Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Wyndham Thomas, a prisoner at HMP Nottingham, on 6 November 2018

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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 Wyndham Thomas died in hospital on 6 November 2018. He had been found hanging in his cell at HMP Nottingham two days earlier. Mr Thomas was 41 years old. I offer my condolences to Mr Thomas' family and friends.

Mr Thomas was a challenging prisoner. He was serving a life sentence and was 11 years over tariff with little realistic prospect of release in the near future. He had a history of substance misuse, self-harm and violence to others, and at the time of his death he was in the segregation unit being managed under suicide and self-harm prevention procedures (known as ACCT).

I am concerned that there were deficiencies in both the ACCT procedures and in the way Mr Thomas was managed in the segregation unit. I am also concerned that when he was seen unresponsive in his cell, there was a delay of two minutes before an ambulance was called.

Following its inspection of HMP Nottingham in January 2018, HM Inspectorate of Prisons (HMIP) concluded that the prison was 'fundamentally unsafe' and invoked the Urgent Notification process to alert Ministers to its concerns. Several of the significant failings identified by HMIP featured in this investigation. HMIP also noted that there had been repeated failures to implement PPO recommendations following the unusually high number of self-inflicted deaths at the prison.

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 **August 2020**

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Summary

Events

1. In 1998, Mr Wyndham Thomas was sentenced to life imprisonment with a tariff of ten years for offences of murder and aggravated burglary. He had long-standing mental health issues and was prescribed medication for depression and anxiety.

2. Mr Thomas initially settled well and progressed to an open prison in 2004. Two years later, he was returned to a closed prison after becoming involved in the supply and use of drugs. Mr Thomas again progressed to an open prison in 2010 but absconded and was returned to closed conditions. He again progressed to an open prison in 2013 but he was returned to a closed prison after five months when he became involved in drugs again. From 2013, he remained in closed conditions until his death.

3. His behaviour deteriorated and he was often suspected of being involved in the supply and use of drugs. He also used psychoactive substances (or PS) and was referred to substance misuse services with which he engaged intermittently.

4. He was sometimes violent towards staff and other prisoners. He frequently moved prisons, mainly because he had got into debt or assaulted other prisoners.

5. Mr Thomas started self-harming by cutting in 2016, often in response to having no tobacco or, after prisons became smoke-free, vape capsules. He also made many ligatures and hanged himself several times, on one occasion losing consciousness. He was frequently managed under suicide and self-harm prevention procedures (known as ACCT) in 2016, 2017 and 2018.

6. On 15 October 2018, Mr Thomas was sentenced to a further 16 weeks imprisonment for assault and was transferred to HMP Norwich. Staff at Norwich opened an ACCT on 19 October after Mr Thomas cut himself. He cut himself again on 24, 26 and 27 October and had to be taken to hospital on the last occasion. He repeatedly told staff he self-harmed because he had no vape capsules.

7. On 29 October, Mr Thomas returned to HMP Nottingham (where he had been prior to his court appearance). He was still on the ACCT. Staff referred him to mental health and substance misuse services. Mr Thomas told staff that he had stopped taking PS and had started using subutex (a synthetic opioid drug). A GP prescribed him medication to manage the withdrawal symptoms. Over the following days, staff suspected he was using PS and he missed appointments with the substance misuse team.

8. On 2 November, Mr Thomas assaulted an officer. He was restrained and taken to the segregation unit. Staff reviewed his ACCT and reduced the frequency of his observations to two hourly.

9. Over the next two days, Mr Thomas' behaviour in the unit was changeable. Sometimes he was calm and sometimes agitated, repeatedly ringing his cell bell asking for vape capsules. He was sometimes abusive or threatening towards staff.

10. On the morning of 3 November, Mr Thomas became aggressive to staff after being refused vape capsules. As a result, he was not let out of his cell that day for exercise or a shower. He asked to see a Listener (a prisoner trained by the Samaritans) but was told this was not possible. In the evening, he began punching the walls and banging his head on the window and self-harmed by re-opening an old wound. Staff did not hold an ACCT review, although a nurse and supervising officer went to see him. He rang his cell bell repeatedly, asking for vape capsules.

11. On 4 November, Mr Thomas was generally calmer but began pressing his cell bell repeatedly again in the early evening. Just after 6.00pm, an officer noticed that Mr Thomas had tied a ligature and was unresponsive. He radioed for assistance. Other staff responded. They went into Mr Thomas' cell and attempted to resuscitate him.

12. Paramedics attended, obtained a pulse and took Mr Thomas to hospital where he was placed on life support. He died on 6 November, after his life support was turned off.

13. Mr Thomas' post-mortem found that he had taken PS before he died.

Findings

ACCT Management

14. Mr Thomas was a very challenging prisoner to manage in that he posed a risk to others as well as to himself.

15. At the time of his death he was subject to ACCT procedures which had been opened nearly three weeks earlier.

16. Mr Thomas' ACCT was not always reviewed at Nottingham following incidents of self-harm, and on one occasion, there was a delay of three days in opening an ACCT. One caremap was left blank and staff did not always adequately record information about Mr Thomas' risk to himself.

17. At the final ACCT review on 2 November staff gave too much emphasis to Mr Thomas' presentation and did not properly consider his many risk factors. We consider that it was an error to have reduced the frequency of ACCT observations at this review (although in practice Mr Thomas was observed more frequently, at least on the afternoon he hanged himself).

18. When Mr Thomas self-harmed in the segregation unit on 3 November, an ACCT review was not held and this was not recorded in the ACCT document.

Segregation

19. Mr Thomas did not have a mental health assessment within 24 hours of being segregated (as required in PSO 1700 for prisoners subject to ACCT procedures).

20. Mr Thomas had a history of self-harming when he did not have vape capsules. Segregation unit staff were given no guidance on how to respond to his repeated demands for capsules.

21. There is insufficient evidence that segregation unit staff attempted to engage positively with Mr Thomas and the overall impression is that they treated him as a badly-behaved prisoner rather than as a prisoner who was also vulnerable and posed a risk to himself as well as to others. We are also concerned that he was told he could not speak to a Listener (a prisoner trained by Samaritans) while segregated.

Drug strategy

22. We are concerned that Mr Thomas was able to obtain PS and subutex with apparent ease at Nottingham, and that he was able to take PS in the segregation unit shortly before he hanged himself without staff noticing.

23. Staff need to record their suspicions that a prisoner might be under the influence of drugs more consistently, and to submit intelligence reports accordingly.

Bullying

24. There is evidence that Mr Thomas was under threat due to the debt he had accumulated because of his PS use. We found that he was not adequately supported by violence reduction procedures.

Clinical care

25. Mr Thomas' clinical care was equivalent to that he could have expected to receive in the community. He was offered ongoing mental health support and assistance from substance misuse services.

Emergency response

26. The officer who saw that Mr Thomas had used a ligature and was unresponsive did not call an emergency medical code as he should have done. The code was not called until after officers had gone into Mr Thomas' cell. This caused a two-minute delay in calling an ambulance.

27. We are concerned that emergency equipment is not located on every wing at Nottingham.

Sentence planning

28. At the time of his death, Mr Thomas was 11 years over tariff, his behaviour was deteriorating and he had no realistic prospect of release. We are concerned that in the last three years of his life he was held in 13 different prisons and we consider that this lack of stability is likely to have made it more difficult for him to address his drug issues and offending behaviour.

Recommendations

- The Governor and Head of Healthcare should ensure that staff manage prisoners at risk of suicide or self-harm in line with national guidelines, including in particular that:
    - such prisoners are only segregated in exceptional circumstances and that alternatives to segregation are always considered and documented in line with PSO 1700;

- all known risk factors are considered when assessing the level of risk of suicide and self-harm;
- ACCT caremap actions are specific and meaningful, aimed at reducing a prisoner's risk and identify who is responsible for them;
- ACCT reviews are held whenever an event occurs that could mean a prisoner is at increased risk; and
- all relevant information regarding risk is documented in the ACCT document.

- The Prison Group Director for the North Midlands should:

  - satisfy himself that processes are in place at Nottingham to ensure that the PPO's recommendations are being implemented and embedded; and
  - report his findings to the Ombudsman.

- The Head of Healthcare should ensure that, in the case of prisoners subject to ACCT procedures, clinical staff who assess fitness for segregation should record in the ACCT document that they have read the document and have spoken to the prisoner concerned (or the reasons why they were not able to do so).
- The Governor should:
  - ensure that staff are vigilant to signs of drug use and take appropriate action, including submitting intelligence reports as required; and
  - consider the most effective way of communicating and embedding this message (as previous notices to staff do not appear to have been effective).
- The Governor should ensure that the key drug issues at Nottingham continue to be identified and that the prison's local drugs strategy is revised to ensure that these key issues are being addressed.
- The Governor should ensure that all information indicating bullying and intimidation is fully coordinated and investigated in line with national and local policies.
- The Governor should ensure that staff manage prisoners held in the segregation unit in line with national guidelines, including that:
  - all staff working in the segregation unit understand and follow the mandatory procedures for safeguarding segregated prisoners set out in PSO 1700, and PSI 64/2011, and are aware of their personal responsibilities for protecting prisoners, particularly those identified as at risk of suicide and self-harm;
  - prisoners subject to ACCT procedures have a mental health assessment within 24 hours of being segregated;
  - prisoners are provided with the means to occupy themselves, at the minimum, reading material and a radio;
  - prisoners have a designated officer who makes three quality entries on a daily history sheet; and
  - prisoners have access to Listeners in line with individual risk assessments.

- The Governor should ensure that all prison staff are aware of and understand PSI 03/2013 and their responsibilities during a medical emergency, including efficient communication of the nature of the emergency and ensuring there are no delays in calling an emergency ambulance.

- The Governor and Head of Healthcare should ensure that emergency equipment and a defibrillator are located on every wing.
- The Executive Director of Prisons in HMPPS should ensure that individualised plans are put in place centrally for prisoners serving indeterminate sentences who are significantly over tariff to help them progress towards release.

The Investigation Process

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

30. The investigator visited Nottingham on 12 November 2018. She obtained copies of relevant extracts from Mr Thomas' prison and medical records.

31. The investigator interviewed 15 members of staff in January 2019.

32. NHS England commissioned an independent clinical reviewer to review Mr Thomas' clinical care at the prison. He conducted several joint interviews with the investigator.

33. We informed HM Coroner for Nottingham City and Nottinghamshire of the investigation. She gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.

34. One of the Ombudsman's senior investigators contacted Mr Thomas' next of kin to explain the investigation and to ask whether she had any matters she wanted the investigation to consider. Mr Thomas' next of kin wanted to know more about which prisons Mr Thomas had been in, and details of his self-harm. This information is contained in the main body of the report.

35. Mr Thomas' next of kin also asked whether she had received all of Mr Thomas' property after his death. The senior investigator advised her to speak to the prison's Family Liaison Officer about this.

36. She also contacted Mr Thomas' next of kin. She wanted to know where Mr Thomas' had been found unresponsive. She also wanted to know why Mr Thomas frequently moved prisons and why he had been segregated when he died. She also asked how the Prison Service had been addressing Mr Thomas' self-harm. These questions are addressed later in this report.

37. Mr Thomas' next of kin also asked why she was not told about his self-harm at the time. The Head of Operations told the investigator that the decision whether to inform a family of a prisoner's risk to himself is made on an individual basis. Often prisoners want to keep their self-harming secret from their family, and staff respect these wishes.

38. Mr Thomas' next of kin also asked what had happened to Mr Thomas' possessions before he went to Nottingham as she had been told there had been a fire. The investigator confirmed that this had been the case and that most of Mr Thomas' property had been destroyed in a cell fire in HMP Leicester. This included clothes, a radio and Mr Thomas' glasses.

39. Mr Thomas' next of kin received a copy of the initial report. The solicitor representing them wrote to us pointing out some factual inaccuracies. The report has been amended accordingly. They also raised a number of questions that do not impact on the factual accuracy of this report. We have provided clarification by way of separate correspondence to the solicitor.

40. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies and their action plan is annexed to this report.

Background Information

HMP Nottingham

41. HMP Nottingham is a local prison holding a maximum of 1,000 men and young adult prisoners. The prison serves the courts of Nottinghamshire and Derbyshire. Nottinghamshire Healthcare NHS Foundation Trust (NHFT) provides health services at the prison.

42. In August 2018, Nottingham was selected to be part of the '10 Prisons Project', which seeks to improve safety, security and decency in the prisons involved. The project is focusing on reducing violence, improving living conditions, preventing drugs from entering the establishment and enhancing the leadership and training available to staff.

HM Inspectorate of Prisons

43. The most recent inspection of HMP Nottingham took place in January 2018. Inspectors reported that the prison was "fundamentally unsafe". On 18 January 2018, HMIP invoked the Urgent Notification process which commits the Secretary of State to respond publicly to the concerns raised within 28 calendar days.

44. The Urgent Notification said that Nottingham had been in decline since 2010 and had been assessed as "unsafe" in three consecutive inspections. Inspectors found that levels of self-harm had risen significantly and there had been eight self-inflicted deaths since the previous inspection. Despite this, they found that there had been repeated failures to achieve or embed improvements following previous recommendations made by the Prisons and Probation Ombudsman (PPO). Nottingham had also failed to act on recommendations from HMIP's previous inspection.

45. Inspectors noted that Nottingham had sufficient staff but many were inexperienced and prisoners lacked confidence in them, which undermined the well-being and stability of the prison. Over two-thirds of prisoners told inspectors that they had felt unsafe at some point during their time at Nottingham. HMIP also had concerns that cell bells were not consistently being answered within five minutes.

46. HMIP noted that prisoners held in the segregation unit had been appropriately authorised. They found that decisions to accommodate prisoners in the unit who were also subject to ACCT procedures were reasonable and carefully documented.

47. Inspectors found that the drug supply reduction policy was not embedded or effective. 57% of prisoners told inspectors that it was easy to obtain illicit drugs at Nottingham.

48. The Secretary of State responded to HMIP's Urgent Notification on 12 February 2018 and provided an action plan for addressing the Inspectorate's concerns.

Independent Monitoring Board

49. 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, published in July 2018, the IMB reported that staffing levels had improved but that the healthcare department was still not fully staffed. The IMB also noted concerns regarding the high level of self-harm in the prison and the operation of the ACCT process.

Previous deaths at HMP Nottingham

50. Mr Thomas was the ninth prisoner to take his own life at Nottingham since the start of 2017. There was also one homicide and one drug-related death at the prison during this time.

51. Our investigations into five of these previous deaths raised concerns about the overall quality of ACCT procedures; three investigations raised concerns about delays entering a cell; three raised concerns about mental health care; and three raised concerns about the supply and use of PS at the prison - Mr Thomas was the third prisoner during this time to hang himself when under the influence of PS and a further prisoner died of PS toxicity.

52. Since Mr Thomas' death, there have been two further deaths in 2018, one due to natural causes and one self-inflicted. At the time of writing (May 2019), there have been no deaths from any cause in 2019.

Assessment, Care in Custody and Teamwork

53. ACCT is the care planning system the Prison Service uses to support prisoners at risk of suicide or self-harm. The purpose of the ACCT is to try to determine the level of risk posed, the steps that staff might take to reduce this and the extent to which staff need to monitor and supervise the prisoner. Checks should be done at irregular intervals to prevent the prisoner anticipating when he will occur. Part of the ACCT process involves assessing immediate needs and drawing up a caremap to identify the prisoner's most urgent issues and how they will be met. Staff should hold regular multidisciplinary reviews and should not close the ACCT plan until all the actions of the caremap are completed.

54. Enhanced case management can be used to support prisoners whose behaviour is so challenging and disruptive that they need additional case management to manage their heightened or exceptional risk of harm to self, others and/or from others. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011, *Management of prisoners at risk of harm to self, to others and from others (Safer Custody)*.

Psychoactive Substances (PS)

55. Psychoactive substances (formerly known as 'new psychoactive substances or 'legal highs') are a serious problem across the prison estate. They are difficult to detect and can affect people in a number of ways including increasing heart rate, raising blood pressure, reducing blood supply to the heart and causing vomiting.

Prisoners under the influence of PS can present with marked levels of disinhibition, heightened energy levels, a high tolerance of pain and a potential for violence. Besides emerging evidence of such dangers to physical health, there is potential for precipitating or exacerbating the deterioration of mental health with links to suicide or self-harm.

56. In July 2015, we published a Learning Lessons Bulletin about the use of PS (still at the time NPS) and its dangers, including its close association with debt, bullying and violence. The bulletin identified the need for better awareness among staff and prisoners of the dangers of PS; the need for more effective drug supply reduction strategies; better monitoring by drug treatment services; and effective violence reduction strategies.

57. HM Prison and Probation Service (HMPPS) now has in place provisions that enable prisoners to be tested for specified non-controlled psychoactive substances as part of established mandatory drugs testing arrangements.

Segregation Units

58. Policy on segregation is set out in Prison Service Order (PSO) 1700. Segregation units are used to keep prisoners apart from other prisoners. This can be because they feel vulnerable or under threat from other prisoners or if they behave in a way that prison staff think would put people in danger or cause problems for the rest of the prison. Segregation is authorised by an operational manager at the prison who must be satisfied that the prisoner is fit for segregation after an assessment by a member of healthcare staff.

Parole Board

59. The Parole Board for England and Wales is an independent public body. Its role is to make risk assessments about prisoners to decide whether they can safely be released into the community once they have served the minimum term imposed by the courts.

Incentives and Earned Privileges (IEP) Scheme

60. Each prison has an Incentives and Earned Privileges (IEP) scheme, which aims to encourage and reward responsible behaviour, encourage sentenced prisoners to engage in activities designed to reduce the risk of re-offending and to help create a disciplined and safer environment for prisoners and staff. Under the scheme, prisoners can earn additional privileges such as extra visits, more time out of cell, the ability to earn more money in prison jobs and to wear their own clothes. There are four levels, entry, basic, standard and enhanced.

Key Events

61. On 9 April 1998, Mr Wyndham Thomas was found guilty of murder and aggravated burglary and sentenced to life imprisonment with a tariff of ten years. This was the minimum amount of time he would spend in prison.

62. He spent time in HMP/YOI Aylesbury where he settled well and moved to the adult estate, HMP Gartree, in 2001. He continued to progress well, complied with the regime and completed offending behaviour related courses. He was involved with mental health services throughout his time in prison as he had a history of anxiety and depression. Mr Thomas transferred to HMP Featherstone in 2002 and, due to exceptional progress, his first Parole Board hearing was brought forward to 2004. At that time, the Board recommended that Mr Thomas move to an open prison. The next Parole Board hearing was scheduled for August 2007, at the expiry of Mr Thomas' tariff.

63. Mr Thomas transferred to HMP Leyhill (an open prison) in October 2004. He completed both offending behaviour and educational courses, as well as substance misuse work. In 2006, Mr Thomas tested positive for cannabis. Staff were concerned that he was involved in the supply and use of drugs at the prison. As a result, he was transferred to HMP Dartmoor (a closed prison) in July 2006. Mr Thomas later reported that this was when he started using heroin.

64. In February 2007, the Parole Board recommended that Mr Thomas should remain in closed conditions until August 2007 when his tariff expired. They said that Mr Thomas needed to complete substance misuse work. He did so and in November 2007, the Parole Board recommended his move to open conditions. In March 2008, he transferred to HMP Usk (an open prison). A few months later, Mr Thomas tested positive for drugs and was returned to closed conditions at HMP Cardiff.

65. In November 2009, Mr Thomas was found with a mobile phone in his possession and in January 2010 he tested positive for subutex (a synthetic opioid drug used to treat opioid addiction). He again completed substance misuse work and in March, the Parole Board recommended that Mr Thomas be transferred to open conditions and set his next hearing for September 2011. Mr Thomas transferred to HMP Prescoed (an open prison) in July 2010. While there, he quickly became involved in the supply and use of drugs. He was due to be moved back to closed conditions on 23 September but absconded the day before. He was arrested on 24 September and sentenced to ten months imprisonment for escaping. He was returned to closed conditions.

66. In February 2013, the Parole Board recommended Mr Thomas' transfer to an open prison. He returned to Leyhill in April 2013. Initially, Mr Thomas engaged well but again began misusing drugs. After acting aggressively towards staff, he was transferred back to closed conditions after five months and taken to HMP Dartmoor.

67. His behaviour deteriorated further after this, he used PS and was sometimes aggressive and violent towards others.

68. In August 2015, the Parole Board recommended that Mr Thomas remained in closed conditions and his next hearing was set for January 2017. During 2016, Mr Thomas continued to use PS and was suspected to be involved in the supply of drugs in prison. He frequently moved prisons due to his behaviour and spent time in HMP High Down, HMP Warren Hill, HMP Wormwood Scrubs, HMP Exeter, HMP Bullingdon, HMP Coldingley and HMP The Mount.

69. Mr Thomas was also subject to Prison Service suicide and self-harm prevention measures, known as ACCT, on four separate occasions. The last of these was in October 2016. Mr Thomas made a ligature and told staff he would hang himself. Staff removed the ligature and gave Mr Thomas anti-ligature clothing and moved him to a safer cell. He said he had run out of tobacco and was withdrawing from nicotine.

70. On 2 March 2017, Mr Thomas transferred to Coldingley. On arrival, he refused to be located on a standard wing. He was taken to the segregation unit where he remained for the rest of his time at Coldingley. On 4 May 2017, Mr Thomas said that he had run out of tobacco and would self-harm or hang himself if he did not get some.

HMP Wayland, 22 May 2017 – 14 September 2017

71. On 22 May, Mr Thomas transferred to HMP Wayland. On 8 June, staff found Mr Thomas with a ligature around his neck, secured to his window. They went into the cell before he had put any pressure on the ligature. Staff opened an ACCT. Mr Thomas continued to be involved in the supply and use of drugs and 'hooch' (illicit, home-made alcohol). He was a disruptive prisoner, who self-harmed frequently. He told staff that he would take his own life unless he was given tobacco or released.

72. On 7 July, the Parole Board recommended that Mr Thomas remained in closed conditions and that consideration be given to transferring him to a Psychologically Informed Planned Environment (or PIPE). PIPE units aim to provide prisoners with progression support after completion of other offending behaviour programmes or treatment. The Board set Mr Thomas' next review for 18 months' time.

73. Staff closed Mr Thomas' ACCT on 24 August. The next day Mr Thomas held his cellmate hostage and was segregated. On 27 August, Mr Thomas tied a ligature around his neck, attached to a light fitting, and jumped from a chair as staff entered the cell. The ligature snapped. He said he did it as he had no tobacco. Mr Thomas also tied a ligature on 28 August and assaulted staff when they prevented him from using it.

HMP Stocken, 14 September 2017 - 12 February 2018

74. On 14 September, Mr Thomas transferred to HMP Stocken. From 18 November, he was located in the segregation unit because he had damaged his cell. He continued to self-harm by cutting saying it was because he had no vape capsules. Staff also suspected he used PS and consumed hooch. On 13 January 2018, Mr Thomas assaulted an officer by punching him and attempting to gouge his eyes

out. He said that he was frustrated as he had no vape capsules. The matter was referred to the police.

75. On 15 January, Mr Thomas tied a ligature around his neck and stepped off a desk as staff entered his cell. The ligature snapped. Staff went into his cell but Mr Thomas refused to hand over the ligature. He became aggressive and staff retreated from the cell. As a manager was talking to him through the observation panel, he hanged himself again and lost consciousness. Staff entered the cell and cut him down. Mr Thomas was moved to a safer cell and made subject to constant supervision. These observations were gradually reduced until 8 February when staff closed Mr Thomas' ACCT.

HMP Bedford, 12 February 2018 - 11 April 2018

76. On 12 February, Mr Thomas transferred to HMP Bedford. On 25 February, Mr Thomas assaulted an officer. He also assaulted prisoners and was suspected to be using PS. On 1 March, Mr Thomas self-harmed by cutting. He told staff that he had done so as he could not live with himself for assaulting a female officer and that he would hang himself. He showed the officer the ligature he planned to use. Staff opened an ACCT which was later closed on 9 March.

HMP Leicester, 11 April 2018 – 17 July 2018

77. On 11 April, Mr Thomas transferred to HMP Leicester. During April, he was suspected to be under the influence of PS on several occasions. On 21 April, staff found Mr Thomas standing on a chair with a ligature around his neck. Staff entered the cell and removed the ligature. Mr Thomas said he was struggling as he was withdrawing from PS and was in debt because of PS use. He was suspected to be under the influence of PS several times during the rest of April.

78. On 4 May, Mr Thomas began making a ligature, staff entered his cell and he was restrained. Mr Thomas said he was going to take his own life. He self-harmed by cutting with increasing frequency, often saying it was because he had no vape capsules. On 1 June, Mr Thomas refused to engage with his offender supervisor to consider his upcoming Parole Board hearing. On 16 June, officers answered Mr Thomas' cell bell to find him with a ligature around his neck, standing on a chair. He said he was fed up with prison life. He continued to self-harm when he did not have vape capsules and was also suspected of using PS on numerous occasions.

79. On 25 June, Mr Thomas smashed his observation panel. On 29 June, he set fire to his cell. He was segregated because of his escalating behaviour. He remained on an ACCT and in segregation for the rest of his time at Leicester, cutting himself on several occasions, sometimes requiring stitches. On 17 July, Mr Thomas told a GP that he had not used PS for 23 days. He said he was feeling better mentally and thinking more clearly.

HMP Nottingham, 17 July 2018 – 15 October 2018

80. On 17 July, Mr Thomas transferred to HMP Nottingham. A GP continued his prescription of mirtazapine (an antidepressant), paroxetine (an antidepressant)

and pregabalin (for anxiety) which Mr Thomas had been taking long-term. None of his medication was held in his possession as Mr Thomas was considered a risk to himself. A nurse assessed him on arrival and referred him to the mental health team. On 20 July, during an ACCT review, Mr Thomas said he wanted to make a fresh start at Nottingham. He had not self-harmed for more than a week and said he had no current thoughts of doing so. Staff closed the ACCT.

81. On 24 July and 25 July, a mental health nurse tried to assess Mr Thomas but staff refused to unlock him due to issues on the wing. On 29 July, Mr Thomas cut himself as he had no nicotine and said he had no other way of coping. Staff opened an ACCT.

82. On 30 July, a nurse referred Mr Thomas to the smoking cessation service. On 31 July, a mental health nurse again tried to assess Mr Thomas but staff could not unlock him as a wing search was taking place. On 1 August, Mr Thomas attended his smoking cessation appointment. He said he had never tried to stop smoking before. He was given advice and prescribed nicotine patches and lozenges. He later cut his arm.

83. On 6 August, a nurse from the mental health team, assessed Mr Thomas. He told the nurse that he struggled with anxiety and low mood when he thought about the length of his prison sentence. Mr Thomas said he liked to keep to himself and did not come out of his cell for association. Her assessment noted that Mr Thomas had symptoms of moderate anxiety and mild depression. Mr Thomas also told the nurse that he had taken PS and wanted to be referred to the substance misuse team. The next day, mental health staff discussed Mr Thomas at their team meeting and he was allocated to the nurse's caseload.

84. On 7 August, staff closed Mr Thomas' ACCT. He said he was much happier since he had been receiving nicotine replacement therapy and had no thoughts of suicide or self-harm.

85. On 11 August, staff suspected Mr Thomas was under the influence of PS. On 13 August, a substance misuse worker assessed Mr Thomas. He said that he was taking PS every other a day as a way of coping. She provided Mr Thomas with harm reduction information and offered ongoing support. Mr Thomas was reluctant to engage with substance misuse services but a nurse told the investigator that they planned monthly visits to encourage his engagement. On 14 August, Mr Thomas was again suspected to be under the influence of PS. A nurse continued to meet regularly with Mr Thomas until she left the prison and mental health practitioner took over Mr Thomas' care.

86. On 6 September, the mental health practitioner met Mr Thomas for the first time. She told the investigator that a nurse had taken an informal approach to meeting with Mr Thomas and she confirmed with Mr Thomas that he would like to continue meeting in the same way. He did not want to receive any structured intervention at that time but was happy for her to check how he was regularly. She spoke to Mr Thomas about his upcoming Parole Board hearing. She said he seemed "fine" about this but asked her for support after the hearing. She said that when she saw Mr Thomas on the wing he often seemed to be under the influence of drugs and she would have to return to see him another time. This is not documented in his medical record.

87. On 9 September, the mental health practitioner went to speak to Mr Thomas on the wing. He had a cut under his eye which he said was from a fight. He did not want to discuss this further with the mental health practitioner. On 11 September, the offender supervisor, asked Mr Thomas if he wanted to make any representations to the Parole Board. He declined to do so.

88. Later that day, Mr Thomas self-harmed by cutting his arm. Staff opened an ACCT. Mr Thomas said that he was stressed on B wing and wanted to move to get away from drugs. He said he was in debt because of PS use. He said he was also waiting to hear about his appeal. (It has not been possible for the investigator to ascertain whether Mr Thomas had lodged an official appeal against his sentence although he made several references to it with staff.) The ACCT assessment the next day noted that Mr Thomas had started to self-isolate. Staff reassured Mr Thomas that they were trying to find a suitable cell for him to move to. Mr Thomas was also concerned as he had not been given his nicotine patches. These were arranged for issue that afternoon. Staff closed his ACCT.

89. On 14 September, the substance misuse team tried to speak to Mr Thomas but could not get access to him. He later cut his arm. Following a further incident of self-harm on 17 September, staff reopened Mr Thomas' ACCT. Staff noted that it appeared that Mr Thomas had been assaulted. He told the officer it had happened that morning but did not name the prisoner responsible. On 19 September, Mr Thomas completed his smoking cessation course. Records noted that he had attended every session and had engaged well. A nurse told the investigator that after Mr Thomas was weaned off nicotine, he seemed happier.

90. On 20 September, Mr Thomas pressed his cell bell on numerous occasions, requesting vape capsules. He self-harmed by cutting. On 21 September, Mr Thomas could not attend his ACCT review as he was under the influence of PS. Staff submitted a security report and noted that they would refer him to the substance misuse team. They noted that a mandatory drug test was not possible since it was Mr Thomas' first suspected drug use since arriving at Nottingham. (This was not the case.)

91. Mr Thomas refused to engage with ACCT reviews on 25 September, 28 September and 1 October and asked for his ACCT to be closed. Staff explained they could not do this until they had had the opportunity to discuss Mr Thomas' issues with him. Mr Thomas was moved to A wing, in line with his wishes.

92. On 2 October, a nurse, from the substance misuse team, tried to speak to Mr Thomas but he asked her to return another day. On 5 October, Mr Thomas refused to engage with the ACCT review. On 8 October, during an ACCT review, Mr Thomas said he had no thoughts of self-harm and had not self-harmed since the ACCT had been opened. Mr Thomas told staff that he did not feel comfortable with peers or staff and preferred to be alone in his cell. Staff closed the ACCT. The caremap for this ACCT is blank.

93. On 9 October, a nurse assessed Mr Thomas. He said he had stopped using PS about three weeks earlier but had started using subutex daily instead. Mr Thomas asked to be prescribed methadone so he could "get stable". He told the nurse that he was appealing his sentence and did not want to engage with parole hearings as he did not accept responsibility for the offence of murder. Mr Thomas' drug test was negative. The nurse explained that, because of this, she could not prescribe

him methadone. She gave Mr Thomas advice on how to reduce the amount of illicit drugs he was using.

94. On 10 October, the mental health practitioner went to see Mr Thomas. He told her he had stopped using PS three weeks earlier. They discussed the impact of withdrawal from PS on his mood and Mr Thomas said his last incident of self-harm may have been due to this. He said he had been using subutex to manage this withdrawal. Mr Thomas said he had had enough of prison but had no thoughts of suicide. He said he had not spoken to his family or next of kin for a long time and wanted to get in contact with them. She agreed to review Mr Thomas weekly.

95. She told the investigator that Mr Thomas said he had thoughts of taking his own life. She said she tried to focus on the positives in Mr Thomas' life with him and to focus him on the future. He said he still wanted to live. She did not think he was an immediate risk to himself and therefore did not open an ACCT.

96. On 15 October, Mr Thomas appeared at Norwich Crown court and was convicted of assaulting prison officers. He received a sentence of 16 weeks imprisonment to be served concurrently with his existing sentence.

HMP Norwich, 15 October 2018 – 29 October 2018

97. After his court appearance Mr Thomas was taken to HMP Norwich. A nurse assessed him and referred him to the mental health team and smoking cessation service. He told a doctor that he had last used subutex the day before. On 16 October, staff submitted a security report about this. A nurse later saw him and gave him nicotine replacement patches. He refused to engage with the substance misuse team while at Norwich.

98. On 17 October, Mr Thomas told staff that he was still taking subutex daily. Staff submitted a security report. On 19 October, Mr Thomas cut his arm. He told staff that it was a means of "release" as he had found out his daughter had had a stillbirth. (After the publication of the initial report, Mr Thomas' family told the investigator that his daughter did not have a stillbirth.) He had received vape capsules the night before but staff had refused to issue them again that evening. Staff opened an ACCT. Mr Thomas was subject to hourly observations and referred to the mental health team.

99. On 20 October, during an ACCT assessment, Mr Thomas told staff that unless he received vape capsules he would self-harm. He said he did not want to be in Norwich and would jump onto the netting that was suspended between floors. Staff moved Mr Thomas to a cell on the ground floor to prevent this. A nurse also assessed Mr Thomas' mental health. They noted that Mr Thomas did not have any acute symptoms of mental illness and no symptoms of anxiety or low mood. He was focused solely on obtaining vape capsules. The nurse discharged him from the care of the mental health team.

100. On 21 October, a Supervising Officer (SO) and a mental health nurse held an ACCT case review with Mr Thomas. Mr Thomas said he had been upset by the loss of his grandchild. He also said he was awaiting an appeal against his conviction. Mr Thomas said that nicotine was his only way of coping and he did not have sufficient funds to buy vape capsules. Mr Thomas said he did not want

any mental health input. His observations were reduced to three per day. Staff gave him one vape capsule.

101. On 22 October, Mr Thomas attended a smoking cessation appointment. On 24 October, Mr Thomas self-harmed by cutting his arm. Staff later gave him some vape capsules. On 26 October, Mr Thomas told an officer that he had self-harmed as he preferred to be in segregation, as he found it hard to cope on the main wings. Later that evening, he self-harmed by cutting his arm and said he did not have any vape capsules. Staff increased his observations to hourly.

102. On 27 October, Mr Thomas self-harmed by cutting his arm. It was a deep cut and he was taken to hospital for treatment. He told an officer he had cut himself as he had no food or vape capsules. He returned to the prison that evening. Mr Thomas told an officer that his money had not yet transferred in from his previous prison so the officer issued him with vape capsules on this basis. The officer then checked Mr Thomas' record and realised he had already been issued some capsules and should not have been issued more. The officer noted that he should not be given any more outside of the canteen system (meaning Mr Thomas would need to purchase capsules with his own money).

103. On 28 October, during an ACCT review, Mr Thomas said he still had thoughts of self-harm. The SO increased Mr Thomas' observations to hourly and assessed him as being a high risk to himself. On 29 October, during an ACCT review, Mr Thomas said he had no issues with returning to Nottingham but he said he would continue to struggle if he did not have nicotine. He said he was hoping to move closer to home once back in Nottingham as all his family were in South Wales.

HMP Nottingham, 29 October onwards

104. On 29 October, Mr Thomas transferred back to Nottingham. An officer met Mr Thomas, they went through his ACCT documentation together, spoke about his triggers for self-harm and coping mechanisms, and agreed what support Mr Thomas needed. Mr Thomas said that he was worried he was starting to enjoy hurting himself. He said he had previously attempted suicide when segregated in another prison. He said he wanted to return to South Wales where his family could provide support.

105. Mr Thomas said that he had last taken PS six weeks earlier and was using subutex. The officer referred Mr Thomas to the substance misuse and mental health teams. Mr Thomas also said that he had issues with (un-named) prisoners on A wing and B wing from his previous time at Nottingham. The officer referred Mr Thomas to the chaplain on account of his alleged loss of his grandchild.

106. A nurse assessed Mr Thomas in reception. He also referred Mr Thomas to the mental health team. Mr Thomas declined a referral to the smoking cessation service. Mr Thomas said he used drugs and a urine sample tested positive for subutex. The nurse referred him to the Integrated Drug Treatment Strategy (IDTS) and substance misuse team. A GP continued Mr Thomas' prescription of mirtazapine, paroxetine and pregabalin.

107. At 5.30pm, Mr Thomas became "refractory" as he said he had not received all his medication. He started taking the stitches out of the wound on his arm. Nurses assessed and re-dressed his wound. A Custodial Manager (CM) said that he

received a telephone call indicating that Mr Thomas did not want to move to the induction wing but wanted to go to the segregation unit. The CM said a manager explained to Mr Thomas that it was the normal process for a prisoner to move to the induction wing. Mr Thomas agreed and at 6.00pm, moved to F wing. Mr Thomas refused a first night telephone call. At 7.30pm, a prison GP noted that Mr Thomas was taking subutex and prescribed him medication to lessen symptoms of subutex withdrawal.

108. On 30 October, Mr Thomas started an induction session but returned to his cell after an hour as he said he did not want to continue. At 6.30pm, staff noted that Mr Thomas was lying on the floor of his cell. They believed he had taken PS. A nurse assessed Mr Thomas. Staff downgraded Mr Thomas to the 'basic' level of the Incentives and Earned Privileges (IEP) scheme for 14 days due to his suspected drug use.

109. On 31 October, Mr Thomas did not attend his appointment with the substance misuse team. The offender supervisor tried to give Mr Thomas documentation from the Parole Board about their recent decision not to recommend his release. Mr Thomas refused the letter and the offender supervisor, offer to summarise its content for him. She told the investigator that she intended to return another day to try and give Mr Thomas the paperwork. She said that she did not think that the decision would have been a surprise to Mr Thomas and did not know whether he had been informed by anyone else, such as his solicitor.

110. On 1 November, Mr Thomas did not attend his appointment with the substance misuse team. Later, Mr Thomas told a healthcare assistant that he would like to engage with the substance misuse team. At 7.15pm, staff noted that Mr Thomas appeared to be "under the influence" but got himself into bed and went to sleep.

111. On 2 November at 12.30pm, Mr Thomas was allocated to the mental health practitioner's caseload. She told the investigator that she planned to see Mr Thomas the following week.

112. Since Mr Thomas had completed his induction, an officer told him he would be moving to B wing. He refused to go. The officer spoke to a SO who asked the officer to check whether there was any intelligence that Mr Thomas' could not be located on B wing. The officer told the SO that there was nothing recorded. The SO went to speak to Mr Thomas and asked him why he could not go to B wing. Mr Thomas said that he had "issues" but would not be more specific. The SO then told Mr Thomas that he needed to move to B wing. He refused and the SO stepped towards Mr Thomas to try to encourage him to move. Mr Thomas punched the SO in the face, causing a minor cut and a small nose bleed. Along with other officers, the SO then restrained Mr Thomas and handcuffed him. He radioed a manager who gave permission for Mr Thomas to be taken to the segregation unit. Mr Thomas was compliant and walked there himself.

113. At 3.10pm, the Head of Operations, chaired Mr Thomas' ACCT case review. She said she spoke to a nurse before the review and read Mr Thomas' last ACCT review. Also present at the review were Mr Thomas, the nurse, IMB staff, and a SO. The Head of Operations told the investigator that Mr Thomas was very "likeable". They discussed Mr Thomas' time in prison so far and he said he felt aggrieved at his original conviction. The SO told Mr Thomas they could work towards his Parole Board hearing and progression from Nottingham. The Head of

Operations asked Mr Thomas to write an action plan over the weekend (it was then Friday) and she would chair an ACCT review with him on Monday to discuss this. He said he had no thoughts of self-harm.

114. The Head of Operations told the investigator that Mr Thomas was "smiley" and "chatty" and seemed to respond quite well to her request. She said the review lasted around 40 minutes. Staff assessed Mr Thomas as being a raised risk to himself and reduced his level of observations to every two hours. She said this was because Mr Thomas had engaged well and there were no risk factors that concerned her at that time. She said Mr Thomas did not speak to her about obtaining vape capsules.

115. The nurse told the investigator that Mr Thomas had engaged in a similar way at previous reviews at which he had been present and had expressed the same frustrations.

116. The nurse completed the initial segregation healthscreen. He noted that Mr Thomas was currently subject to ACCT monitoring but that he did not think Mr Thomas's mental health would deteriorate significantly if he was segregated. He concluded that Mr Thomas was fit for segregation and no healthcare intervention was needed at that time.

117. A SO said that, after his ACCT review, Mr Thomas apologised to him for assaulting him. The SO shook Mr Thomas' hand and told him not to worry about it.

118. At 4.00pm, the chaplain saw Mr Thomas who told him he had no issues to discuss. At 5.10pm, an officer gave Mr Thomas his vape and charger and he asked them about his other property. The officer said they would go through this in the morning as it was in the office. At 7.00pm, an officer recorded that Mr Thomas' mood had been changeable since he had been in the segregation unit but he had settled down when given his vape.

119. On 3 November, at 8.00am, Mr Thomas asked staff for vape capsules. Officers said they could not provide any but gave him some puzzles and his property from the wing. A SO started his daily rounds visiting all the prisoners in the segregation unit, accompanied by three officers. He said Mr Thomas was quite aggressive, shouting and demanding vape capsules. The SO said he told him that this would not be possible and Mr Thomas became threatening. As a result, the SO decided to shut his cell door and recorded that Mr Thomas had "lost his regime". He told the investigator that this meant that Mr Thomas would not be unlocked from his cell that day due to the risk he presented to staff. Mr Thomas would not have been able to have a shower or exercise and would be reassessed the following morning.

120. At 9.00am, a nurse went to see Mr Thomas to complete the daily nurse check in the segregation unit. She recorded that he had no thoughts of suicide or self-harm. She told the investigator that she could not recall speaking to Mr Thomas or whether she had asked him directly if he had any thoughts of suicide or self-harm. She could not recall whether she had read his ACCT folder but said she would usually do so before seeing a segregated prisoner.

121. At 9.45am, the SO recorded that Mr Thomas was misusing his cell bell and becoming aggressive with staff. He recorded that Mr Thomas had asked for a Listener (a prisoner trained by Samaritans) which they could not provide in the segregation unit. The SO told the investigator that he offered Mr Thomas the Samaritans' telephone, although he did not document this. He said Mr Thomas aggressively declined the telephone. The SO recorded that staff would only answer Mr Thomas' cell bell in line with his ACCT observations (that is, once every two hours), not every time he pressed his bell if this was more frequent.

122. At 10.15am, an officer noted that Mr Thomas was making threats to staff over vape capsules. At 11.45am, the chaplain spoke to Mr Thomas who said he was "not okay" because he did not have a vape. He did not want to discuss it further. Mr Thomas rang his cell bell 53 times between 4.45pm and 8.45pm. He repeatedly requested vape capsules and was abusive to staff when they did not provide any.

123. An officer had been responding to Mr Thomas' cell bells that evening. At 6.30pm, when the officer looked through Mr Thomas' observation panel, he saw him punching the walls and banging his head on the window. He then saw Mr Thomas remove the bandage from a previous self-harm wound and realised he was in possession of a plastic knife. At 7.05pm, Mr Thomas opened the wound. He noted the wound was bleeding but not greatly. He radioed for a nurse and informed a CM, the Orderly Officer (who was in charge of the prison at the time). The CM told the investigator that at the same time as receiving this radio message, he also received an emergency call from another wing. The CM therefore dealt with the other prisoner and sent the SO to the segregation unit.

124. The SO and a nurse went straight to Mr Thomas' cell. The CM had not authorised opening his cell door due to the potential risk to staff which Mr Thomas presented. The nurse noted a small amount of blood on Mr Thomas' arm but he refused a dressing.

125. The CM then arrived in the segregation unit. Mr Thomas had told the SO that he wanted some vape capsules and would continue to ring his cell bell if he did not receive them. The CM, the SO and the officer then discussed Mr Thomas in the wing office. They agreed the officer would carry on monitoring him. The CM allocated another member of staff to the segregation unit to assist the officer. The CM told the investigator that he could not remember whether he had seen Mr Thomas himself but was satisfied, from what other staff had said, that there was no need to increase his ACCT observations. He logged the information that Mr Thomas had self-harmed in the daily operational report.

126. Mr Thomas continued to press his cell bell as soon as the officer had left the cell. He said he would continue to misuse the bell all night until he received his vape capsules. At 10.00pm, staff noted that Mr Thomas appeared to be asleep.

Events of 4 November

127. Mr Thomas woke at about 6.00am on 4 November and again repeatedly rang his cell bell asking for vape capsules, saying he would continue until he got what he wanted. Between 8.30am and 11.20am, he rang his cell bell 20 times.

128. On 4 November at 9.15am, a nurse noted that he had no concerns about Mr Thomas. He told the clinical reviewer that he could not recall meeting Mr Thomas but that he would have checked his ACCT documentation before speaking to him.

129. At 9.45am, Mr Thomas was given adjudication paperwork relating to the alleged assault on 2 November. This indicated that his case would not be heard before 5 November. During the morning he became agitated with staff over getting access to a shower but then, having taken one, he apologised for his behaviour. At 2.10pm, he asked for vape capsules again. At 4.00pm, staff noted that Mr Thomas was relaxing in his cell. He declined use of the telephone but was given a radio at 5.00pm. Staff noted that Mr Thomas had "no real problems". An officer said that Mr Thomas did not raise any issues at this point and was calm.

130. At 5.19pm, an officer noted Mr Thomas was misusing his cell bell, continually demanding vape capsules. He had rung his cell bell four times since 5.00pm. Mr Thomas said he would carry on ringing his cell bell all night. According to the electronic cell bell record, Mr Thomas last pressed his cell bell at 5.30pm. An officer reset the bell just under five minutes later. The officer said that he left Mr Thomas' observation panel open so that he could discreetly check on him when walking past his door without disturbing him. When he checked on Mr Thomas at 5.39pm and 5.46pm, Mr Thomas told him to "fuck off" each time. He heard Mr Thomas had his taps running and was concerned he might be trying to flood his cell.

131. The officer said that the last time he checked Mr Thomas (CCTV shows it was at 5.54pm), Mr Thomas was standing near his cell door but did not say anything to him.

132. CCTV shows the officer next looked into Mr Thomas' cell at 6.04pm. He told the investigator that he could only see Mr Thomas' head below the observation panel, and his legs, stretched out on the floor in front of him. He then saw a ligature but thought that Mr Thomas might be "messing about" trying to "entice" staff in to fight with them. Mr Thomas did not respond to him. He radioed requesting the Orderly Officer to attend the segregation unit to remove a ligature. The Orderly Officer then radioed for all response staff to attend the segregation unit as he was dealing with another incident.

133. The officer said that he then noticed how still Mr Thomas was and became concerned for his welfare. He went up the stairs to turn the landing lights on, by which time an officer and a SO had arrived on the unit and they all went to Mr Thomas' cell.

134. The SO recorded that she could see the ligature through the observation panel. The officer unlocked the door and all three members of staff went into the cell. This was around 90 seconds after the officer had first looked into Mr Thomas' cell. The SO passed the officer her anti-ligature knife and he cut the ligature. The SO radioed requesting an ambulance and another officer radioed a code blue emergency. Control room staff telephoned for an ambulance immediately.

135. The nurse was with another nurse when they heard a code blue called over the radio. They were the only healthcare staff in the prison at the time. They both immediately went towards the segregation unit. A nurse diverted to collect the emergency equipment on her way. When the nurse got to the cell, staff had just

gone in. The nurse checked Mr Thomas for signs of life and the officer started CPR. The nurse arrived with the emergency bag and they attached the defibrillator. Nurses inserted an airway and administered oxygen. They briefly detected a pulse but started chest compressions again when it was lost.

136. At 6.17pm, paramedics arrived at the cell. They regained a pulse. At 6.45pm, Mr Thomas was taken to hospital by ambulance and placed on life support.

137. The details Mr Thomas had provided for his next of kin were no longer correct. As they lived so far from the prison, the Duty Governor, called Gwent and South Wales Police to ask them to inform Mr Thomas's next of kin that he had been taken to hospital.

138. On 5 November, at 3.00am, Mr Thomas was given a CT scan. Since the police had not managed to contact Mr Thomas' next of kin, the duty governor telephoned his next of kin whose details were on Mr Thomas' telephone records. He informed her of Mr Thomas' condition and she passed on the news to Mr Thomas' next of kin. At 10.35am, a doctor informed the escorting staff that Mr Thomas was unlikely to survive due to his injuries. He met Mr Thomas' family at the hospital that afternoon.

139. On 6 November, a chaplain, was appointed as family liaison officer (FLO). He met Mr Thomas' family, along with the Duty Governor, at the hospital at 10.45am. Mr Thomas' life support was turned off and he died at 4.40pm with his family present. The FLO telephoned Mr Thomas' next of kin to offer his condolences. He remained in contact with them over the following weeks and offered a contribution to funeral expenses in line with Prison Service instructions. He returned Mr Thomas' property to his next of kin.

Support for prisoners and staff

140. After Mr Thomas' death, the duty governor 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 were not available at the time. Most staff said that they had been well supported after Mr Thomas' death. However, the officer said he would have liked more formal support although he said that his colleagues had been very supportive. An officer, who had left the prison since Mr Thomas' death, was not informed of his death until the investigator emailed her.

141. The prison posted notices informing other prisoners of Mr Thomas' 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 Thomas' death.

Post-mortem report

142. The post-mortem report found that the cause of Mr Thomas' death was hanging. There was evidence that Mr Thomas had used PS before he died which may have affected his cognitive function and behaviour.

Findings

Management of ACCT

143. Mr Thomas had been assessed as a risk of suicide and self-harm repeatedly since 2016. Much of his self-harming behaviour related to his addiction to nicotine and arose when he did not have access to tobacco or, in more recent years, to vape capsules. He cut his arms, sometimes requiring stitches. He also made several ligatures and staff found him hanging three times; on one occasion he had lost consciousness. As a result, he had spent a lot of time in the three years before his death being monitored under the ACCT process.

144. Although there was some good practice at Nottingham – for example, case reviews were generally multi-disciplinary and often involved mental health staff - our investigation identified procedural failings in the operation of the ACCT process, meaning that Mr Thomas did not always receive an appropriate level of support in the last few months of his life.

145. On 11 September 2018, Mr Thomas self-harmed and an ACCT was opened. This ACCT was closed the next day when staff assessed that Mr Thomas's issues had been resolved as he had moved wings. On 14 September, Mr Thomas again self-harmed. The ACCT was not re-opened until three days later, after Mr Thomas self-harmed again. No ACCT review was held until 21 September. PSI 64/2011 states that following any incident of self-harm an ACCT should be opened, or if one is already open, an ACCT review should take place.

146. Staff closed this ACCT on 8 October. The caremap was blank. PSI 64/2011 states that caremap actions should be detailed and time-bound and aimed at reducing risk. They should reflect prisoners' needs, level of risk, and the triggers of their distress. An ACCT should not be closed until the actions on a caremap have been addressed.

147. Another ACCT was opened at Leicester on 19 October after Mr Thomas self-harmed. This ACCT was still open when he transferred back to Nottingham on 29 October. However, when Mr Thomas self-harmed on the evening of 29 October, staff at Nottingham did not hold an ACCT review as they should have done.

148. The last ACCT case review, held on 2 November, lasted around 40 minutes. We recognise that the head of operations, the chair, and other staff present made considerable efforts to understand Mr Thomas and to agree how they could best support him.

149. However, we question the decision taken at the review to reduce Mr Thomas' observations to every two hours.

150. The Head of Operations described Mr Thomas as being very 'likeable', 'smiley' and 'chatty' at the review and we are concerned that staff may have placed too much emphasis on Mr Thomas' presentation and not enough on his many risk factors.

151. Mr Thomas was more than 10 years over his tariff and had become increasingly depressed about his prospects of release. He had just received an additional sentence for assault which would have made early release even less likely and

two days earlier, he had been told that the Parole Board had decided he should not be released. He had cut himself four times in the previous 14 days, the last time requiring hospital treatment, and had just assaulted an officer to avoid being located to a wing where he had told staff he had 'issues' (presumably related to drug debts). He was diagnosed with depression and anxiety. He was known to find it very difficult to cope without nicotine and had a long history of self-harming by cutting and ligaturing when he did not have vape capsules. He was now in the segregation unit where he would spend long periods in his cell with no TV and very few distractions.

152. Mr Thomas' behaviour was also known to be very changeable. Although there are many references in his prison records to him being 'smiley', 'polite' and 'respectful', he could also be aggressive, threatening and violent, particularly when he did not have vape capsules. So, his demeanour in the review meeting could not be taken as evidence that his risk had reduced.

153. It is important that ACCT risk assessments and observation levels take full account of the prisoner's risk factors. Although in practice Mr Thomas was checked very frequently by staff on the evening of 4 November, the decision to reduce his level of observations may have affected staff's perception of his risk and the way in which they dealt with him in the segregation unit.

154. Given the well documented importance of Mr Thomas' nicotine addiction in determining his mood and behaviour, we are also concerned that there is no evidence that this was taken into account at the ACCT review on 2 November. Not having vape capsules was an established trigger for Mr Thomas' self-harm and we, therefore, consider that this should have been addressed in the caremap. We also consider that segregation unit staff should have been given guidance on how to respond when Mr Thomas started demanding vape capsules, as he almost inevitably would. Should they simply treat it as poor behaviour and respond punitively (which is what they did); should they give him vape capsules to keep him calm; or should they offer alternatives (such as nicotine replacement patches)?

155. We are also very concerned that no ACCT review took place when Mr Thomas self-harmed in the segregation unit on 3 November. Mr Thomas had been ringing his cell bell repeatedly during the day and had asked to see a Listener (which indicated a level of distress). In the evening he began punching the wall and banging his head on the window (which are forms of self-harm) and then began unpicking the stitches from a previous self-harm wound.

156. A CM and a SO both told the investigator that, on 3 November, they were not concerned that Mr Thomas was a risk to himself, although it is not clear why they reached this view. The CM said that the information that Mr Thomas had self-harmed was submitted in an operations report which he believed would trigger an ACCT review the next morning. None of the CM's decision making or the SO's conversation with Mr Thomas was logged in the ACCT ongoing record as it should have been, and no ACCT review took place the following morning.

157. The Head of Safety when Mr Thomas was at Nottingham, told the investigator that ACCT documentation was not always completed correctly at Nottingham and sometimes caremaps were not filled in. She said she found it "disappointing" that this had been the case for Mr Thomas. She acknowledged that consistency of

ACCT case management had been an issue, along with the inexperience of many staff. She said that it was her experience that often staff were caring well for prisoners but not documenting this adequately.

158. She said that, along with wing CMs, she used to undertake random audits of ACCT documents. She said she was trying to work with newly promoted SOs to improve the quality of the documents. She had also compiled a best practice working document which was issued to all case managers.

159. Nottingham has had an unusually high number of self-inflicted deaths in recent years and we have made repeated recommendations designed to improve the prison's management of ACCT procedures. However, in January 2018, HMIP found that there had been repeated failures to achieve or embed improvements following previous recommendations made by the PPO. The action plan in response to HMIP's Urgent Notification included the deployment of specialist safety staff to work intensively to produce a package of measures to address the establishment's safety needs and ensure the implementation of the PPO's recommendations.

160. Many of the same failings we had previously identified occurred again in this case. We make the following recommendations:

The Governor and Head of Healthcare should ensure that staff manage prisoners at risk of suicide or self-harm in line with national guidelines, including in particular that:

- **all known risk factors are considered when determining the level of risk of suicide and self-harm;**
- **ACCT caremap actions are specific and meaningful, aimed at reducing a prisoner's risk and identify who is responsible for them;**
- **ACCT reviews are held whenever an event occurs that could mean a prisoner is at increased risk; and**
- **all relevant information about risk is documented in the ACCT document.**

The Prison Group Director for the North Midlands should:

- **satisfy himself that processes are in place at Nottingham to ensure that the PPO's recommendations are being implemented and embedded; and**
- **report his findings to the Ombudsman.**

Segregation

Reasons for segregation

161. Mr Thomas was located in the segregation unit on 2 November after he assaulted a prison officer who was trying to move him to B wing.

162. Mr Thomas had been placed on an ACCT at Nottingham on 11 September after he self-harmed saying he was at risk on B wing because he had drug debts there. He was moved to another wing and the ACCT was closed the next day because staff

considered that his issues had been resolved. Mr Thomas was on another ACCT when he returned to Nottingham on 29 October after repeatedly self-harming at Norwich. An officer went through his ACCT documentation with him in reception and he told her that he had issues with prisoners on A and B wings from his previous time at Nottingham.

163. Given this history and given that Mr Thomas was on an ACCT and had self-harmed again since returning to Nottingham, we find it very difficult to understand why he was allocated to B wing and why staff insisted he move there on 2 November. If this had not happened, it is possible that Mr Thomas would not have been segregated.

Alternatives to segregation

164. Prisoners who are being managed under ACCT procedures are particularly vulnerable, and both PSI 64/2011, *Safer Custody*, and PSO 1700, *Segregation*, make it clear that locating them in segregation units should be avoided wherever possible. PSI 64/2011 says:

> "Prisoners on open ACCT plans must only be located or retained in Segregation Units only in exceptional circumstances. The reasons must be clearly documented in the ACCT Plan and include other options that were considered but discounted."

165. We recognise that some vulnerable prisoners may also be very challenging, and may be a risk to others as well as to themselves, as Mr Thomas was. This can leave prison staff with some very difficult decisions about where prisoners managed under ACCT procedures should be held, in order to minimise the risk of harm to themselves and others. As a result, there will sometimes be exceptional circumstances to justify holding prisoners at risk of suicide or self-harm in segregation units. However, this should only happen when all other options have been considered and exhausted.

166. Mr Thomas was a challenging prisoner to manage and an assault on an officer (for whatever reason) is a very serious matter. It may be that segregation was the only realistic option for him in the circumstances. Once he was told he would be segregated, Mr Thomas complied with staff and did not indicate any concerns with the decision. He had been segregated for short periods in the past and had sometimes told staff that he felt more able to cope in segregation than on a standard residential wing. We are, however, concerned that we have seen no evidence that any options other than segregation were considered.

Fitness for segregation

167. In June 2015 we published a learning lessons bulletin based on learning from our investigations into the self-inflicted deaths of prisoners in segregation. This concluded, among other things, that healthcare staff should consider a prisoner's full history when assessing their ability to cope in segregation, not just their current demeanour.

168. We are satisfied that a nurse who conducted Mr Thomas' initial segregation health screen, had attended the ACCT review and was aware of Mr Thomas' history. However, although a nurse (who assessed Mr Thomas as fit for segregation on 3 November) told us that she would 'usually' read a prisoner's ACCT document before assessing him, she could not recall how she had reached the conclusion that

Mr Thomas had no thoughts of suicide or self-harm or whether she had spoken to him. A nurse (who assessed Mr Thomas as fit for segregation on 4 November) told us that he 'would have' read Mr Thomas' ACCT document, but again could not recall if he had spoken to him. There is no record of how they made their assessments.

169. It is important that clinical staff who assess prisoners' fitness for segregation take this responsibility seriously and do not see it simply as a 'tick box' exercise. We consider that they should always attempt to speak to the prisoner and that it should be unusual – and, therefore, memorable – if they were not able to do so. This is particularly important in the case of prisoners on an ACCT. We, therefore, recommend:

The Head of Healthcare should ensure that, in the case of prisoners subject to ACCT procedures, clinical staff who assess fitness for segregation should record in the ACCT document that they have read the document and have spoken to the prisoner concerned (or the reasons why they were not able to do so).

Special provisions for prisoners subject to ACCT

170. Where there are exceptional reasons to justify holding prisoners who are managed under ACCT procedures in segregation units, there are some additional requirements that need to be met by prisons. As well as the initial health screen for all prisoners moved to a segregation unit, PSO 1700 says that prisoners subject to ACCT procedures should have a mental health assessment within the first 24 hours of their segregation, and mental health safeguards, for example observations and dialogue, should also be put in place, and consideration should be given to moving the prisoner to a safer cell.

171. PSO 1700 also says that all prisoners in segregation must have a designated officer who records three quality entries daily on a segregation history sheet. This does not need to be the same person every day. Prisoners should be encouraged to change their behaviour and this should be recorded.

172. Mr Thomas did not have a mental health assessment during his two days in the segregation unit. A nurse who had planned to see Mr Thomas the following week, was working that weekend. She knew nothing of the difficulties Mr Thomas was having but told us that, if she had been asked, she would have gone to see him.

173. We have seen no evidence that any special safeguards to counteract the negative effects of segregation were considered or put in place for Mr Thomas. We have already mentioned that staff were given no guidance on how to respond to his demands for vape capsules. We are also concerned that that there is no evidence that anyone considered the effect of refusing him exercise on 3 November, and that he was not given a radio to occupy himself until 5.00pm on 4 November (by which time he had been segregated for more than two days). The overall impression is that staff viewed Mr Thomas simply as a disciplinary problem, rather than a prisoner who also posed a risk to himself.

174. The post-mortem found that Mr Thomas had used PS before he hanged himself. We are concerned that he was able to do this in the segregation unit while on an ACCT without staff noticing. This raises questions about the quality of staff

interactions with him. We are concerned that there is no evidence that any staff had, or attempted to have, a quality discussion with Mr Thomas three times a day. Although staff told us at interview that they had a lot of interactions with Mr Thomas, these were not recorded as PSO 1700 requires. An officer said that he would never write in segregation paperwork, as he does not usually work in the unit and has not received any guidance on doing so.

175. The Head of Safety acknowledged that the segregation history sheet had not been adequately filled in and that there should have been more detail about Mr Thomas' behaviour. She said that she now checked the history sheets when she went to the segregation unit.

Listeners in the segregation unit

176. On 3 November, Mr Thomas requested a Listener. A SO told him this was not possible as he was in the segregation unit. He told us that he offered Mr Thomas the Samaritans' telephone, although he did not document this. Both the SO and an officer said that, in their years of working in the segregation unit, they had never known a Listener to be allowed to see a prisoner in the unit. The SO therefore assumed this was prison policy.

177. The Head of Safety told the investigator that there had never been a policy that prisoners in the segregation unit could not have access to Listeners. She acknowledged that this rarely happened because of the behaviour of prisoners located in the unit and said it was therefore very unlikely that Mr Thomas would have been allowed access to one. However, she said it should be a decision based on an individual risk assessment. The Governor issued a notice to all staff to this effect on 9 November 2018 after Mr Thomas' death.

178. We make the following recommendations:

The Governor should ensure that staff manage prisoners held in the segregation unit in line with national guidelines, including that:

- **all staff working in the segregation unit understand and follow the mandatory procedures for safeguarding segregated prisoners set out in PSO 1700, and PSI 64/2011, and are aware of their personal responsibilities for protecting prisoners, particularly those identified as at risk of suicide and self-harm;**
- **prisoners subject to ACCT procedures have a mental health assessment within 24 hours of being segregated;**
- **prisoners are provided with the means to occupy themselves, at the minimum, reading material and a radio;**
- **prisoners have a designated officer who makes three quality entries on a daily history sheet; and**
- **prisoners have access to Listeners in line with individual risk assessments.**

Drug strategy at Nottingham

179. From July 2018, Mr Thomas was suspected to be under the influence of PS, requiring an emergency response on six occasions. In September 2018, he told

staff at Nottingham that he had acquired debt due to his use of PS. When he returned to Nottingham at the end of October, he refused to be located on A or B wing, presumably due to the drug debt he had accumulated there and was segregated after he assaulted an officer. The toxicology report showed that Mr Thomas had used PS before he died. This may have influenced his decision to hang himself.

180. We are concerned about the absence of consistent formal recording about Mr Thomas' drug use. On 21 September, staff submitted a security report saying that Mr Thomas was suspected to be under the influence of PS but that he could not be tested as this was the first time he had been suspected of use. In fact, he had been suspected on numerous occasions but no intelligence reports had been submitted.

181. The Head of Drug Strategy told the investigator that she was aware of this issue and she has sent out two notices to staff to remind them that they must submit intelligence reports if they suspect someone to be under the influence of drugs. She told the investigator she would send out another notice. We are not convinced that repeating this notice will be effective. We make the following recommendation:

The Governor should:

- **ensure that staff are vigilant to signs of drug use and take appropriate action, including submitting intelligence reports as required; and**
- **consider the most effective way of embedding this message (as previous notices to staff do not appear to have been effective).**

182. Staff did repeatedly refer Mr Thomas to substance misuse services at Nottingham. The clinical reviewer noted that Mr Thomas did not want to engage in structured interventions in relation to his substance misuse but ongoing support was offered to attempt to engage him.

183. We note that in the year before Mr Thomas' death, two other prisoners at Nottingham had taken PS before they hanged themselves and another died due to PS toxicity. We are concerned that Mr Thomas was apparently able to obtain both PS and subutex without difficulty at Nottingham.

184. As part of Nottingham's Urgent Notification process, the Prison Service's Drugs Task Force analysed Nottingham's drug strategy and made several recommendations which fed into Nottingham's *Substance Misuse Strategy* issued in August 2018, which identifies that PS is the most commonly used drug in the prison.

185. Since June 2018, Nottingham has obtained two scanning machines which test all the mail entering the prison for drugs. Nottingham has also introduced dedicated staff in the visits area who have specialist training to try to reduce the supply of drugs coming in this way. The prison has also increased staff searching and is installing grilles on windows that are closest to the perimeter wall where most illicit items were being thrown over. It has also commissioned several outside agencies to deliver services for drug users. The Head of Drugs Strategy has also introduced a weekly meeting between prison, healthcare and security staff to

analyse substance misuse intelligence. Nevertheless, we make the following recommendation:

The Governor should ensure that the key drug issues at Nottingham continued to be identified and that the prison's local drugs strategy is revised as necessary to ensure that these key issues are being addressed.

Bullying

186. Mr Thomas said that he was in debt due to PS use and could not be located on certain wings at Nottingham. Staff suspected that he had been assaulted because of this debt. Nottingham's violence reduction strategy sets out measures to support victims of bullying, threats and intimidation. It says that suspected bullying should be investigated and, if necessary, escalated to the safer custody team, and measures should be put in place to support the victim. There is no evidence that Mr Thomas was supported by violence reduction procedures. We therefore make the following recommendation:

The Governor should ensure that all information indicating bullying and intimidation is fully coordinated and investigated in line with national and local policies.

Cell bells

187. On the morning of 3 November, a SO documented that staff would only answer Mr Thomas' cell bell in line with ACCT observations. At the time this would have been every two hours. The SO told the investigator that this was his understanding of the policy from a previous notice to staff. In practice, staff continued to answer Mr Thomas cell bell more frequently than this.

188. The head of safety said that a previous notice to staff had said that if a prisoner was misusing his cell bell, a SO could make a dynamic risk assessment about how often they would answer the it. On 9 November 2018, the Governor issued a notice to staff that this decision must be made by a CM. However, the notice specified that if the prisoner was on an ACCT, staff needed to answer the cell bell whenever it rang.

189. Mr Thomas rang his cell bell 90 times from 3.00pm on 2 November (when he was taken to the segregation unit) until he was found unresponsive just over two days later. Most of these cell bell calls were grouped into periods of up to a few hours when Mr Thomas repeatedly pressed his cell bell. Most of these calls were answered within the five minutes expected by HMIP. However, a significant proportion were not, particularly when Mr Thomas was repeatedly pressing his cell bell within a short period. Response times varied, up to a maximum of 22 minutes.

190. We recognise the very real problems for staff if prisoners use their cell bells repeatedly. However, we do not consider that delays in answering cell bells are ever acceptable in the case of prisoners on an ACCT, and we welcome the Governor's acknowledgement of this in the recent notice to staff.

Obtaining vape capsules

191. Much of Mr Thomas' risk to himself was related to his addiction to nicotine and his difficulties in coping when he had no vape capsules. (It appears he did not have enough money to buy as many capsules as he wanted as he was left with very little money each week because he was paying compensation for damage he had caused to his cell in the past.) All staff at Nottingham were clear that they would not give a prisoner vape capsules unless there were exceptional circumstances and that this had been agreed by a senior manager. They said that such circumstances would only occur if the prison was somehow at fault (for example, if it failed to issue Mr Thomas with capsules he had purchased).

192. We note that Mr Thomas had declined a referral to the smoking cessation service when he returned to Nottingham, and we recognise that his incessant demands for vape capsules created a real dilemma for staff at Nottingham. As we have already said, however, we consider that the ACCT careplan should have included advice to segregation unit staff on how to handle this issue.

Clinical care

193. The clinical reviewer concluded that Mr Thomas's clinical care at Nottingham was good and equivalent to that he would have received in the community.

Mental health care

194. The clinical reviewer concluded that Mr Thomas "received responsive interventions from mental health services; his vulnerability was recognised and although he did not engage with structured mental health interventions, ongoing support and monitoring was offered".

195. While at Nottingham, Mr Thomas was regularly reviewed by mental health staff, who were also present at ACCT reviews before he transferred to Norwich.

196. Mr Thomas was reallocated to a mental health practitioner's caseload when he returned to Nottingham and she intended to see him the week after he arrived. While this might have been an appropriate decision at the time it was taken, we consider that the position changed when Mr Thomas was segregated later that day. As a prisoner subject to ACCT procedures, Mr Thomas should have had a mental health assessment within 24 hours of being segregated, and we are concerned that this did not happen.

Substance misuse care

197. On 29 October, Mr Thomas was prescribed medication to minimise his withdrawal symptoms from subutex. He should have had daily assessments to monitor the effect of any withdrawal. However, he did not attend subsequent appointments until 1 November when he said he would like support from the substance misuse team. The clinical reviewer is satisfied that this was appropriate.

Emergency response

198. PSI 03/2013 requires governors to have a two-code medical emergency response system that ensures an ambulance is called immediately when staff have serious concerns about the health of a prisoner. Nottingham's medical emergency response protocol requires staff to call either a code blue (when a prisoner is unconscious or having difficulty breathing) or a code red (when a prisoner has severe bleeding or burns). These should trigger the control room to call an ambulance immediately.

199. Mr Thomas was alive when an officer looked into his cell at 5.54pm. When he checked again at 6.04pm, he could see a ligature and could not get a response from him, and he radioed for staff assistance. There were 90 seconds between the officer first looking into Mr Thomas' cell and staff unlocking the door.

200. Given Mr Thomas' recent behaviour and his potential risk to staff, we consider it reasonable in the circumstances that the officer waited for other staff to arrive before unlocking Mr Thomas' door.

201. The officer told the investigator that he had not seen the ligature when he called for staff assistance, and that he then radioed a code blue once he became more concerned for Mr Thomas's welfare. This is not correct. The investigator listened to the radio traffic after her interview with the officer. It is clear from this that he initially asked the Orderly Officer to go to the segregation unit to remove a ligature. Two minutes later, after entering Mr Thomas' cell, a SO requested an ambulance and another officer radioed a code blue 15 seconds after this.

202. While we appreciate that an officer was not initially sure of the gravity of the situation, he had seen a ligature and knew Mr Thomas was on an ACCT. We consider that he should, therefore, have radioed a code blue emergency immediately.

Emergency equipment

203. When the two nurses, who had been together, heard the code blue emergency called, one went straight to the unit while the other diverted to fetch the emergency bag, arriving at Mr Thomas' cell over three minutes after the first nurse. The clinical reviewer was concerned that there was no emergency bag in the segregation unit and concluded that consideration should be given to locating emergency bags on every unit.

204. We make the following recommendation:

The Governor should ensure that all prison staff are aware of, and understand PSI 03/2013 and their responsibilities during a medical emergency, including efficient communication of the nature of the emergency and ensuring there are no delays in calling an emergency ambulance.

The Governor and Head of Healthcare should ensure that emergency equipment and a defibrillator are located on every wing.

Sentence planning

205. Mr Thomas was serving a life sentence with a 10-year tariff which expired in August 2007. He initially progressed well and was moved to an open prison in preparation for release three times between 2004 and 2013. On each occasion he was returned to closed conditions as a result of his involvement with drugs. After 2013, his behaviour deteriorated significantly: he used drugs on a regular basis and was at times violent to staff and other prisoners. From 2016, he began to self-harm frequently. At the time of his death he was 11 years over tariff and had become despondent about his chances of being released.

206. From August 2015 to May 2017, Mr Thomas spent time in seven different prisons. From May 2017 until his death in November 2018, he was in a further six different prisons: Wayland (three months); Stocken (five months); Bedford (two months); Leicester (three months); Nottingham (three months); Norwich (two weeks); and back to Nottingham for the last six days of his life. Mr Thomas only engaged intermittently with substance misuse services and was a very challenging prisoner to manage. However, we consider that the number of times he was moved between different prisons is likely to have made it more difficult for him to settle and address his drug issues and offending behaviour. It appears that his behaviour was in fact deteriorating rather than improving. We recommend:

The Executive Director of Prisons in HMPPS should ensure that individualised plans are put in place centrally for prisoners serving indeterminate sentences who are significantly over tariff to help them progress towards release.

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