friends.

In September 2019, Mr Sunderland referred himself to the mental health team because he was concerned his paranoia was affecting his relationship with his partner. A mental health nurse met with him several times and had no concerns about his risk of suicide and self-harm. A few days before Mr Sunderland's death, his partner ended their relationship. Staff did not know this. Mr Sunderland left a note to his partner saying he could not live without her.

I am satisfied that Mr Sunderland gave no indication to staff that he was at imminent risk of suicide and that staff could not have foreseen his death.

However, the investigation found failings in the assessment of Mr Sunderland's risk when he first arrived at Isle of Wight. Although we do not consider that this contributed to his death 19 months later, such failings could be significant in other cases.

We also found that Mr Sunderland's key worker failed to meet with him at all in the two months before his death. It is possible that his key worker may have known about Mr Sunderland's relationship problems, and put appropriate support in place, if they had met regularly.

Mr Sunderland was found hanged in his cell by a prisoner at about 9.00am around 15 minutes after cells had been unlocked remotely. Staff recorded that they had carried out a roll check at 6.00am, but it is unclear whether it included a check on prisoners' welfare. There was confusion among staff about what checks were required. It is not acceptable that a prisoner discovered Mr Sunderland. The prison must ensure that they give clear guidance to staff on checking the welfare of all prisoners before they are unlocked in the morning.

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 **October 2020**

Contents

Summary

Events

1. On 12 April 2017, Mr Dwayne Sunderland was sentenced to 17 years imprisonment for child sexual offences.

2. Between 9 and 10 April 2018, while at HMP Leicester, Mr Sunderland was monitored under suicide and self-harm prevention procedures (known as ACCT) when he threatened to kill himself after he was told he would be moving to HMP Isle of Wight.

3. Mr Sunderland was moved to Isle of Wight on 12 April. He told staff that he wanted to move to another prison as it would be difficult for his family to visit him there. However, in December 2018, he said he no longer wanted to move as he was settled at Isle of Wight and enjoying his work as a gym orderly. He was receiving regular visits and telephone contact from his partner and family.

4. On 25 September 2019, Mr Sunderland referred himself to the mental health team. He had three appointments with a mental health nurse in October. Mr Sunderland told the nurse he was concerned that his paranoia was affecting his relationship with his partner. At his last appointment on 12 October, the nurse recorded that she had no concerns about suicide or self-harm. She agreed to see him again in early November but was unable to do so.

5. Sometime before 8 November, Mr Sunderland's partner ended their relationship. Mr Sunderland did not tell staff about this.

6. At around 8.45am on 10 November, the cells on Mr Sunderland's wing were unlocked remotely. Around 15 minutes later, a prisoner pressed the general alarm. Staff attended and found Mr Sunderland hanging from a hinge behind his cell door. Staff called a medical emergency code over the radio and cut him down. There were signs that Mr Sunderland had been dead for some time so staff did not try to resuscitate him.

7. Ambulance staff attended at approximately 9.15am and confirmed that Mr Sunderland was dead.

8. Mr Sunderland left a suicide note addressed to his partner. It said that he loved her and could not live without her.

Findings

9. Staff did not know that Mr Sunderland's partner had ended their relationship a few days before his death, and Mr Sunderland gave no indication to staff that he was at imminent risk of suicide. We consider that staff could not have foreseen his actions.

10. However, there were failings in the assessment of Mr Sunderland's risk when he first arrived at Isle of Wight in April 2018. Mr Sunderland was in the post-closure phase of ACCT monitoring when he moved from Leicester to Isle of Wight. Reception staff did not recognise this and assessed him as suitable for in-possession medication, despite him having recently been monitored under ACCT

and telling the reception nurse that he had previously attempted suicide by overdose. Staff at Isle of Wight also failed to hold an ACCT post-closure interview with Mr Sunderland.

11. Although we do not consider that these failings contributed to Mr Sunderland's death 19 months later, they could be significant in other cases.

12. We are concerned that Mr Sunderland's new key worker did not see him at all in the two months before he died. This may have been a missed opportunity to identify that Mr Sunderland's relationship problems placed him at risk of suicide and self-harm.

13. A prison GP stopped prescribing Mr Sunderland's antidepressant medication in June 2018, after he stopped collecting it. The clinical reviewer considered that the GP should have reviewed Mr Sunderland's medication, rather than just stopping it.

14. We are also concerned about the checks carried out on prisoners' welfare on the morning of Mr Sunderland's death. It is unclear whether the roll check carried out at 6.00am included a check on prisoners' welfare. Welfare checks were completed at 7.30am, but only for prisoners who were being monitored under ACCT, so Mr Sunderland was not checked.

15. Checks should be made on all prisoners' welfare before they are unlocked in the morning and the prison needs to ensure that staff have clear guidance on this.

Recommendations

- The Governor and Head of Healthcare should ensure that reception staff:
    - examine all available documentation on the prisoner and consider and record all known risk factors for suicide and self-harm; and
    - where there are risk factors for suicide and self-harm, consider carefully whether the prisoner should be given in-possession medication and record the reasons for the decision.
- The Governor should ensure that staff follow ACCT post-closure procedures, including that they hold ACCT post-closure interviews and complete the correct paperwork.
- The Governor should ensure that:
    - the key worker scheme is effective in providing meaningful support to prisoners;
    - staff are provided with adequate key worker time and promptly informed of any changes to their caseload; and
    - contacts take place in accordance with the national policy framework.
- The Governor should review the prison's local instructions on roll checks and welfare checks to ensure that:
    - staff are clear about the type of check required, when they should do it, and how the check should be carried out;
    - a welfare check is carried out on all prisoners at or before unlock;
    - completion of checks is accurately recorded; and

    - staff carry out checks in accordance with the prison's local instruction and relevant national guidance.
- The Head of Healthcare should ensure that staff carry out a review when a prisoner stops collecting their prescribed medication and that they clearly record the decision to alter dosages or discontinue medication.

The Investigation Process

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

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

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

19. The investigator and clinical reviewer jointly interviewed six members of staff at Isle of Wight. The investigator separately interviewed two members of staff and one prisoner. The interviews took place between November 2019 and May 2020.

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

21. One of the Ombudsman's family liaison officers contacted Mr Sunderland's next of kin to explain the investigation and to ask whether there were any matters she wanted the investigation to consider. Mr Sunderland's next of kin asked whether he was being monitored under suicide and self-harm procedures.

22. We shared our initial report with Mr Sunderland's family. They identified a factual inaccuracy which has been amended on this report.

23. We shared our initial report with the Prison Service. The Prison service identified a factual inaccuracy which has been amended on this report. We also agreed to change the wording on one of our recommendations.

Background Information

HMP Isle of Wight

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

25. Mr Sunderland lived on House Unit 12 on the Albany site. This House Unit has an electronic unlocking system operated by the prison's control room. At night, prisoners are electronically unlocked one at a time if they need to use the toilet.

HM Inspectorate of Prisons

26. The most recent full inspection of HMP Isle of Wight was in April and May 2019. Inspectors reported that there had been a deterioration in the areas of safety and rehabilitation and release planning. Levels of self-harm were high and some previous PPO recommendations on the response to medical emergencies had not been implemented. Inspectors found that prisoners had reasonable time out of their cells and were engaging in purposeful activity. They also found that relationships between staff and prisoners were good.

27. HMIP conducted an Independent Review of Progress at Isle of Wight in January 2020 to assess the prison's progress towards meeting the Inspectorate's key recommendations. Taken as a whole, they found progress had not been good enough in the majority of areas. However, they found a significant difference between how work had progressed in areas local managers had responsibility for and those that required national support from HMPPS. Local managers had made reasonable or better progress in five out of seven recommendations, including ensuring that staff understood their roles and responsibilities in a medical emergency and that an ambulance was called when an emergency code was used.

Independent Monitoring Board

28. 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 31 December 2018, the IMB reported a 26% increase in incidents of self-harm during 2018. They welcomed improvements in the reception process and the development of the keyworker scheme. They also reported that prison staff provided fair and equitable treatment for all prisoners.

Previous deaths at HMP Isle of Wight

29. Mr Sunderland was the 16th prisoner to die at Isle of Wight since November 2017. Of the previous deaths, two were self-inflicted and 13 were from natural causes.

30. Our investigation into the death of a prisoner in November 2018, found that the quality of roll checks was poor and staff should have identified that the prisoner needed medical attention much sooner than they did.

Key worker scheme

31. 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.

Key Events

32. On 31 October 2016, Mr Dwayne Sunderland was remanded in custody and sent to HMP Altcourse. He was moved to HMP Liverpool in February 2017. On 12 April, he was sentenced to 17 years imprisonment for child sexual offences.

33. After Mr Sunderland was sentenced, staff at Liverpool monitored him under suicide and self-harm prevention procedures (known as ACCT) for two days. Mr Sunderland was subsequently moved back to Altcourse and then to HMP Leicester in February 2018.

34. On 9 April, staff at Leicester started ACCT procedures after Mr Sunderland said that he would kill himself, when staff told him that he was going to be moved to HMP Isle of Wight. Staff stopped ACCT monitoring the following day after Mr Sunderland said he accepted his move to Isle of Wight was necessary and he understood that his family would still be able to visit him.

HMP Isle of Wight

2018

35. Mr Sunderland was moved to Isle of Wight on 12 April. The Person Escort Record (PER – a document that accompanies prisoners between police custody, courts and prisons, which sets out the risks they pose) showed that he had recently been monitored under ACCT.

36. A nurse completed Mr Sunderland's reception healthcare screening. Mr Sunderland told the nurse that he had previously attempted suicide in 2016 but that he had no current thoughts of suicide or self-harm. She noted that he was on prescribed medication for depression and anxiety but she did not record that he had recently been monitored under ACCT procedures. She assessed that he was suitable to have his medication in possession and referred him to the doctor. She noted that Mr Sunderland did not want to be referred to the substance misuse team.

37. On 13 April, a prison GP saw Mr Sunderland. The GP noted that Mr Sunderland had a depressive disorder, but that he had no current thoughts of suicide or self-harm and he did not want to be referred to the mental health team. The GP did not record that Mr Sunderland had recently been monitored under ACCT. Mr Sunderland asked for an increased dose of his antidepressant medication. The GP prescribed Mr Sunderland's usual dose but noted that he would review the request for an increased dose once he had settled in.

38. On 15 April, a Custodial Manager (CM) updated Mr Sunderland's prison record (NOMIS) to say that an ACCT post-closure review had been held with Mr Sunderland and the ACCT was closed. No further detail of the discussion with Mr Sunderland was noted in NOMIS or the ACCT document. The CM told the investigator that he did not carry out a post-closure interview with Mr Sunderland. He said that the entry in NOMIS was automatically generated when he reviewed the ACCT alert. The CM said he had not seen Mr Sunderland's ACCT document at that time but decided to close off the ACCT alert on NOMIS after he checked that

Mr Sunderland was settled and he was no longer considered to be at risk of suicide or self-harm.

39. In June, a prison GP stopped Mr Sunderland's antidepressant medication after he stopped collecting it. We found no evidence that anyone discussed this with Mr Sunderland.

40. In July, a substance misuse worker met Mr Sunderland. She gave him some in-cell work to do and arranged to see him again in four weeks.

41. In August, Mr Sunderland requested a transfer to another prison.

42. In September, an officer met with Mr Sunderland for the first time and introduced himself as his allocated personal officer. The officer noted in Mr Sunderland's prison record that he had no concerns about him and that he was making good progress.

43. Later that month, a substance misuse worker completed the substance misuse in-cell work with Mr Sunderland. She told the investigator that she had decided to help him with it after Mr Sunderland told her he had problems with reading and writing. She noted that Mr Sunderland engaged well with the work. She noted that he had a supportive family and was receiving daily phone contact and fortnightly visits. She agreed to see him again in three months.

44. On 29 September, Mr Sunderland's personal officer saw Mr Sunderland again. He reported no concerns and considered Mr Sunderland was making positive progress. Mr Sunderland's personal officer met with him again on 28 October and 24 November.

45. In November, Mr Sunderland completed modules one and two of the substance misuse Introduction to Recovery programme and started the peer support group. In December, Mr Sunderland completed the Alcohol Awareness Workshop.

46. On 27 December, Mr Sunderland told his offender supervisor that he no longer wanted to move away from Isle of Wight. He said he was settled and enjoying his work as a gym orderly and he wanted to work towards getting gym qualifications.

2019

47. On 25 January 2019, an officer noted that Mr Sunderland was enjoying his work as a gym orderly, he was keeping himself and his cell clean and tidy and he had good relationships with staff and prisoners. The officer noted that Mr Sunderland continued to have a good level of family contact.

48. On 3 May, Mr Sunderland completed the substance misuse Inclusion Recovery Programme.

49. On 31 May, an officer, who had been appointed as Mr Sunderland's key worker, had an initial key worker session with Mr Sunderland. He noted that he asked Mr Sunderland to think about his future goals and targets and they would discuss further at their next session.

50. On 5 July, Mr Sunderland told his key worker that he needed to complete a specific relationships programme as part of his sentence progression. The officer advised him to discuss it with his offender supervisor and to apply for the course.

51. On 17 July, Mr Sunderland received a reward and recognition bonus for helping others. Mr Sunderland's key worker noted that he was in good spirits and proud of his achievement when they met later that day.

52. On 19 July, the substance misuse worker met with Mr Sunderland. She recorded that he reported being fit and healthy and he had worked on losing weight. She had no concerns about Mr Sunderland and felt he was making positive progress.

53. On 1 August, Mr Sunderland received a further positive behaviour entry for helping out and taking part in a charity gym event.

54. On 15 August, Mr Sunderland's key worker noted that Mr Sunderland continued to make positive progress and he had no concerns about him.

55. On 20 August, the substance misuse worker noted that she met with Mr Sunderland. He told her that he was hoping to stay at Isle of Wight as he felt settled. She noted no concerns about substance misuse. This was her last appointment with Mr Sunderland.

56. On 9 September, Mr Sunderland's key worker told him that he had received a reply about his sentence progression and attendance on the relationships programme. The officer said that, as Mr Sunderland was not eligible for parole until around 2025, he was not a priority for attending the programme. The officer told the investigator that Mr Sunderland appeared to accept this.

57. On 23 September, an officer noted on Mr Sunderland's prison record that he had been appointed as his new key worker but that he did not have time to see him. He wrote a similar entry on 30 September. The officer told the investigator he works on reception which makes key worker duties more difficult than if working on the wing with prisoners. He said that, although he was allocated key worker time, this was often late in the evening when prisoners were locked up. He said it was not practical to carry out key worker sessions with Mr Sunderland at the times he was allocated.

58. On 25 September, Mr Sunderland made a self-referral to the mental health team. He said he needed help to address paranoia and depression. Mr Sunderland was allocated to a mental health practitioner.

59. The mental health practitioner met Mr Sunderland on 2 October for a mental health assessment. She noted that his main concerns were around paranoia and the effect on his relationship. Mr Sunderland told her that this was a long-term issue which was linked to past traumatic experiences and a mistrust of others. She noted that he had made good progress in engaging with the substance misuse team - he had tested negative in mandatory drugs tests in July and on 1 October - and looking after his health. She noted that he was looking for psychological work to help his recovery and his anxiety about relationships. She noted no concerns about suicide or self-harm. She agreed to see him the following week.

60. On 8 October, the mental health practitioner saw Mr Sunderland again. He told her that he had tried to be aware of his paranoia and anxiety when speaking to his

partner on the phone but he had found it difficult. The mental health practitioner provided him with some guidance sheets on managing intrusive thoughts and traumatic experiences. She noted no concerns about suicide or self-harm and agreed to see him the following week.

61. On 12 October, the mental health practitioner saw Mr Sunderland for another session. He told her that he was having problems sleeping and concentrating. He said his paranoia and anxiety were continuing to affect his relationship and he had questioned his partner about having an affair. Mr Sunderland said that his partner told him she was unable to cope with his behaviour, but he said he had apologised to her and he was working on trying to address his issues.

62. The mental health practitioner noted that Mr Sunderland had some negative thoughts about himself and his behaviour, but she did not consider he was at risk of harm to himself or others. She put a plan in place that he should start some group work around anxiety and should continue to engage with the substance misuse team. She agreed to see him again in the first week of November. However, this meeting did not go ahead as she was unexpectedly away from work following an accident.

63. On 25 October, Mr Sunderland's offender supervisor saw him while he was at work in the gym. He noted that Mr Sunderland wanted to talk about his security category review and they agreed to arrange a more in-depth discussion at a later date.

Events of 9-10 November

64. On the evening of 9 November, an officer carried out the evening roll check on House Unit 12 (HU12) at around 7.15pm. The officer said that she spoke briefly to Mr Sunderland before the prisoners were locked in their cells for the night. She said they spoke about his day at work and she described him as being in good spirits. She said she had no concerns about him. She completed a handover with the night operational support grade (OSG), and went off duty around 8.20pm.

65. The night sanitation record shows that Mr Sunderland left his cell for a few minutes, shortly after 1.00am, to use the toilet.

66. At 6.00am on 10 November, the night OSG signed the wing observation diary to show that he had completed a morning roll check of all prisoners on HU12.

67. At 7.30am, an officer signed the wing diary to show that a welfare check had been completed on all prisoners on HU12. At interview, the officer said that a welfare check had not in fact been completed on all prisoners, only those who were subject to ACCT monitoring. She said that in the past, staff had done a welfare check on all prisoners at 7.30am, but this was no longer required. She believed that the welfare check was carried out by the night OSG at the same time as the 6.00am roll check.

68. The prisoners on HU12 were automatically unlocked by the control room using the electronic unlock system at around 8.45am.

69. At approximately 9.00am, the prisoner in the neighbouring cell to Mr Sunderland pressed a general alarm. An officer responded immediately and looked through the observation panel of Mr Sunderland's cell. He knew that something was wrong so he went into the cell and saw Mr Sunderland hanging from the hinge behind the

door. He immediately called a code blue (a medical emergency code which tells the control room that a prisoner is unresponsive or not breathing and that an ambulance needs to be called immediately).

70. An officer said he was ready to cut the ligature but he could not see it straightaway. Another officer arrived and helped to lift Mr Sunderland's body so that the officer could cut the ligature. Both officers described Mr Sunderland's body as being stiff and they believed he was dead. Healthcare staff arrived and confirmed that rigor mortis was present so cardiopulmonary resuscitation (CPR) was not attempted.

71. Paramedics arrived around 9.15am and confirmed that Mr Sunderland was dead.

Information received after Mr Sunderland's death

72. Mr Sunderland's telephone records showed that he had made calls to his next of kin and his partner on 8 and 9 November. His partner did not want to speak to him as she had ended their relationship. He suspected that she was in a relationship with someone else and he was upset about this when speaking to his next of kin on the afternoon of 9 November.

73. Mr Sunderland left a suicide note addressed to his partner in his cell. He wrote that he loved her and their child, but he could not live without her.

Contact with Mr Sunderland's next of kin

74. Mr Sunderland's partner was listed as his next of kin. As she lived some distance from the prison, the local police broke the news of his death to her. Mr Sunderland's partner said that she had ended their relationship and she asked that the prison liaise with his mother as his next of kin instead. The prison's family liaison officer contacted Mr Sunderland's next of kin by phone at approximately 3.00pm on 10 November to tell her that her son had died. The prison contributed to the cost of Mr Sunderland's funeral in line with national guidance.

Support for prisoners and staff

75. The duty governor held a debrief for staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and for managers to offer support. The staff care team also offered support.

76. The prison posted notices informing staff and prisoners of Mr Sunderland'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 Sunderland's death.

Post-mortem report

77. The post-mortem examination found that Mr Sunderland died as a result of hanging. The toxicology tests found no traces of alcohol or illicit substances in Mr Sunderland's body.

Findings

Assessment of risk of suicide and self-harm

78. Mr Sunderland's partner ended their relationship a few days before he died, but staff were unaware of this and Mr Sunderland gave no indication to staff that he was at imminent risk of suicide. We are satisfied that staff could not have foreseen his actions.

79. However, we are concerned that there were failings in the assessment of Mr Sunderland's risk when he first arrived at Isle of Wight on 12 April 2018 only two days after ACCT monitoring had been stopped at his previous prison.

80. Prison Service Order (PSO) 1025, Communicating Information About Risks on Escort or Transfer, sets out when the suicide and self-harm section of the PER should be completed, which includes when the prisoner "has recently been, at risk of self-harm (e.g. post closure phase of ACCT plan, PNC suicide/self-harm warning marker in the last six months)". The PER that accompanied Mr Sunderland noted that he had recently been monitored under ACCT procedures until 10 April.

81. Despite the information received from Leicester, reception staff at Isle of Wight failed to recognise that Mr Sunderland was in the post-closure phase of an ACCT. He told staff that he had no recent thoughts of suicide or self-harm and no one challenged this. Furthermore, he was prescribed in-possession medication even though he told staff that he had previously attempted suicide by overdose in 2016.

82. During the investigation, the ACCT document was made available to the investigator but it is not clear when this was received at Isle of Wight. However, staff at Leicester had noted in Mr Sunderland's NOMIS record, as well as in the ACCT document, that he was due to have an ACCT post-closure interview by 16 April. A CM updated Mr Sunderland's NOMIS record on 15 April to show that the post-closure interview had taken place, even though it had not. The CM did not include any other information to show that he had not seen Mr Sunderland's ACCT document, nor did he record the basis on which he considered that Mr Sunderland was no longer at risk. We do not consider that this was acceptable.

83. We are concerned that Mr Sunderland was not adequately assessed on reception and that ACCT procedures were not correctly followed. While we do not consider that this affected the eventual outcome for Mr Sunderland, it could be crucial in other similar situations. We therefore make the following recommendations:

The Governor and Head of Healthcare should ensure that reception staff:

- **examine all available documentation on the prisoner and consider and record all known risk factors for suicide and self-harm; and**
- **where there are risk factors for suicide and self-harm, consider carefully whether the prisoner should be given in-possession medication and record the reasons for the decision.**

The Governor should ensure that staff follow ACCT post-closure procedures, including that they hold ACCT post-closure interviews and complete the correct paperwork.

Key worker support

84. We found that Mr Sunderland had a satisfactory level of support from his allocated personal officer. When another officer took over as Mr Sunderland's key worker in May 2019, we found evidence that he had regular contact with Mr Sunderland. We also consider that Mr Sunderland engaged well with the officer and it is likely that he found the key worker sessions of some benefit.

85. However, Mr Sunderland was not informed when his key worker changed and after 9 September he had no key worker sessions in the two months before he took his life. The newly allocated key worker said that he did not have time to see Mr Sunderland due to his own working patterns and the key worker times that were allocated to him. We consider that this was unacceptable and not in accordance with the requirements of the key worker scheme. We are concerned that this was a possible missed opportunity to identify that Mr Sunderland's relationship problems placed him at risk of suicide and self-harm.

86. We make the following recommendation:

The Governor should ensure that:

- **the key worker scheme is effective in providing meaningful support to prisoners;**
- **staff are provided with adequate keyworker time and promptly informed of any changes to their caseload; and**
- **contacts take place in accordance with the national policy framework.**

Roll and welfare checks

87. We have concerns about the effectiveness of the checks that were carried out and the way they were documented.

88. Guidance on conducting roll checks at Isle of Wight is set out in a local instruction dated April 2014. It says that the purpose of a roll check is to ensure that the prison roll is correct and that every prisoner is accounted for. The instruction does not specify exactly what staff need to do at a roll check.

89. Following a PPO investigation into the death of a prisoner at Isle of Wight in November 2018, the Governor issued a Notice to Staff (NTS) on 16 May 2019, stating:

"I would like to remind staff of the importance of ensuring that a welfare check on all residents is conducted at the morning unlock. All staff must ensure that they are satisfied that all residents are alive and well and that a verbal response is obtained on morning unlock."

90. We found, however, that staff do not carry out a welfare check on HU12 prior to unlock as the prisoners are unlocked electronically by the control room. The CM said that staff on HU12 carry out the welfare check after the cells have been electronically unlocked.

91. Following Mr Sunderland's death, the Governor issued a further NTS on 19 November 2019. It said there was 'confusion' and 'misunderstanding' around roll checks and welfare checks. It went on to say that "a roll check is a welfare check and physical count of each prisoner" and it then set out the times that checks should be made. The notice stated that staff should sign the wing diary to confirm they have completed the check as required.

92. There is no CCTV on HU12 so we relied on the information recorded in the wing diary and obtained at interview. The night OSG signed the wing diary to say he had conducted a roll check at 6.00am on 10 November. A roll check should include a visual sighting of the prisoner so, if the information in the wing diary is correct, the OSG would have seen Mr Sunderland alive at 6.00am. We were unable to interview the OSG as he is an agency worker who no longer works at Isle of Wight and did not respond to requests to be interviewed.

93. An officer signed the wing diary to say that a welfare check on all prisoners had taken place at 7.30am. The officer said at interview that the 7.30am welfare check was only for prisoners who were subject to ACCT monitoring, not all prisoners. A welfare check should involve a visual sighting and a verbal response from the prisoner.

94. We found the guidance on roll and welfare checks to be inconsistent and unclear. Indeed, the NTS that was issued after Mr Sunderland's death referred to confusion and misunderstanding among staff. We are concerned that the wing diary was signed to show that a full welfare check had been completed when it had not. This was inaccurate and misleading. We do not consider this to be a failing on the part of any particular staff member. Rather, we found it to be a failing in the guidance provided to staff. The local instruction on roll checks was updated in February 2020, but it still did not clearly set out exactly what staff need to do, in terms of checking on the prisoner, when conducting a roll check.

95. We do not know the exact time of Mr Sunderland's death but we know he was alive shortly after 1.00am when he came out of his cell to use the toilet. We also know that Mr Sunderland had been dead for some time by the time he was found at 9.00am as rigor mortis (which normally sets in two to six hours after death) was present. It is, therefore, possible that Mr Sunderland was already dead when an OSG said he carried out the roll check at 6.00am. And he was certainly dead at 7.30am when the welfare check took place on the prisoners subject to ACCT.

96. If a welfare check had taken place before prisoners were unlocked, as should have happened, Mr Sunderland would have been discovered by staff. As it was, he was discovered by a vulnerable prisoner who was subject to ACCT monitoring at the time.

97. We therefore make the following recommendation:

The Governor should review the prison's local instructions on roll checks and welfare checks to ensure that:

- **staff are clear about the type of check required, when they should do it, and how the check should be carried out;**
- **a welfare check is carried out on all prisoners at or before unlock;**
- **completion of checks is accurately recorded; and**

- **staff carry out checks in accordance with the prison's local instruction and relevant national guidance.**

Clinical care

98. The clinical reviewer found that Mr Sunderland received a good standard of clinical care. Mr Sunderland was offered appropriate support for his mental health and substance misuse issues and he engaged well.

99. However, the clinical reviewer was concerned that Mr Sunderland was not offered a review when he stopped collecting his antidepressant medication. A prison GP stopped the medication in June 2018 but there is no evidence that anyone discussed this with Mr Sunderland. There is also no evidence that any consideration was given to reducing the dosage gradually, in line with best practice. We make the following recommendation:

The Head of Healthcare should ensure that staff carry out a review when a prisoner stops collecting their prescribed medication and that they clearly record the decision to alter dosages or discontinue medication.

Prisons & Probation Ombudsman
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