

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Haik Nikolyan, a prisoner at HMP/YOI Aylesbury, on 11 March 2019

A report by the Prisons and Probation Ombudsman



Our vision

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



Our values

We are:

Impartial: we do not take sides

Respectful: we are considerate and courteous

Inclusive: we value diversity

Dedicated: we are determined and focused

Fair: we are honest and act with integrity

OGL

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

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

Mr Haik Nikolyan died on 11 March 2019 after he was found hanged in his cell at HMYOI Aylesbury. He was 21 years old. I offer my condolences to his family and friends.

This is a tragic story of a young and very vulnerable man, with significant risk factors: it was Mr Nikolyan's first time in prison, he was autistic, and he had a history of attempted suicide, self-harm, substance misuse, mental health issues and violence. All of this meant that he found it particularly difficult to cope in prison.

Mr Nikolyan could be challenging to manage at times. He assaulted a female member of staff and fantasised about violent sexual assaults on named female staff.

Mr Nikolyan engaged with the mental health team and drug misuse services but continued to use psychoactive substances (PS). As a result, he accumulated drug debts. This, together with the vulnerabilities resulting from his autism, led to him being bullied both physically and by being made to perform humiliating and demeaning acts.

Mr Nikolyan required additional support but staff did not consistently address his risk factors holistically, and his complex issues warranted enhanced case management. There were also a number of deficiencies in the management of ACCT (Assessment, Care in Custody & Teamwork). In particular, although there is evidence that there was a lot of discussion about Mr Nikolyan's issues, I do not consider that enough was done to identify specific actions that might have helped to resolve these problems.

I am very concerned about the underlying culture of bullying and the availability of PS at Aylesbury. In particular, I am troubled that in trying to manage Mr Nikolyan's risk of bullying, staff moved him to F Wing. On the face of it, this might have appeared an appropriate transfer as F Wing is designated for prisoners less able to cope on a standard wing. However, it was there that his situation deteriorated and his risk of suicide and self-harm significantly increased. Not only did staff not monitor him more closely, but CCTV was not in operation on the landing where Mr Nikolyan lived. In 2017, HM Inspectorate of Prisons drew attention to the fact that prisoners on F Wing felt less safe there than on other wings. Mr Nikolyan's death would suggest that this position has not changed.

I am also concerned that there were deficiencies in the emergency response when Mr Nikolyan was found hanged in his cell.

This version of my report, published on my website, has been amended to remove the names of staff and prisoners involved in my investigation.

Contents

Summary	1
The Investigation Process.....	5
Background Information.....	6
Key Events.....	8
Findings	29

Summary

Events

1. On 6 March 2018, Mr Haik Nikolyan was remanded to HMP Pentonville for robbery and possession of a bladed article. It was his first time in prison. He was autistic and had longstanding and complex mental health issues, including depression, anxiety and a personality disorder. He used psychoactive substances (PS) in prison and was twice monitored under suicide and self-harm procedures, known as ACCT.
2. In May, Mr Nikolyan was sentenced to six and a half years in prison. On 5 July, he was transferred to HMYOI Aylesbury, where his behaviour deteriorated and he was found under the influence of PS on more than one occasion.
3. The mental health and substance misuse teams supported Mr Nikolyan throughout his time at Aylesbury. However, he continued to experience mental health issues and repeatedly found himself in debt (because of his continued use of PS) which jeopardised his safety as it led to him being bullied in an extreme manner, including being made to participate in risky and demeaning behaviour. His own behaviour was challenging to staff, and included expressing explicit sexualised thoughts and creating drawings with inappropriate sexual content. He also assaulted a female member of staff on 6 September 2018 which led to him spending a period in the segregation unit.
4. Mr Nikolyan frequently expressed thoughts of suicide and self-harm and was monitored by ACCT procedures on four occasions after he tried to take his own life and harmed himself. The prison psychiatrist had recorded after an early assessment that Mr Nikolyan was struggling to cope in prison. Despite being moved to F Wing, a wing designated for those less able to cope on a standard wing, on 27 January 2019, his situation deteriorated.
5. On 5 February, Mr Nikolyan turned 21.
6. At 12.56am on 11 March, the night duty officer found Mr Nikolyan hanging from a ligature made from bedsheets. Staff radioed a medical emergency code blue, and the control room called an ambulance. Prison staff tried to resuscitate Mr Nikolyan and when the paramedics arrived, they took over his care. At 2.01am, they recorded that Mr Nikolyan had died.

Findings

Management of risk

7. Mr Nikolyan found it very difficult to cope in prison.
8. He had a number of factors that significantly increased his risk of suicide and self-harm. On the whole, when Mr Nikolyan self-harmed, staff appropriately assessed that he was at risk and monitored him under ACCT procedures.

9. However, we identified a number of deficiencies in the way they did so, including that staff did not start ACCT procedures after two incidents of self-harm, no one from the healthcare team attended two ACCT reviews, Mr Nikolyan did not have a consistent ACCT case manager and staff did not always record information about Mr Nikolyan's risk in his ACCT document and medical records.
10. We are particularly concerned that ACCT caremaps did not identify all the key issues and did not include actions designed to help address them; that there is no evidence that staff considered using the enhanced case review approach (for prisoners with complex needs); and that there is no evidence that anyone considered involving Mr Nikolyan's supportive family.

Location and monitoring Mr Nikolyan on F Wing

11. Mr Nikolyan was moved to F Wing, a wing designated for those who were less able to cope on a standard wing, but his risk increased there as the bullying, PS use, drug debt and risky and challenging behaviour increased. Staff did not monitor him more closely and did not consider moving him to another wing or prison. We are concerned that, although staff knew Mr Nikolyan was vulnerable and was being badly bullied, he was located on the third floor, far away from the staff office on the ground floor. In addition, the CCTV cameras had not worked on the landing where he lived for a number of weeks before his death. This meant that staff were not able to monitor him effectively.

Bullying

12. We are very concerned that although staff knew that Mr Nikolyan was being badly bullied, the bullying continued.
13. Although Aylesbury had a local Preventing Violence Strategy, it did not include formal instructions or guidance for victim support. There is little information recorded to evidence whether or how Mr Nikolyan was supported when he was bullied.

Substance misuse

14. We are very concerned that Mr Nikolyan was able to obtain PS so easily at Aylesbury.

Mr Nikolyan's debt problems

15. Aylesbury does not have a policy about managing prisoners' debt issues. There is scant evidence to demonstrate how staff supported Mr Nikolyan in relation to the drug debts that he accumulated.

Safeguarding of young adults

16. Aylesbury had no links with the local Adult Safeguarding Board and no staff had received safeguarding training to discharge their duty of care for vulnerable prisoners like Mr Nikolyan.

Emergency response

17. Two of the three staff who responded to the emergency had had no recent first aid training. Staff failed to bring a defibrillator to Mr Nikolyan's cell.

Clinical care

18. The clinical reviewer concluded that the healthcare that Mr Nikolyan received at Aylesbury was equivalent to that which he could have expected to receive in the community. Although prison staff supported Mr Nikolyan with his substance misuse issues and warned him of the dangers of using PS, he continued to use them.

Recommendations

- The Governor and Head of Healthcare should ensure that staff manage prisoners at risk of suicide and self-harm in line with national guidelines, in particular:
 - Staff (including healthcare staff) have a clear understanding of their responsibilities and the need to record and share relevant information about risk.
 - Prison, healthcare and mental health staff work jointly to manage prisoners at risk of suicide and self-harm. Healthcare staff should be invited to and attend at least the first ACCT review.
 - Staff hold multidisciplinary ACCT reviews, with the same case manager, which involve staff who contribute to a prisoner's care.
 - Staff consider managing complex cases under the enhanced case management process.
 - Staff consider involving the family in the ACCT process.
 - ACCT case managers complete caremaps, setting specific and meaningful caremap actions, identifying who is responsible for them and reviewing progress at each review.
 - Staff should ensure that the impact on the risk of suicide and self-harm is always considered for apparent victims of bullying and intimidation.
- The Governor should ensure that prisoners are appropriately located and moved, where necessary, so that they remain safe.
- The Governor should develop a strategy to manage prisoners on F wing who pose a risk to other vulnerable prisoners.
- The Governor should ensure that all CCTV cameras are working.
- The Governor should ensure that staff report and record all instances of drug debt, including submitting information to the security team, and take action, where appropriate.

- The Governor should ensure that all information indicating bullying and intimidation is fully investigated and that apparent victims are effectively supported and protected with meaningful solutions which address their individual situation, including through ACCT procedures where appropriate.
- The Governor should ensure that the key drug issues at Aylesbury are identified and that the prison's local drugs strategy is promptly revised to address these issues.
- The Governor and Head of Healthcare should ensure that:
 - staff maintain links with the Adult Safeguarding Board in the community in line with PSI 16/2015;
 - relevant prison staff receive comprehensive safeguarding training to support vulnerable prisoners and keep them safe; and
 - a safeguarding and appropriately qualified lead is appointed.
- The Governor should ensure that adequate first aid arrangements are in place to provide first aid, especially during night state and including that staff are trained on where to find a defibrillator and how to use one.
- The Governor and Head of Healthcare should ensure that information about the management and care of a prisoner is recorded and promptly shared with the relevant staff to assist in identifying and reducing that prisoner's risk.

The Investigation Process

19. The investigator issued notices to staff and prisoners at HMYOI Aylesbury informing them of the investigation and asking anyone with relevant information to contact him. One prisoner responded.
20. The investigator visited Aylesbury in March 2019. He obtained copies of relevant extracts from Mr Nikolyan's prison and medical records.
21. NHS England commissioned a clinical reviewer to review Mr Nikolyan's clinical care at the prison. They interviewed, some jointly, 18 members of staff and one prisoner at Aylesbury during the investigation.
22. We informed HM Coroner for Buckinghamshire of the investigation. He gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.
23. One of the Ombudsman's family liaison officers (FLO) contacted Mr Nikolyan's family to explain the investigation and to ask if they had any matters they wanted us to consider. The FLO and the investigator visited Mr Nikolyan's parents. They wanted to know as much information as possible about the circumstances which led to their son's death. In particular, they were concerned that:
 - Mr Nikolyan had a statement of special needs and had autism. They said that this meant that he had social communication difficulties, and often misunderstood people. They wanted to know what measures Aylesbury put in place to manage his needs.
 - Mr Nikolyan regularly asked them for increasing sums of money to pay his drug debts.
 - They said that Mr Nikolyan was being bullied. They said that during a visit, they saw that he had black eyes and bruises. They had written to the Governor about their concerns and the Governor had responded.
24. Mr Nikolyan's family received a copy of the draft report. The solicitor representing them wrote to us raising 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.

Background Information

HM Young Offender Institution (YOI) Aylesbury

25. HMYOI Aylesbury holds around 440 young adult men who are serving the longest sentences for their age group in the country. Around two thirds of the population are aged between 18 and 21 years, with a third over the age of 21 and awaiting transfer to the adult prison estate.

HM Inspectorate of Prisons

26. The most recent inspection of HMYOI Aylesbury was in April 2017. Inspectors reported a combination of volatile and frustrated young people, too few staff, many of whom were inexperienced, and prisoners locked up for long periods with no activity and too little sentence progression. Some officers were dismissive or appeared too busy to fully engage with prisoners, and others seemed to lack confidence. Supervision on wings by residential officers was sometimes insufficient, and they did not always challenge inappropriate conduct from prisoners appropriately.
27. Inspectors noted that these factors led to some poor outcomes and safety was a major concern. They found that nearly two-thirds of prisoners reported that they had felt unsafe at some point, particularly those on F Wing, and that there were high levels of sometimes very serious violence. Inspectors noted that the prison had a safeguarding policy and good links to the local safeguarding adults board. They were concerned about weak, internal arrangements to safeguard prisoners from violence. Despite a challenging population, they noted that there had been no self-inflicted deaths but levels of self harm were high and had increased since the previous inspection. Inspectors found that staff did not consistently identify and support prisoners at risk.

Independent Monitoring Board

28. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report for the year to June 2018, the IMB reported that less than half of the prisoners are of white ethnic origin, lower than in most other prison establishments. The institution had a capacity of about 440 and had been almost full for most of the reporting year. Prisoner intake covered most of England and Wales. The prisoners were some of the most disruptive and challenging young men in the prison system. Halfway through the reporting year, Aylesbury YOI became part of the Long-Term and High Security Estate (LTHSE), recognising the challenging nature of its occupants. The incidence of acts of self-harm by prisoners had been dramatically reduced from 451 in the previous year (2016/17) to 255 in 2017/18.

Previous deaths at HMYOI Aylesbury

29. The last death of a prisoner at Aylesbury before Mr Nikolyan's death was in November 2011. It was a self-inflicted death.

Assessment, Care in Custody and Teamwork

30. ACCT is the Prison Service care-planning system used to support prisoners at risk of suicide or self-harm. The purpose of ACCT is to try to determine the level of risk, how to reduce the risk and how best to monitor and supervise the prisoner.
31. After an initial assessment of the prisoner's main concerns, levels of supervision and interactions are set according to the perceived risk of harm. Checks should be irregular to prevent the prisoner anticipating when they will occur. There should be regular multidisciplinary reviews, involving the prisoner. As part of the process, a caremap (plan of care, support and intervention) is put in place. The ACCT plan should not be closed until all the caremap actions have been completed. All decisions made as part of the ACCT process and any relevant observations about the prisoner should be written in the ACCT booklet, which accompanies the prisoner as they move around the prison. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011.

Psychoactive substances (PS)

32. PS (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 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.
33. In July 2015, we published a Learning Lessons Bulletin about the use of PS 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.
34. HM Prison and Probation Service (HMPPS) now has in place provisions that enable prisoners to be tested for specified non-controlled PS as part of established mandatory drugs testing arrangements.

Key Events

35. Mr Haik Nikolyan was 21 years old. He had moved to the UK from the US in 2004. He regularly misused illicit drugs and prescribed medication. He had autism, anxiety, depression and a personality disorder. He was regularly prescribed mirtazapine, sertraline (both antidepressants) and quetiapine (an antipsychotic).

HMYOI Pentonville

36. On 6 March 2018, Mr Nikolyan was remanded to HMP Pentonville, charged with robbery and possession of a bladed weapon. Mr Nikolyan arrived in prison with a Person Escort Record (PER) which noted his history of attempted suicide and self-harm and that he had autism which made him vulnerable.
37. Staff recorded in reception that it was Mr Nikolyan's first time in prison. A nurse completed an initial health screen and noted that had no thoughts of suicide or self-harm, he had not harmed himself for seven months, he had autism, anxiety and depression and had previously taken an overdose of prescribed medication. Mr Nikolyan told the nurse that he was currently taking mirtazapine (an antidepressant). A prison GP reviewed Mr Nikolyan and referred him to the mental health team.
38. On 9 March, staff started suicide and self-harm procedures, known as ACCT, after Mr Nikolyan tried to hang himself from the pipes in his cell. Staff referred him to the mental health team, monitored him regularly and completed ACCT reviews. In April, staff stopped ACCT monitoring and noted that Mr Nikolyan had settled well and had no thoughts of self-harm.
39. The next day, a member of the mental health team saw Mr Nikolyan because he reported that he was depressed and not sleeping well. The nurse increased his mirtazapine dosage and referred him to the prison psychiatrist. A member of the substance misuse team offered Mr Nikolyan support and advice after he admitted taking cannabis and codeine.
40. In late April and at Mr Nikolyan's request, a prison GP changed his antidepressant to sertraline because he said that mirtazapine did not work.
41. In May, staff found Mr Nikolyan under the influence of PS. His pupils were dilated and his speech was slurred. A member of the healthcare team examined him and offered support. Staff later started ACCT procedures after Mr Nikolyan harmed himself by cutting the name of his ex-girlfriend on his arm. Staff also found a noose in his cell. Mr Nikolyan said that his relationship with his girlfriend had ended, he had regularly used PS and he felt paranoid.
42. Staff completed regular ACCT reviews which healthcare staff attended. Mr Nikolyan said that he found it difficult to cope as it was his first time in prison and that he had used PS daily as a coping mechanism. He was worried about his court hearing on 30 May. The substance misuse team offered him support.
43. On 28 May, Mr Nikolyan made a phone call to his family. He asked them to pay money into two bank accounts (for £25 and £50) to settle his drug debts. Mr

Nikolyan told his family that he was not coping in prison and needed PS. His family were unhappy and although they had previously paid his debts, they refused to do so any more.

44. On 30 May, Mr Nikolyan was sentenced to six years and six months in prison. Three days later, he cut his right arm and neck. He said that he had used PS because he was stressed about the length of his sentence and had been bullied by another prisoner on the wing. He asked for a transfer to another prison and staff told him to submit a transfer application. They offered to move Mr Nikolyan to a different wing but he refused. Staff continued to monitor Mr Nikolyan under ACCT procedures and set hourly observations.
45. On 7 June, Mr Nikolyan reported that his cellmate had assaulted him and he received a black eye. Staff moved Mr Nikolyan to a different wing while they investigated. An ACCT review was completed during which Mr Nikolyan admitted that he had also swallowed a razor blade. Healthcare staff examined him but raised no concerns. He spoke to a Listener that day. (Listeners are prisoners trained by the Samaritans to provide confidential emotional support to their peers.)
46. Staff completed regular ACCT reviews with Mr Nikolyan which healthcare staff attended. Mr Nikolyan denied thoughts of suicide or self-harm, although his mood fluctuated. He said that he tended to harm himself when he smoked PS. Staff told him that he would soon be transferred to HMYOI Aylesbury.
47. At an ACCT review on 3 July, Mr Nikolyan said that he only had occasional thoughts of harming himself but did not intend to act on them. He said that he had stopped using PS and was eager to move to another prison. The mental health nurse who attended the review noted that she had no concerns about Mr Nikolyan's mental health. She noted that he had regularly attended support groups in the day care centre and appeared positive. The review panel noted that Mr Nikolyan's mood was stable and that he had good family support. The case review decided that Mr Nikolyan was no longer at risk of suicide or self-harm and ended ACCT monitoring.

HMYOI Aylesbury

48. On 5 July, Mr Nikolyan was transferred to Aylesbury. A nurse completed his initial health screen. He noted that Mr Nikolyan had a history of attempted suicide and self-harm, overdose, substance misuse (PS), anxiety, depression, autism, Asperger's syndrome and learning difficulties. He noted that Mr Nikolyan was prescribed sertraline. Mr Nikolyan told the nurse that he had coped well since ACCT procedures were stopped (two days earlier) and had no current thoughts of self-harm. He was located on D Wing.
49. On 6 July, a prison GP, saw Mr Nikolyan and increased Mr Nikolyan's sertraline dosage after he had complained that the medication was not working and he was not sleeping well.
50. A nurse from the mental health team met Mr Nikolyan on 12 July. She noted that Mr Nikolyan engaged well, was polite and had no thoughts of self-harm. The nurse agreed that a mental health assessment would be completed on 17 July and Mr

Nikolyan would be added to the list of patients to be discussed at the weekly multidisciplinary complex case meeting.

51. A learning disability nurse and mental health team leader completed Mr Nikolyan's mental health assessment on 17 July. She noted his medical history. Mr Nikolyan said that his mood was low, admitted that he felt paranoid and hearing the voices of a male and female who talked to him. He asked for his medication to be changed to olanzapine (an antipsychotic). She referred Mr Nikolyan to the prison psychiatrist to assess his intelligence and cognitive ability.
52. On 19 July, an officer recorded in Mr Nikolyan's prison records that he had settled well on the wing. The officer described him as polite and quiet and said that he kept to himself. Mr Nikolyan had raised no concerns.
53. On 7 August, the prison psychiatrist, and a nurse assessed Mr Nikolyan. He denied thoughts of self-harm. He said that he was in a single cell on B wing but expected to be moved to A Wing that day. However, he wanted to be moved to F wing (the Vulnerable Prisoners' Wing). The prison psychiatrist noted that Mr Nikolyan had failed to collect his sertraline on a number of occasions and as a consequence, the GP stopped his prescription. Mr Nikolyan said that he had auditory and visual hallucinations. She discussed how he could manage these symptoms. She noted that Mr Nikolyan had an autism spectrum disorder and depression. She questioned whether his symptoms of auditory and visual hallucinations amounted to the early onset of psychosis or an emerging personality disorder. She noted that the mental health team would continue to monitor Mr Nikolyan weekly and if his symptoms persisted, she suggested that he might be referred to a secure hospital. (It was later decided that Mr Nikolyan's mental health concerns and issues could be managed in prison.) She restarted Mr Nikolyan's sertraline prescription and noted that she would see him again in two weeks' time.

A Wing

54. On 8 August, Mr Nikolyan was moved to A Wing.
55. On the night of 11 August, staff responded to Mr Nikolyan's emergency cell bell and found that he had tied a ligature around his neck that had been attached to a screw in the wall. Mr Nikolyan was tearful and said he had received the news that a childhood friend had recently died. Staff started ACCT procedures. Mr Nikolyan spoke to a Listener. He told staff that he had no intention to self-harm again or repeat his actions as he had scared himself. Staff emailed the mental health team to raise their concerns about Mr Nikolyan and agreed to monitor him three times an hour under ACCT procedures.
56. On 12 August, an officer completed an ACCT assessment and noted that Mr Nikolyan was upset, his mood was low and he admitted to hearing voices. He had no current thoughts of suicide or self-harm and spoke openly about his concerns and difficulties. The assessment identified some coping mechanisms: a potential wing move, getting a job, engaging with the chaplaincy, mental health and substance misuse team support and consideration of whether he should be prescribed antipsychotic medication.
57. Afterwards, a nurse saw Mr Nikolyan and discussed the previous day's events.

58. On the same day, a Supervising Officer (SO) chaired the first ACCT review. Two officers and a staff member from the chaplaincy team were present. No one from the healthcare team attended. Mr Nikolyan reiterated that he was upset because of his friend's death. The SO, as his ACCT case manager, recorded issues of boredom, the death of friend, anxiety/depression and drugs on Mr Nikolyan's caremap. A member of the chaplaincy team had also spoken to Mr Nikolyan and offered him support.
59. On 13 August, a nurse saw Mr Nikolyan. She recorded that he was tearful when he talked about his friend who had died and said that he was hearing voices. He said that another prisoner had also told him to take his own life. Mr Nikolyan said that wing staff had offered to move him to F Wing. The nurse noted that she would conduct some work with Mr Nikolyan about him "hearing voices" but wanted to talk to him about his friend and his attempted suicide. She noted that Mr Nikolyan was taking his medication and that he said that he had no current thoughts of self-harm.
60. On 14 August, the prison psychiatrist and a nurse assessed Mr Nikolyan who reported having auditory hallucinations. He described hearing a female voice which comforted and encouraged him to do positive things and a male voice which made derogatory remarks about him and told him to kill himself and harm others. He said that he was disappointed that he had not succeeded in taking his own life and it was inevitable that he would kill himself. He described his mood as persistently low and said that he felt hopeless. Despite this, Mr Nikolyan told her that he had no intention to act on his thoughts.
61. During the assessment, Mr Nikolyan twice said that the male voice in his head had told him to sexually assault a female wing officer whom he had seen that day. He believed that his actions would ensure that staff would move him to F wing as he would be considered a sex offender. (He believed that F Wing was only for sex offenders. This was not the case.) The prison psychiatrist explained to Mr Nikolyan the possible consequences of acting on his thoughts. This included moving him to the segregation unit, facing a disciplinary hearing, being charged with a sexual offence which would likely increase his prison sentence and mean that he would be placed on the sex offenders register. She noted that Mr Nikolyan appeared surprised. She told Mr Nikolyan that he would not end up on F Wing and it would not solve his problem of wanting to move from his current wing. She highlighted to him that his autism made it less likely that he would think of the impact of his actions on others. She told him that he needed to speak to staff if he was struggling or was having such thoughts so that they could support him.
62. The prison psychiatrist recorded that Mr Nikolyan was struggling to cope in custody, had maladaptive personality traits and difficulty managing his emotions and risky behaviour, partly due to his autism. Mr Nikolyan had described having auditory hallucinations which were worse when he felt stressed or upset, for example, telling him to sexually assault someone so he could move to F Wing. She noted that Mr Nikolyan was developing possible depression and symptoms of psychosis, which were causing him distress. She suggested that Mr Nikolyan might benefit from a trial of antipsychotic medication. She prescribed him olanzapine (an antipsychotic), as well sertraline which had already been prescribed. She noted that the nurse would continue to support Mr Nikolyan and provide him with psychoeducation to address his hearing of voices. She submitted a security intelligence report that

noted that Mr Nikolyan had thoughts of sexually assaulting a female officer to try to be moved to F Wing. She agreed to review Mr Nikolyan.

63. The nurse and Mr Nikolyan created a ACCT care plan. She gave Mr Nikolyan a self-help booklet on hearing voices. The care plan noted that staff should:
 - help Mr Nikolyan access healthcare and provide primary mental health intervention;
 - make sure that the ACCT document accompanied Mr Nikolyan to the healthcare unit; and
 - ensure that Mr Nikolyan's mental health keyworker attended ACCT reviews.
64. The security team recorded in Mr Nikolyan's prison records that he was a "risk to females" as he was fixated with female staff. It noted that if any future intelligence was received, a protocol for how to manage Mr Nikolyan would be put in place.
65. On 23 August, the SO chaired an ACCT review. A member of the chaplaincy and substance misuse team were present, and a member of the mental health team contributed by phone. Mr Nikolyan said that he felt much more settled in prison. He said he still heard voices and the mental health team was supporting him. The case review team decided that Mr Nikolyan was no longer at risk of suicide or self-harm and ended ACCT monitoring. The SO updated Mr Nikolyan's caremap and indicated that all actions had been completed. The mental health, substance misuse and chaplaincy teams supported Mr Nikolyan who had also applied for a job.
66. On 28 August, Mr Nikolyan reported to staff that a prisoner was threatening him. Staff submitted a security intelligence report and took action to address the perpetrator's behaviour.
67. On 30 August, staff gave Mr Nikolyan a prison warning for repeatedly making inappropriate and misogynistic comments in front of a female member of staff.
68. A forensic psychiatrist, reviewed Mr Nikolyan on 3 September. Mr Nikolyan said that his mood was still low but he no longer had thoughts of self-harm. He had a job in the horticultural workshop which he attended daily. He talked about his friend who had recently died. The forensic psychiatrist offered to refer him for bereavement support. He changed his olanzapine to quetiapine as Mr Nikolyan complained it had made him put on weight.
69. On 4 September, staff submitted a security intelligence report that noted they had found sexually explicit material written by Mr Nikolyan in his cell. Mr Nikolyan wrote that the "voices" had told him to sexually assault and rape a female member of staff, whom he named. When staff challenged Mr Nikolyan about the content of the written material, he said that he had no intention of acting on these thoughts. That day, a Supervising Officer (SO) spoke to Mr Nikolyan about the inappropriate comments he had made.
70. From August to February 2019, Mr Nikolyan was discussed at the weekly healthcare multi-professional complex case meetings, which members of staff from the healthcare, substance misuse, psychology and pathways attended.

71. On 6 September, the horticultural teacher, asked Mr Nikolyan to leave the workshop after she found him with inappropriate written material, which included violent and sexual content about her and other female members of staff. Mr Nikolyan refused to leave the workshop. She tried to open the classroom door so that she could escort Mr Nikolyan to prison staff. Mr Nikolyan pulled her violently backwards by her hair, and dragged her across the classroom. Other prisoners intervened, attacked and beat Mr Nikolyan. Mr Nikolyan then threw furniture around the room. An officer, who was also present, raised the alarm.

Segregation unit

72. Staff responded to the alarm in the workshop and moved Mr Nikolyan to the segregation unit. A nurse examined Mr Nikolyan and assessed that he was fit to remain in the segregation unit. However, the nurse sent Mr Nikolyan to hospital because of a wound to his eyelid that he had sustained during the incident.
73. Mr Nikolyan returned to prison that same day. He was charged with the assault on the horticultural teacher, and having a book of drawings that he had completed which depicted graphic sexual situations.
74. The security team issued a security notice to warn staff that Mr Nikolyan was a risk to females and they should not have contact with him alone. Mr Nikolyan's allocated mental health nurse was changed to a male nurse. Staff searched Mr Nikolyan's cell and found more material, depicting suicide and self-harm and containing sexual comments about female staff.
75. On 7 September, two nurses, also a mental health nurse, saw Mr Nikolyan who talked about the previous day's incident and described having sexual fantasies about female staff. A nurse passed this information to the security team and the prison managers.
76. There was a disciplinary hearing on 8 September at which Mr Nikolyan pleaded guilty to the charges. The hearing was adjourned. A psychological assessment was arranged for Mr Nikolyan to assess his risk, including to staff. Aylesbury also referred the incident to the police.
77. While in the segregation unit, prison staff, including prison managers, healthcare staff and members of the chaplaincy team, reviewed Mr Nikolyan daily to check on his wellbeing. Staff reported that Mr Nikolyan adhered to the segregation regime and was polite.
78. On 13 September, the Safer Custody Hub Manager, emailed numerous prison staff, including a SO from the segregation unit, Mr Nikolyan's offender supervisor, a psychologist, the Head of Residence, and members of the mental health team. The Safer Custody Hub Manager noted that the Interdepartmental Risk Management Team (IRMT) agreed that Mr Nikolyan would be returned to B Wing once his time in the segregation unit came to an end and that anti-violence procedures would be put in place to monitor Mr Nikolyan's behaviour and ensure staff safety before he returned to the wing.
79. On 18 September, two nurses reviewed Mr Nikolyan who denied thoughts of suicide and self-harm but said that he was still hearing voices and had sexual thoughts

about staff. They discussed moving him to a standard residential wing. Mr Nikolyan said that if he was bullied, he would consider hanging himself.

80. On 20 September, the psychologist, saw Mr Nikolyan in the segregation unit. He discussed Mr Nikolyan's recent behaviour and explained to him that he was assessing what support he needed from staff in the segregation unit to help him move back to B Wing.
81. The Safer Custody Hub Manager chaired the multidisciplinary meeting that day and discussed how to manage Mr Nikolyan when he returned to B Wing.
82. On 3 October, the psychologist emailed a number of staff, including the safer custody and mental health team, about how to support Mr Nikolyan. He attached Mr Nikolyan's intelligence and cognitive ability report which noted that Mr Nikolyan's cognitive functioning was above average which indicated that he could follow instructions and rules and access mainstream interventions. Mr Nikolyan was assessed as having autism spectrum issues such as inflexible thinking, poor awareness of consequences and problems understanding others' perspectives. The report noted that staff should not shout at Mr Nikolyan when making requests as this would make him very anxious, noted that he liked rules, routine and structure, and that he lacked empathy and often fixated on specific people. The psychologist noted that he also intended to complete some individual sessions with Mr Nikolyan the following week and would report back to staff.
83. On 23 October, two nurses reviewed Mr Nikolyan. Mr Nikolyan told them that he fantasised about female prison staff but denied thoughts of self-harm. A nurse told Mr Nikolyan that it was likely that he would return to a standard wing that week. Mr Nikolyan said that if he was bullied, he would hang himself. She reminded Mr Nikolyan that the substance misuse, psychology and mental health teams would continue to support him.

Mr Nikolyan's relocation to B Wing

84. Mr Nikolyan was relocated to B Wing on 24 October. He had a care plan in place. Healthcare staff continued to review and discuss Mr Nikolyan regularly at their multi-disciplinary healthcare meetings.
85. On 29 October, staff submitted a security intelligence report after Mr Nikolyan made unacceptable sexual comments about a female member of staff on B Wing. The next day, a nurse and the offender supervisor saw Mr Nikolyan to discuss the incident with him. Mr Nikolyan said that he made the comment as a compliment to the officer but accepted that his comment was inappropriate.
86. Staff continued to monitor Mr Nikolyan under the anti-violence procedures. They noted that he still made some inappropriate comments about female staff. When a nurse saw Mr Nikolyan on 19 November, Mr Nikolyan said that he was managing well on B Wing, his medication was working and he had no thoughts of self-harm.
87. On 22 November, Mr Nikolyan was admitted to hospital with a fractured jaw. He initially told staff that he had fallen over but subsequently admitted that another prisoner had assaulted him.

88. On the same day, the police contacted Aylesbury's security team to tell them that Mr Nikolyan had recently written to a former victim in which he made threats to rape and murder her if she did not write back to him. They told the mental health team and put in place procedures to monitor Mr Nikolyan's mail.

Segregation unit

89. On 23 November, the hospital discharged Mr Nikolyan with strong pain relief medication and he returned to Aylesbury. Staff located him in the segregation unit temporarily for his own safety. A nurse recorded in Mr Nikolyan's medical record that managers were considering where to move him and whether to move him to another prison.
90. The nurse reviewed Mr Nikolyan on 26 November. Mr Nikolyan said that he was not happy in the segregation unit and felt that he was being punished for being assaulted. He said that it was affecting his mental health and the "voices" were getting worse. He wanted to return to B Wing as the prisoner who had assaulted him had been moved to D Wing.

B Wing

91. Mr Nikolyan was moved to B Wing on 26 November. On 27 November, an IRMT meeting took place to discuss Mr Nikolyan and his recent behaviour. The mental health team continued to review him weekly.
92. On 2 December, an officer recorded that during the association period, he noticed that Mr Nikolyan had a fixation on female staff.
93. The next day, security intelligence reported that Mr Nikolyan had said in telephone calls that he was in debt to other prisoners because of his PS use. Mr Nikolyan had asked his mother to pay his drug debts and had given her bank account details of whom to pay.
94. On 6 December, staff searched Mr Nikolyan's cell. They found numerous names of female staff written on paper. They informed the security team and staff were reminded to be alert to Mr Nikolyan's inappropriate behaviour.
95. When the nurse saw Mr Nikolyan on 7 December, he said that he was getting on well on B Wing. Mr Nikolyan said that the prison GP had stopped his pain relief medication four days earlier and replaced it with a mild analgesic to help with his jaw pain. Mr Nikolyan said that he had cut his arm to cope with the "physical and mental" pain of no longer having access to strong pain relief. He had submitted an application to see the GP to discuss this. She saw that Mr Nikolyan had fresh cuts on his arm. He discussed distraction techniques with Mr Nikolyan who responded positively to suggestions made. ACCT procedures were not started.
96. On 8 December, staff started ACCT procedures after they found Mr Nikolyan distressed in his cell, having a "breakdown". He was stammering, trembling and crying. Mr Nikolyan said that he could not cope. A nurse escorted him to the healthcare unit. Mr Nikolyan told her that he had cut his left forearm five days earlier but had not told anyone. Mr Nikolyan calmed down intermittently but said that he wanted to die.

97. Following this incident, staff submitted a security intelligence report. It noted that Mr Nikolyan had been upset because he had borrowed a vape capsule (from an unnamed prisoner) who had demanded immediate payment for it and had threatened to beat him up. Staff had identified the possible perpetrator and informed security.
98. The next day, a SO chaired Mr Nikolyan's first ACCT review. A nurse and an officer attended. Mr Nikolyan said that he had been okay until his codeine was stopped. He said that his jaw still hurt, he felt anxious and had fleeting thoughts of self-harm. However, Mr Nikolyan had made plans for his future and said that he was happy to remain on B Wing. He asked about whether he could be transferred to HMP Grendon and wanted to speak to his offender supervisor about this. The review panel reminded Mr Nikolyan of the support available to him. They set his observations at one every two hours during the day, hourly during patrol state and staff were required to have three conversations with him daily. The nurse booked an appointment for Mr Nikolyan to see the prison GP to discuss his medication and noted this in the ACCT caremap. The SO the case manager, did not include that Mr Nikolyan wanted to see his offender supervisor about a possible transfer. The review panel scheduled the next review for 14 December and noted that members of the substance misuse and chaplaincy team should be invited.
99. A Custodial Manager (CM) completed Mr Nikolyan's ACCT review on 14 December. The SO, a nurse, chaplaincy staff, Mr Nikolyan's offender manager, the substance misuse and psychology teams were present. Mr Nikolyan said that he had attended a workshop daily, and watched television in his cell to manage his stress levels. He said that he had managed to clear his drug debts. Mr Nikolyan admitted that he had used PS the previous week as a one off and had received support from the substance misuse team. The review panel agreed to chase Mr Nikolyan's appointment with the prison GP. They scheduled the next review for 21 December and made no changes to his ACCT observations or caremap.
100. A prison GP, saw Mr Nikolyan on 17 December. He recorded that Mr Nikolyan's jaw injury was healing well and there was no need to prescribe stronger pain killers.
101. A CM chaired Mr Nikolyan's ACCT review on 21 December. The SO and a nurse were present. Mr Nikolyan told them that he self-harmed as a coping mechanism when other prisoners made negative comments about him. Mr Nikolyan said that he had had a good week and the pain killers he had had taken for his jaw injury had helped. He said that he did not want to be monitored under ACCT procedures but the panel agreed to continue monitoring him. They reduced the frequency of his observations to one observation every two hours at night and for staff to have three conversations with him daily. The next ACCT review was scheduled for 28 December.
102. The forensic psychiatrist and a nurse reviewed Mr Nikolyan on 24 December. Mr Nikolyan said that he felt better and things on the wing had improved. He said that he still heard voices occasionally. He said that he had no thoughts of self-harm but said that this could easily change if his situation deteriorated. He said that he felt pressurised to use PS on the wing. He said that other prisoners had given him what he believed were free PS samples but he accumulated drug debts for them. The forensic psychiatrist warned Mr Nikolyan that if he used PS, his quetiapine medication would be stopped.

103. On 28 December, a SO chaired an ACCT review. An officer attended. No one from the healthcare team attended. Mr Nikolyan said that through his medication, he had learned to cope better with his anxiety and would continue to engage with the prison's support services. The review panel agreed that Mr Nikolyan's risk of harm was low and ended ACCT monitoring. The SO updated the caremap and noted that the healthcare team had given Mr Nikolyan pain relief for his jaw.
104. That evening, a nurse briefly spoke to Mr Nikolayan when he was on his way to collect his medication. Mr Nikolyan said that he was okay, and had been watching television and listening to music to reduce his stress level. He said that he had no thoughts of self-harm. The nurse noted that the SO had told him that they had stopped ACCT monitoring earlier that day.
105. On 30 December, Mr Nikolyan's parents telephoned the prison and said they were concerned about him. They reported that Mr Nikolyan had telephoned them and asked them to pay £150 into a bank account to pay for his PS debts. Mr Nikolyan said that he had been forced to test unknown drugs and afterwards, the perpetrators told him that he had to pay for them or he would be attacked. Mr Nikolyan's parents said that they had previously paid some of their son's debts. A security intelligence report was generated and the supervising officer on the wing offered Mr Nikolyan support. Staff were to review whether Mr Nikolyan should be moved to a different wing but nothing was recorded about this.

January 2019 onwards

106. On 1 January, staff found and removed items of pornography and photos of a female from Mr Nikolyan's cell during a routine search.
107. On 2 January, Mr Nikolyan's mother emailed the Governor to raise concerns about her son. She said that Nikolyan was vulnerable, had accumulated significant drug debts, was being bullied and had been assaulted.
108. The Governor replied to Mr Nikolyan's mother the next day to say that different services, including the substance misuse team and the mental health team, were supporting Mr Nikolyan's complex needs. She wrote that an IQ assessment had been completed to determine Mr Nikolyan's level of functioning to guide staff in how best to engage with him. She noted that Mr Nikolyan had assaulted a female member of staff, and that Aylesbury was concerned about his risk to staff. The Governor noted that she had asked a member of the security team to speak to Mr Nikolyan and to offer support.
109. The psychologist, mentioned in an e-mail to the Governor that the psychology department had discussed Mr Nikolyan and it was thought that it might be best for him to access interventions in the adult estate because of his risky behaviour towards female staff and because his autistic traits may be more of an issue when he mixed with young offenders.
110. A nurse saw Mr Nikolyan on 4 January for his weekly review. Mr Nikolyan said that he had not been feeling well physically but had not harmed himself. The nurse noticed that Mr Nikolyan's CD player was not in his cell. Mr Nikolyan said that he had lent it to another prisoner and denied that he had been forced to give it away to settle a debt.

111. On 8 January, the forensic psychiatrist reviewed Mr Nikolyan's medication after he told the substance misuse team that he continued to use PS. The forensic psychiatrist replaced his quetiapine prescription with sertraline. He told us that since Mr Nikolyan had only taken quetiapine intermittently, the risk of drug interaction with PS was greater than any withdrawal risk if quetiapine was stopped. She noted that the medication would not be reinstated until Mr Nikolyan stopped using PS.
112. On 16 January, staff started ACCT procedures after Mr Nikolyan was found making a ligature from a shoelace which he had tied to the window in his cell. He had also made superficial scratches on his arm and written a suicide letter. Mr Nikolyan said that he was being bullied on the wing and named three prisoners. Staff set his ACCT observations at twice hourly, with staff required to have three conversations with him a day. A security intelligence report noted that Mr Nikolyan was being bullied for his television and other items. Other prisoners had apparently teased him because of his stammer and told him to do things like getting into a dustbin. The report said that staff should be vigilant and take the necessary action against the prisoners who had bullied Mr Nikolyan. Mr Nikolyan refused to name the prisoner(s) to whom he was in debt. The care plan created by the psychologist was attached within the ACCT document for staff reference.
113. On 17 January, a SO chaired a first ACCT review. An officer, the ACCT assessor, and members of staff from the chaplaincy team, from the substance misuse team and a nurse attended. Mr Nikolyan said that he regretted his actions from the previous day. He said that he was frustrated about being bullied and he found it difficult to cope. He wanted his medication reinstated as he felt it helped him to calm down. He said that his stammer had returned since his medication was stopped and he was not sleeping well. The panel explained again to Mr Nikolyan why his medication was stopped. They did not change the frequency of his ACCT observations. The SO recorded on the ACCT caremap that staff had removed Mr Nikolyan's laces, that he should have a drug test and would be moved to F Wing. Nothing was recorded about what action would be taken about his drug debt and bullying.

F Wing

114. On the same day (17 January), Mr Nikolyan moved to a single cell on the third floor landing on F Wing, the wing for prisoners who found it difficult to cope on a standard wing, and was removed from the workshop he attended. Mr Waters told us that when Mr Nikolyan was on B Wing, he was located near the staff office where they could keep an eye on him. He said that monitoring him on F wing would have been less effective because the staff office was on the ground floor. Mr Waters also said that it was likely that Mr Nikolyan's debts followed him to F Wing.
115. On 18 January, two nurses saw Mr Nikolyan. Mr Nikolyan said that he was happy on F Wing, was in good spirits and had no thoughts of self-harm although he had cut his arm the previous day. A nurse reminded Mr Nikolyan of coping techniques.
116. That day, a female officer reported that she felt unsafe because Mr Nikolyan kept staring at her bottom. She suggested that Mr Nikolyan should be moved to the ground floor near the staff office. There are no records about whether this was considered.

117. On 21 January, a SO chaired an ACCT review. Another SO, staff from the substance misuse team and a nurse attended. Mr Nikolyan said that he was happy on F Wing, had applied for a job in the laundry and had no thoughts of self-harm. He said that he had not used PS for two weeks. Mr Nikolyan asked when his antipsychotic medication would be reinstated. The panel told him that he would have to be free from illicit substances for at least 30 days and test negative for drugs before the psychiatrist would review this. The panel did not change the frequency of his ACCT observation levels or record anything new on the caremap.
118. On 23 January, the psychologist emailed a SO and sent her Mr Nikolyan's segregation review to share with F Wing staff. He noted that Mr Nikolyan should not have lone female contact, he should only be unlocked by male staff and should be located on the ground floor so that staff could see him.
119. A security intelligence report that day noted that Mr Nikolyan had displayed inappropriate sexual behaviour towards a female member of staff.
120. On 25 January, a SO chaired an ACCT review. Staff from the chaplaincy team, and a nurse attended. Mr Nikolyan said he had no thoughts of self-harm, felt well and had felt better able to control his emotions since moving to F Wing. He had made several friends on the wing and had not experienced any bullying or harassment. The case review panel assessed Mr Nikolyan's risk as low and ended ACCT monitoring.
121. The next morning, staff found Mr Nikolyan unconscious and having a seizure in the exercise yard. Staff called a medical emergency code blue and Mr Nikolyan was taken to hospital. At the hospital, Mr Nikolyan admitted that he had taken PS before he collapsed. He said that a prisoner on F Wing had given him PS but he would not say who it was. A security intelligence report noted that Mr Nikolyan had said that he did not have to pay for the PS.
122. On 27 January, a nurse spoke to Mr Nikolyan about his PS attack. Mr Nikolyan said that he wanted his antipsychotic medication restarted. That day and again on 29 January, a security intelligence report noted that Mr Nikolyan had offered sexual services to prisoners on F Wing.
123. Mr Nikolyan started working in the laundry room on F Wing on 29 January and told staff that he was happy.
124. On the afternoon of 1 February, staff saw Mr Nikolyan collapse and he hit his head on a pool table before he landed on the floor. He then started having seizures. Staff called a code blue, the healthcare team attended and Mr Nikolyan was taken to hospital. Mr Nikolyan later said that he had taken PS.
125. That day, a security intelligence report noted that Mr Nikolyan had offered sexual favours to another prisoner in exchange for PS. This incident was reported as occurring shortly before Mr Nikolyan had collapsed on the wing.
126. On 4 February, a nurse saw Mr Nikolyan who said that other prisoners had offered him "ID-card size spice (PS) for £100". The nurse discussed Mr Nikolyan's use of illicit substances and told him that the forensic psychiatrist had now stopped his sertraline medication because of the potentially fatal risk of taking PS with it. Mr

Nikolyan was not happy and said that he had no thoughts of self-harm and had provided a negative drug test result the previous week. A nurse said that Mr Nikolyan's drug test results were not yet known. The forensic psychiatrist noted that the mental health team should monitor Mr Nikolyan's mood and mental health closely and he would continue to discuss him at multidisciplinary healthcare meetings. The nurse telephoned F Wing to ask staff to monitor Mr Nikolyan.

127. That day, a security intelligence report noted that prisoners on F Wing had made Mr Nikolyan drink shampoo in exchange for paper soaked in PS.
128. On 5 February Mr Nikolyan turned 21 years old.
129. On 7 February, during a routine cell search, staff found pictures drawn by Mr Nikolyan, depicting a named member of staff being raped by him along with other prisoners. Staff also found racist material and statements in which Mr Nikolyan threatened to rape and kill staff. Mr Nikolyan told staff that the pictures of rape and threats to kill related to a member of the public and that this was therefore acceptable. Staff gave Mr Nikolyan a disciplinary warning, and attended a disciplinary hearing on 9 February, where he pleaded not guilty. Staff referred the matter to the police.
130. On 11 February, a nurse met Mr Nikolyan who looked unsteady on his feet, had a vacant look and his eyes were dilated. Mr Nikolyan later admitted that he had taken PS. The nurse noted that the meeting ended abruptly as Mr Nikolyan started vomiting. A nurse escorted Mr Nikolyan to the healthcare clinic. The nurse noted that he appeared under the influence of PS. The nurse attended a multidisciplinary healthcare meeting that day, where Mr Nikolyan's behaviour was discussed.
131. On 14 February, the offender supervisor, met Mr Nikolyan and discussed his recent substance misuse. Mr Nikolyan told him that he was happy on F Wing as he had fewer issues from other prisoners.
132. On 15 February, a nurse met Mr Nikolyan who denied thoughts of self-harm but said that he was stressed about a number of things. Mr Nikolyan said that the police wanted to interview him about another offence. He said that he was aware that as he was 21 years old, he would be transferred to an adult prison, where he might have to share a cell. He was worried about rumours on the wing that he would do "odd" things for £5 of spice (PS). Mr Nikolyan confirmed that he had kissed other prisoners' shoes and chewed their dirty socks. He said that he had recently passed a drug test and wanted his medication reinstated to help him manage his stress. The nurse said that he would find out Mr Nikolyan's drug test result and let the psychiatrist know. (There is no record of the result of the drug test.)
133. The next day, a security intelligence report noted that Mr Nikolyan and five other prisoners were seen under the influence of PS during the association period. The report named two prisoners also suspected of bullying prisoners on F Wing.
134. On 17 February, a security intelligence report noted that Mr Nikolyan and a number of other prisoners were again seen under the apparent influence of PS during the association period. Mr Nikolyan was seen crawling on his hands and knees, pretending to be a dog. It noted that Mr Nikolyan repeated this behaviour the

following day in the exercise yard. The security intelligence report noted that the safer custody and substance misuse team had been told about Mr Nikolyan's behaviour. There was intelligence that prisoners were bullying Mr Nikolyan and making him complete unacceptable and demeaning tasks in exchange for PS. The report noted that these prisoners were suspected of planning to strip Mr Nikolyan of his clothes and to tie him up to film him on a mobile phone. Security staff completed an investigation which later seized an illegal mobile phone which was to be used to film Mr Nikolyan. Staff also continued trying to stop the supply of drugs through surveillance interventions.

135. On 18 February, a security intelligence report noted that Mr Nikolyan had been offered money by a prisoner to assault another prisoner. Staff noted this in the wing observation book.
136. That evening, staff started ACCT procedures after Mr Nikolyan made superficial cuts to left arm. He said that he did this because he was being bullied, his girlfriend had ended their relationship and because of his PS use. He also said that several prisoners had told him to hang himself. Staff set hourly ACCT observations, with staff required to have two conversations with him each day. They reminded Mr Nikolyan of the support available to him, which included access to the Samaritans and Listeners.
137. On the morning of 19 February, a security intelligence report noted that a named prisoner had bullied Mr Nikolyan in an extreme manner, including forcing him to undertake demeaning and humiliating tasks in exchange for PS. These included licking the prisoner's shoes, eating off the floor, licking his crotch (while clothed) and sniffing washing powder.
138. That day, an officer completed Mr Nikolyan's ACCT assessment. Mr Nikolyan stated that he harmed himself as a coping mechanism but did not intend to take his life despite having suicidal thoughts. The assessment noted Mr Nikolyan's main issues were peer pressure and that he wanted his medication reinstated. Although Mr Nikolyan denied completing degrading tasks for PS, the officer noted that he could not maintain eye contact with him. The officer noted that Mr Nikolyan displayed paranoia that the teacher, whom he had assaulted, had told other prisoners about his offence. Mr Nikolyan said that he was also hearing voices. He said that his family was very supportive and he was in regular contact with them. He asked for his transfer to another prison to be discussed at his ACCT case review.
139. Afterwards, the offender supervisor, met the officer and Mr Nikolyan to discuss the forthcoming ACCT first review, which he was unable to attend. Mr Nikolyan said that he felt anxious and did not sleep well without medication. He was expecting a visit from his family that day.
140. At 4.00pm, a SO chaired Mr Nikolyan's first ACCT review. A nurse and staff from the chaplaincy team attended. Mr Nikolyan said that he had always harmed himself as a coping mechanism when stressed. He said that he was being bullied by other prisoners who had spread rumours about him and his relationship with his girlfriend had ended. He said that he had not used PS recently and wanted his medication reinstated. The panel told him to tell staff who was bullying him so that action could be taken. The panel did not change Mr Nikolyan's ACCT observations and

scheduled his next review for 22 February. The ACCT caremap was left empty and did not refer to action to address the bullying and possible prison transfer.

141. That evening, a nurse saw Mr Nikolyan who told her that he still felt suicidal because of his relationship breakdown. However, he had had a visit from his family that day and felt much better. He said that he was sleeping well and had no hallucinations.
142. On 20 February, staff called an emergency code blue after they found Mr Nikolyan in the laundry room, unconscious on the floor and having seizures. When the healthcare team arrived, Mr Nikolyan was having trouble breathing but gradually regained consciousness after treatment. The nurse noted that Mr Nikolyan had had a PS attack. Mr Nikolyan was suspended from his job in the laundry because of his inappropriate behaviour. A security intelligence report noted that Mr Nikolyan may have been bullied for his canteen.
143. Two mental health nurses saw Mr Nikolyan in his cell that evening. Mr Nikolyan said that he was tired and asked to reschedule his meeting with the nurses to the next day. A nurse noted that she was aware of entries in the wing observation book about Mr Nikolyan's recent behaviour. She had read that other prisoner had apparently told him to perform sexual favours, to assault another prisoner and to behave in demeaning ways in return for PS. A nurse told the second nurse and the healthcare manager. They had told a nurse that the safer custody team was aware of these incidents and were discussing safeguarding concerns as Mr Nikolyan appeared vulnerable.
144. On the morning of 21 February, another prisoner attacked Mr Nikolyan who sustained bruising to his left eye. Mr Nikolyan said that he was assaulted because of drug debts. Despite intelligence about the possible perpetrator, staff initially had no evidence of the assault as the CCTV on the third landing was not working. Mr Nikolyan asked for the incident to be referred to the police.
145. A SO completed an incident investigation during which witnesses came forward and identified the perpetrator, who was subsequently punished. Mr Nikolyan also agreed to participate in mediation with the perpetrator.
146. Later that morning, the Safer Custody Hub Manager, spoke to Mr Nikolyan after the Clinical Lead for Primary Care, raised concerns about his behaviour. The Safer Prisons Hub Manager told the investigator that Mr Nikolyan was in good spirits and appeared open and honest. He admitted that he had used PS but said he had now stopped because he was aware that his medication would not be prescribed if he continued to use illicit substances. He said he that he had behaved in a degrading way but denied that he had offered sexual favours to other prisoners for PS. He described his behaviour as submitting to "dares" for drugs. Mr Nikolyan said that his mood was very low and he no longer cared about anything. However, he said that wing staff were now aware of the situation and had supported him. He denied having thoughts of self-harm.
147. Two nurses met Mr Nikolyan in the afternoon to discuss his recent behaviour. Mr Nikolyan said that the incidents might be perceived as him being bullied but he said that his actions were "dares" initiated by other prisoners. The nurses again warned him of the dangers of using PS and how it increased his vulnerability and exposed

him to bullying. They said that staff were concerned that Mr Nikolyan might have been accosted for sexual favours and was at risk of being exploited for his canteen. Mr Nikolyan said that he had been asked to have oral sex in return for PS. He said that he had declined but asked what was wrong with sexual favours between two consenting adults. Mr Nikolyan said that he used PS because his medication had been stopped. He said that he wanted to move to another prison as he did not feel safe on F Wing. A nurse noted that Mr Nikolyan had limited insight into his current difficulties and felt that if his medication was reinstated, it would solve all his problems.

148. A security intelligence report noted that staff searched Mr Nikolyan's cell that day and found a book which contained sexual references to gang raping women. When staff challenged Mr Nikolyan about the inappropriate material, he said that as the drawings had not referred to any staff, he thought it would be acceptable.
149. On 22 February, an officer recorded that she had had a meeting with the mental health and safer custody teams to consider contacting the Safeguarding Adult Board for advice about Mr Nikolyan's PS use and risky behaviour. Ms Harrison referred Mr Nikolyan to the Safer Custody Hub Manager who was responsible for safeguarding issues and intended to raise the issue at the next healthcare multidisciplinary team meeting to consider contacting Adult Safeguarding Board. However, Mr Nikolyan died before Aylesbury did so.
150. In the afternoon, a SO chaired Mr Nikolyan's second ACCT review. An officer, and a member of staff from the chaplaincy and a nurse attended. A member of staff from the substance misuse team also contributed by sending an update to say that they were continuing to support Mr Nikolyan. Mr Nikolyan said that he had completed a mediation session with the prisoner who had assaulted him and no longer felt under threat on the wing. He was more concerned that he may be subject to new criminal charges and that his relationship with his girlfriend had ended. He said that he had daily thoughts of self-harm although he did not intend to act on them. He said that wing staff and the mental health team had supported him well, and was aware that he could access the Samaritans and Listeners. He said that he occupied his time by watching television and listening to the radio. He said that he also wanted to apply for a new job. The panel did not change Mr Nikolyan's ACCT observations which remained hourly, with staff required to have two conversations with him each day. The next ACCT review was scheduled for 25 February.
151. On 23 February, staff completed a routine search of Mr Nikolyan's cell and found material of a sexual nature and a piece of paper with a list of the names of prisoners and what looked like the amount of money owed to each.
152. The Clinical Lead for Primary Care discussed Mr Nikolyan at the weekly healthcare multidisciplinary complex case meeting on 25 February. The Safer Custody Hub Manager attended. He told the investigator that staff at the meeting indicated that Mr Nikolyan had behaved differently with different members of staff. At the meeting, they agreed that the mental health team should continue to support him and that he would be discussed at multidisciplinary meetings.
153. On 25 February, a SO chaired Mr Nikolyan's third ACCT review. A nurse, and a staff from the chaplaincy, a member of staff from the substance misuse team and

an officer attended. Mr Nikolyan said that he had fleeting thoughts of suicide and self-harm but felt okay at the time of the meeting. His mood was low because he had lost his job in the laundry and he was spending more time in his cell. He claimed that he had had an anxiety attack in the laundry room and denied that he had used PS. The officer said that she would find out if it was possible to reinstate Mr Nikolyan's job. Mr Nikolyan said that he was upset that the security team had removed items from his cell that he had used to harm himself but said that he understood why this had been done. Earlier that day, he had handed a member of the chaplaincy team a shoe lace and said that he did not want to use it to do anything stupid. The nurse confirmed that Mr Nikolyan had an appointment with the psychology team on 4 March to discuss his medication. The panel did not change the frequency of the ACCT observations. The next review was scheduled for 4 March. The caremap was updated to include that staff would make enquiries about Mr Nikolyan's job.

154. On the morning of 27 February, an officer spoke to Mr Nikolyan. She offered to relocate him to a cell nearer to the staff office because of his recent behaviour and use of illicit drugs. Mr Nikolyan denied that he used PS. He said that he did not want to move to the proposed cell because it was next to the cell of a prisoner whom he said bullied him. (Staff were monitoring that prisoner under the prison's anti-violence procedures.) The officer noted that she would try to find Mr Nikolyan an alternative cell or move the other prisoner.
155. That day, the offender supervisor emailed a SO to say that he was surprised that Mr Nikolyan had been moved to F Wing as he had had a care plan in place while on B Wing, the safer custody, mental health, psychology and offender management teams supported him and he was near the B Wing staff office so that staff could check on him. The offender supervisor asked whether F Wing had been briefed about Mr Nikolyan's risks before he moved there. The SO responded by email and said that F Wing staff were aware, and had received the guidance produced to manage Mr Nikolyan in the segregation wing. The SO noted that the safer custody team had also told her that Mr Nikolyan was going to be moved to another prison as he had turned 21 years old and because of the concerns about his behaviour.
156. That day, one of the prisoners identified as bullying Mr Nikolyan transferred to another prison.
157. Two nurses reviewed Mr Nikolyan on 28 February. Mr Nikolyan reiterated that he wanted his medication reinstated. He said that he had struggled mentally since he had lost his laundry job. He again denied that this was caused by his use of PS. He said that he had fleeting thoughts of suicide but did not intend to act on them. However, he said that he had recently used a paperclip to make scratches on his arms. Mr Nikolyan said that he was hearing girls' voices that told him to harm himself. The nurses told him to speak to staff and that a psychiatrist would see him on 4 March. Mr Nikolyan said that he had telephoned the Samaritans and his family for support.
158. On 1 March, a security intelligence report noted that staff had found a debt list which contained names, bank details, amounts of money owed and hand-drawn pictures of naked women and suicide. The next day, a security intelligence report noted that Mr Nikolyan and seven other prisoners were acting strangely on the wing during the association period. Staff suspected that the prisoners had taken PS.

159. On 4 March, a SO chaired Mr Nikolyan's ACCT review. A nurse, and a member of staff from the substance misuse team and staff from the chaplaincy attended. Mr Nikolyan said that he still used PS. A nurse told us at interview that the panel was not concerned about Mr Nikolyan because he was making plans for his future and had no thoughts of suicide or self-harm. The panel stopped ACCT procedures and scheduled a review to take place in a week. There is no record that the review panel considered Mr Nikolyan's recent self-harm or that he had heard voices.
160. A forensic psychiatrist and a nurse reviewed Mr Nikolyan that day, and noted that he was subdued and had lost weight. Mr Nikolyan said that things had spiralled out of control on F Wing, and PS was freely available. He admitted that he used PS at the weekend and said that he had no structure on F Wing since he had lost his job. He denied having any thoughts of self-harm and attributed his anxiety to his PS use. He said that the coping strategies that the substance misuse team had suggested, had not worked. He asked if he could be prescribed a different and safer medication. The forensic psychiatrist told Mr Nikolyan that if he remained drug-free for four weeks, she would consider prescribing him sertraline and quetiapine again.
161. A keyworker, saw Mr Nikolyan in his cell that day. Mr Nikolyan told him that he had received a letter from the court which suggested that he would be moved to another prison on 20 March. He said that F Wing staff had supported him well. The keyworker said that he would return to see Mr Nikolyan in a week.
162. On 5 March, a security intelligence report noted that staff had caught a prisoner by surprise, standing near Mr Nikolyan's cell door. Staff found Mr Nikolyan at the back of his cell and noted that he looked scared. Mr Nikolyan refused tell staff what had happened. Staff ordered the prisoner to return to his cell and took steps to monitor him.
163. On 7 March, a security intelligence report noted another prisoner who had bullied Mr Nikolyan, was moved to another prison.
164. On 9 March, an officer recorded in the wing observation book that he responded to Mr Nikolyan's emergency cell bell during the association period. Mr Nikolyan was upset and said that he was scared to leave his cell to collect his food. He named a prisoner who was bullying him (directly and indirectly) and had taken his canteen for several weeks. The officer told the wing manager and submitted a security intelligence report.

Events of 10 March

165. On 10 March, Mr Nikolyan mixed with other prisoners during the morning association period and he collected his lunch from the kitchen servery. The SO saw Mr Nikolyan but raised no concerns.
166. At 4.56pm, Mr Nikolyan used his in-cell PIN phone and telephoned his family. He spoke to his younger brother and mother for around 47 minutes. His brother and he discussed and listened to music, talked about his brother's school life and homework. Mr Nikolyan spoke to his mother about their family. He said that he wished sometimes that he was not alive. Mr Nikolyan's mother said that was a sad thing to have said and told him that the family was all worried him. Mr Nikolyan said

that he did not want his family to attend his court hearing on 20 March. His mother said that she intended to visit him before then. He told his mother that he had no news about a prison move.

167. By 5.06pm, all prisoners were locked into their cells for the night. The CCTV on the third landing on F Wing was not working at the time.
168. An officer was tasked with conducting the evening roll check on F Wing. She told the investigator that when she checked Mr Nikolyan between 7.00pm and 7.30pm, he looked at her when she opened his cell door observation panel. Mr Nikolyan was awake and appeared relaxed, lying on his bed.
169. At approximately 8.00pm, an officer completed a handover of her duties to an Operational Support Grade (OSG). When night duty staff arrive on duty, they should complete an initial roll check of their allocated wing and then complete a welfare check on each prisoner at different intervals throughout the night. The first welfare check is conducted between 11.00pm and 1.00am, the second between 1.00am and 3.00am, and the third between 3.00am and 5.00am. The OSG then completed another roll check before the end of their duty at between 5.00am and 7.00am. There is no requirement for operational support grades to record welfare checks.
170. The OSG started her roll check of F Wing shortly after 8.00pm and had no concerns about Mr Nikolyan.
171. Mr Nikolyan telephoned his family at 9.15pm and had a short conversation with his mother. They had a general discussion about Mr Nikolyan's siblings.
172. Mr Nikolyan telephoned his family again at 9.17pm and spoke to his brother. They talked about music and songs. Mr Nikolyan told his brother to play a song called nightmare after which they discussed the meaning of the song. Mr Nikolyan's brother said the song was about someone dying. Mr Nikolyan told his brother that he loved him and he should take care of himself. His brother reminded Mr Nikolyan that he would always be there for him and that everyone supported him. Mr Nikolyan briefly spoke to his mother and told her that he loved all the family. Mr Nikolyan's mother said she had sent Mr Nikolyan a letter that day.

Events of 11 March 2019

173. The OSG started her first welfare check of the third landing of F Wing at around 12.55am.
174. When she arrived at Mr Nikolyan's cell, she looked through the observation panel. She saw Mr Nikolyan hanged from a ligature made from a bedsheet, attached to the window at back of cell. The OSG immediately used her radio to call an emergency code blue (which indicates that a prisoner is unconscious or has breathing difficulties).
175. Another OSG, the control room operator, recorded that a medical emergency code blue was received at 12.56am. He called an ambulance straightaway and ensured that a CM and other staff were aware of the incident. (The ambulance service log recorded that the emergency call was received from the prison at 12.57am.)

176. The OSG broke the seal on her key pouch and used the key to enter the cell. She used her anti-ligature knife to cut the ligature and she tried to support Mr Nikolyan's body. Body-worn camera footage shows that an officer and a CM arrived at the cell at 12.56:58 am. The CM said that the cell was dark and he saw the OSG supporting Mr Nikolyan's body at the back of the cell. An officer immediately supported Mr Nikolyan's body and cut the ligature from around his neck. The two officers then laid Mr Nikolyan on the floor. The CM used his radio to ensure an ambulance had been called. He said he saw what appeared to be a suicide letter on Mr Nikolyan's bed.
177. The officer checked Mr Nikolyan for signs of life but found none. He noticed that Mr Nikolyan's airway appeared slightly obstructed. The officer started cardiopulmonary resuscitation (CPR) by doing chest compressions. None of the staff present retrieved a defibrillator, and the officer did not know where it was kept.
178. The ambulance arrived at the prison at 1.01am and at Mr Nikolyan's cell at 1.07am. The paramedics took over resuscitation efforts. An emergency air ambulance crew that included a doctor, arrived to assist the paramedics at 1.32am. Despite their attempts, they pronounced Mr Nikolyan's death at 2.01am. The police arrived at the prison at 2.37am.

Contact with Mr Nikolyan's family

179. A manager, and the Governor attended the prison shortly after Mr Nikolyan's death. They agreed that the police would be able to inform Mr Nikolyan's parents of his death sooner than if the prison contacted them as it was the early hours of the morning, there were a limited number of prison staff on duty, prisoners had access to in-cell telephones and had access to illicit mobile phones. They did not want Mr Nikolyan's parents to hear of his death through prisoners.
180. A prison manager was appointed as the prison's family liaison officers (FLO). The police contacted him later that morning and said that they had visited Mr Nikolyan's parents but no one was at home. The police had also tried to visit Mr Nikolyan's aunt but found that she no longer lived at the address. Shortly afterwards, the police spoke to Mr Nikolyan's father and broke the news of his son's death. Mr Nikolyan's mother was away at the time. The FLO spoke to Mr Nikolyan's father that afternoon and offered support.
181. On 14 March, the FLO and the Governor visited Mr Nikolyan's parents. Aylesbury contributed to the cost of Mr Nikolyan's funeral in line with national instructions.

Support for prisoners and staff

182. A manager and the Governor attended the prison in the hours after Mr Nikolyan's death. They debriefed the staff involved in the emergency response to ensure that they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support. The prison posted notices informing other prisoners of Mr Nikolyan's death and offering support. Staff reviewed all prisoners assessed as at risk of suicide or self-harm in case they had been adversely affected by Mr Nikolyan's death.

Post-mortem report and toxicology results

183. The post-mortem examination established that Mr Nikolyan's death was caused by hanging. Post-mortem toxicology results did not identify the presence of psychoactive substances (PS).

Findings

Management of Mr Nikolyan's risk

184. Mr Nikolyan had several factors that increased his risk of suicide and self-harm. He had autism and a personality disorder, and a history of significant self-harm, attempted suicide, substance misuse and mental health issues, including anxiety and depression. Mr Nikolyan found it difficult to cope at Aylesbury. His behaviour was challenging, violent and disruptive and this made it difficult for staff to manage him. His behaviour prompted multiple referrals to the substance misuse and mental health teams.
185. PSI 64/2011 on safer custody states that the ACCT process relies on staff using their experience and skills when they assess risk. However, while a prisoner's presentation is important and reveals something of their level of risk, it is only one piece of evidence in judging risk. Staff should make a considered, objective evaluation of all risk factors when assessing a prisoner's risk of suicide and self-harm.
186. The PPO published a learning lessons bulletin on 'Prisoner Mental Health' in January 2016. In this bulletin, we identified that difficulties in coping with mental health problems could be made worse when a prisoner also has to cope with difficulties of battling substance dependence.

Management of ACCT procedures

187. In Mr Nikolyan's case, although he was managed under ACCT procedures at times, ACCTs were not opened after some incidents of self-harm; ACCT reviews were not always multi-disciplinary (which was particularly important given Mr Nikolyan's significant mental health and substance misuse issues); there was not always consistent case management; some key issues were not properly considered; there is no evidence that consideration was given to an enhanced case management approach (given the complexity of Mr Nikolyan's issues) or to involving his supportive family; and the caremaps failed to cover some important issues or to identify clear actions to tackle them. As a result, although there was a lot of discussion about Mr Nikolyan, we consider that his risk to himself was underestimated and not enough was done to help address and resolve his risk factors. These concerns are discussed in more detail below.
188. Mr Nikolyan was appropriately identified as at risk of suicide and self-harm and managed under ACCT procedures on four occasions at Aylesbury. However, although staff generally managed him in line with national instructions, there were two occasions (7 December 2018 and 27 February 2019) when the mental health nurse failed to start ACCT procedures after Mr Nikolyan disclosed that he had recently self-harmed by making cuts to his arm and was hearing voices that told him to harm himself. This is contrary to PSI 64/2011 that requires staff to start ACCT monitoring after an incident of self-harm. There is also no evidence that this information was shared with prison staff after either incident.
189. When ACCT procedures were started after Mr Nikolyan said on 7 December that he had harmed himself, staff reported that he was having a "breakdown" but did not

pass on information about his self-harm. After the second incident on 27 February, staff completed an ACCT review a week later and ended ACCT monitoring. If the review panel had been told that Mr Nikolyan had recently self-harmed, they could have used the information to decide whether it was appropriate to stop ACCT monitoring.

190. PSI 64/2011 requires a multidisciplinary approach for ACCT case reviews and, where possible, the ACCT assessor and healthcare staff, including the mental health team, should attend the first ACCT review. No one from healthcare attended Mr Nikolyan's first ACCT review on 11 August 2018 nor his ACCT review on 28 December, at which ACCT monitoring was stopped. When ACCT monitoring started again on 16 January 2019, there were different case managers at the three ACCT reviews held.
191. Mr Nikolyan had complex mental health issues which significantly affected his wellbeing and safety. While the mental health team regularly saw Mr Nikolyan, staff should have integrated the management of his mental health needs, substance misuse and behaviour to ensure a balanced, holistic and consistent approach. The lack of input from healthcare staff and inconsistent case management at ACCT reviews led to some important information about Mr Nikolyan's risk not being shared or addressed.
192. Mr Nikolyan was a known PS user and was known to have drug debts but these issues were sporadically linked and not always considered in the caremap. For example, on 24 December 2018, Mr Nikolyan disclosed to the psychiatrist that he felt pressured on the wing to use PS and had accumulated drug debts because of this. Four days later staff ended ACCT monitoring but did not refer to this issue or say how it had been resolved. When staff started ACCT procedures on 16 January 2019, the caremap did not refer to Mr Nikolyan's drug debts or how staff should support him. Staff ended ACCT monitoring on 4 March 2019 and again failed to refer to Mr Nikolyan's drug debts. Mr Nikolyan's PS use meant that healthcare staff withheld his antipsychotic medication because of the potentially fatal risk of taking them in combination. The ACCT procedures should have taken account of these risk factors as it might have given a better understanding of Mr Nikolyan's risk.
193. The PSI requires that ACCT caremaps reflect a prisoner's needs, level of risk and the triggers of their distress. They should aim to address issues identified in the ACCT assessment interview. They must be tailored to meet prisoners' individual needs and reduce risk. They must be time-bound and say who is responsible for completing the action.
194. Staff did not include some important issues in Mr Nikolyan's caremaps. They did not include that Mr Nikolyan had wanted to speak to his offender supervisor at his ACCT review on 9 December to ask about a transfer, and the caremap contained no actions to help progress his transfer to another prison, one of the things that might have helped to reduce his risk.
195. A particular issue for Mr Nikolyan was that he said he felt less anxious and more able to cope when he was receiving antipsychotic and antidepressant medication but that this medication was stopped because of the safety concerns of combining it with PS use. Although these concerns were legitimate, stopping Mr Nikolyan's medication may have made him more likely to use PS to help reduce his anxiety.

We would have expected to see more consideration of this 'Catch 22' situation and some specific care map actions designed to help resolve it.

196. After Mr Nikolyan harmed himself on 18 February, the ACCT assessment identified his main issues as his medication, peer pressure (being bullied), and wanting a transfer to another prison. The caremap failed to reflect any of these issues and simply stated "N/A" (nil to action at present)". This was not acceptable. It is not sufficient for ACCT reviews simply to identify issues; they must also try to identify actions to help resolve them.
197. In our Learning Lessons Bulletin about young adult prisoners, published in August 2014, we identified that challenging behaviour can mask vulnerability and that managing risk of suicide and self-harm, treating mental health and managing behaviour needs to be better integrated to ensure a balanced, holistic and consistent approach. What became apparent was that Mr Nikolyan's needs were complex and he needed additional case management to manage his risk to himself and to and from others. PSI 64/2011 notes that the use of an enhanced case management approach allows staff to respond more effectively to a prisoner's individual needs to help reduce or modify their challenging behaviour.
198. The enhanced case review process would have meant that a nominated individual/team would have had the overall responsibility for ensuring Mr Nikolyan's risk factors and challenging behaviour were managed in a co-ordinated manner. In Mr Nikolyan's case, staff could have considered monitoring him on enhanced case management, to ensure his safety, from as early as August 2018 when they started ACCT procedures.
199. Furthermore, it was noted on more than one occasion that Mr Nikolyan had good family support but there is no evidence that staff considered involving his family in ACCT reviews. This might have happened if he was subject to enhanced case reviews. The PSI states that involving family members could prove beneficial as they can provide vital insights into a prisoner's behaviour and motivations.
200. We make the following recommendations:

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

- **Staff (including healthcare staff) have a clear understanding of their responsibilities and the need to record and share relevant information about risk.**
- **Prison, healthcare and mental health staff work jointly to manage prisoners at risk of suicide and self-harm. Healthcare staff should be invited to and attend at least the first ACCT review.**
- **Staff hold multidisciplinary ACCT reviews, with the same case manager, which involve staff who contribute to a prisoner's care.**
- **Staff consider managing complex cases under the enhanced case management process.**

- **Staff consider involving the family in the ACCT process.**
- **ACCT case managers complete caremaps, setting specific and meaningful caremap actions, identifying who is responsible for them and reviewing progress at each review.**
- **Staff should ensure that the impact on the risk of suicide and self-harm is always considered for apparent victims of bullying and intimidation.**

Location and monitoring Mr Nikolyan on F Wing

201. Mr Nikolyan spent time on three wings and the segregation unit during his stay in Aylesbury. He experienced bullying and harassment on all three wings.
202. On B Wing, his cell was located near the staff office to minimise his risk of being bullied and allow wing staff to monitor him. However, he was still able to obtain and use PS which resulted in him accumulating debt and he was still bullied, including being physically assaulted. In view of the bullying and his subsequent injuries when he was assaulted, Mr Nikolyan was transferred to F Wing.
203. Staff told us that F Wing was historically used as a wing for sex offenders and vulnerable prisoners. It was subsequently used as a wing that holds prisoners less able to cope on a mainstream wing and was an “enabling environment”. Ironically, HMIP reported in 2017 that the vast majority of prisoners felt less safe on F Wing and experienced higher levels of victimisation, intimidation, bullying, sexual abuse and assault compared to all the other prison wings.
204. We are concerned that Mr Nikolyan’s transfer to F Wing to address his issues of vulnerability and bullying appears to have exacerbated the situation and resulted in increased bullying. Despite Mr Nikolyan’s known and increasing issues, staff appeared to make no additional attempts to reduce his risks.
205. On F Wing, Mr Nikolyan was located on the third floor, two floors above the F wing staff office. Prison staff were less able to monitor his condition and the bullying. When staff offered to move Mr Nikolyan to a cell near to the staff office on 27 February because of concerns about his behaviour, they inadvertently offered him a cell next door to a prisoner he had identified as bullying him.
206. CCTV cameras were not working on Mr Nikolyan’s landing on F Wing. He continued to be bullied by other prisoners, his use of PS continued, he started to exhibit risky behaviour and was assaulted on 21 February. When he died nearly three weeks later, the CCTV cameras were still not working. The lack of working CCTV equipment prevents staff detecting and reviewing incidents and hindered our ability to complete a comprehensive investigation into Mr Nikolyan’s death. Active CCTV improves security, reduces the frequency of violent incidents and acts as a deterrent.
207. We are very concerned that a prisoner as obviously vulnerable as Mr Nikolyan, with a history of being bullied, was located where it was particularly difficult for staff to monitor him. We share the offender supervisor’s concerns about whether staff on F wing were sufficiently briefed before Mr Nikolyan moved there.

208. We are also concerned that, although F wing is used for prisoners who are less able to cope on a standard wing, and therefore vulnerable in some way, some of those prisoners may themselves present a significant risk to other vulnerable prisoners. Staff need to be aware of potential conflicts between individuals with different vulnerabilities, and of the need to manage potential aggressors appropriately and proactively.
209. Although Mr Nikolyan was being considered for a move to another prison from as early as 23 November 2018 (due to his behaviour, being bullied and assaulted), nothing happened. Mr Nikolyan's offender manager told us that a transfer before Mr Nikolyan turned 21 years old on 5 February 2019 would be more difficult and needed to be authorised at governor grade level. We recognise the pressures of managing prison populations and the difficulties that Governors face in trying to transfer prisoners, especially when they have complex needs. Nonetheless, Mr Nikolyan's risks and behaviours should have prompted staff to consider a transfer to another prison. We make the following recommendations:

The Governor should ensure that prisoners are appropriately located and moved, where necessary, so that they remain safe.

The Governor should develop a strategy to manage prisoners on F wing who pose a risk to other vulnerable prisoners.

The Governor should ensure that all CCTV cameras are working.

Mr Nikolyan's debt problems

210. PSI 64/2011 requires that all verbal and physical acts of violence must be challenged, appropriate sanctions for perpetrators applied robustly, fairly and consistently, and victims supported and protected. Being a victim of intimidation or violence is a recognised risk factor for suicide and self-harm. Mr Nikolyan's use of PS jeopardised his safety by increasing his level of debt, increasing his risk of bullying and him giving out sexual favours. This appeared to be a major challenge for the prison to manage and one certainly that they struggled to achieve because of his challenging behaviour.
211. We also note that Aylesbury's drug and violence reduction strategies are not supported by a policy or guidance for staff and prisoners about how to deal with debts in prison. We recommend that:

The Governor should ensure that staff report and record all instances of drug debt, including submitting information to the security team, and take action, where appropriate.

Bullying

212. There were a significant number of recorded incidents which indicated that Mr Nikolyan was a victim of bullying by other prisoners. This bullying extended to alleged risky sexual practices and degrading behaviour. His PS debts, his autism and his behaviours in prison (assaulting an education officer and expressing

sexualised thoughts about prison officers) made him vulnerable to being bullied. He expressed suicidal intent as a result of bullying on at least two occasions.

213. Staff took some measures to prevent Mr Nikolyan being bullied. This included punishing the perpetrators and moving Mr Nikolyan between wings.
214. While staff investigations and other security intelligence sometimes resulted in the perpetrators being punished or moved, we found little evidence to demonstrate how Mr Nikolyan was supported after reported incidents of bullying, other than through ACCT procedures). The week before Mr Nikolyan's death, two incidents were reported of Mr Nikolyan being found scared, as a result of being bullied. While staff refer to taking action against the perpetrators, little or no information was recorded about how they supported Mr Nikolyan. There was one incident when Mr Nikolyan was scared to leave his cell to collect his meal. Staff did not state how this was rectified, how they arranged for Mr Nikolyan to collect his meal and whether they later checked on his wellbeing.
215. Aylesbury have a local Preventing Violence Strategy, published in 2018, which aims to ensure that prisoners feel safe, free from harm, abuse and fear. However, this strategy mainly focuses on the perpetrator of an incident. It does not include specific instructions and guidance for staff on how to support victims of bullying. Aylesbury does not have a formal victim support monitoring procedure in place. Given Mr Nikolyan's known history, we consider that a formal support network should have been put in place as part of his care maps. For example, we have seen interventions put in place in other prisons to support victims, including peer support and daily interaction with a keyworker/wing officer. While we do not know whether an intervention would have changed the outcome for Mr Nikolyan, it may have given him some hope that he was being fully supported.
216. We understand that since 1 May 2019, Aylesbury has introduced HMPPS' Challenge, Support and Intervention Plan (CSIP) which aims to manage individuals who pose a raised risk of harming others and provide victim support. We make the following recommendation:

The Governor should ensure that all information indicating bullying and intimidation is fully investigated and that apparent victims are effectively supported and protected with meaningful solutions which address their individual situation, including through ACCT procedures where appropriate.

Drug strategy at Aylesbury

217. The prison has a local drugs strategy policy, issued in 2016, which sets out a number of actions to reduce the demand and supply of illicit drugs. It is a concern that, despite measures currently in place, Mr Nikolyan was able to obtain drugs regularly and suggests that much more needs to be done to tackle the issue of drugs at Aylesbury.
218. Drug taking and trading is a serious problem across much of the prison estate. Individual prisons are for the most part doing their best to tackle the problem by developing their own local drug strategies. However, the PPO has called for national guidance to prisons from HMPPS providing evidence-based advice on what works. We welcome the fact that such guidance has now been issued,

together with a Prison Service strategy to reduce the supply of and demand for drugs in prisons.

219. In relation to reducing the supply of drugs, the new Prison Service strategy says:

“Every prison is different, and will benefit from tools to assess their specific security needs. We have worked with prisons to carry out Vulnerability Assessments in prisons to build a picture of the security risks and enable establishments to better target their resources to tackle them. This resource will continue to be offered across the estate. The Drug Diagnostic toolkit used for the prisons in the 10 Prisons Project has also proved to be useful in identifying key issues in different establishments and so we will share this for use across the whole estate, supporting prisons to identify where changes could have the greatest impact.”

220. We make the following recommendation:

The Governor should ensure that the key drug issues at Aylesbury are identified and that the prison’s local drugs strategy is promptly revised to address these issues.

Substance misuse

221. Mr Nikolyan had a history of substance misuse. When he arrived at Aylesbury, he was promptly referred to the substance misuse services and saw them throughout his time in prison. Mr Nikolyan was fully aware of the risks of PS to his physical and mental health, and staff reminded him but he continued to use it. We are satisfied that Aylesbury offered Mr Nikolyan appropriate support in managing his substance misuse problem.

Safeguarding of young adults

222. The Care Act 2014 states that prisons are responsible for the safeguarding of vulnerable adults in their care. Prison Service Instruction 16/2015 on safeguarding adults in prison requires that prisons put in place processes to ensure that prisoners who are at risk of abuse or neglect receive a level of protection equivalent to that available in the community. It encourages Governors to engage with local authority Safeguarding Adults Boards as a valuable resource for prisons in dealing with vulnerable prisoners.

223. Contrary to HMIP’s findings in their last inspection in 2017, The Safer Prisons Hub Manager told us that the safer custody team had limited links with the community safeguarding board and that prison staff had not received safeguarding training. The Clinical Lead for Primary Care said that she had wanted to contact the Adult Safeguarding Board for help with developing a detailed safeguarding plan for Mr Nikolyan to ensure that he was appropriately supported. Unfortunately, Mr Nikolyan took his own life before Aylesbury did so.

224. It is important that staff at Aylesbury are appropriately trained to discharge their duty of care for vulnerable prisoners and have clear links with their local safeguarding boards to meet prisoners’ needs. We make the following recommendation:

The Governor and Head of Healthcare should ensure that:

- **staff maintain links with the Adult Safeguarding Board in the community in line with PSI 16/2015;**
- **relevant prison staff receive comprehensive safeguarding training to support vulnerable prisoners and keep them safe; and**
- **a safeguarding and appropriately qualified lead is appointed.**

Emergency response

225. Prisons operate at a reduced staffing level during the night state. Aylesbury do not have a 24-healthcare service and so there were no nurses on duty when Mr Nikolyan was found hanged.
226. PSI 03/2013 states that, “Where no nurse cover is available, other staff attend with necessary equipment.” Prison staff responded quickly to the medical emergency code blue on 11 March 2019 and called an ambulance for Mr Nikolyan. Staff conducted CPR but told the investigator that no one asked for a defibrillator. At interview, staff told us that they were unsure where the defibrillator was kept. Two of the three staff who attended the emergency response had had no recent first aid training.
227. We cannot say whether not using a defibrillator and staff not being trained in first aid affected the outcome for Mr Nikolyan but these issues may be critical in other life-threatening situations. We make the following recommendation:

The Governor should ensure that adequate first aid arrangements are in place to provide first aid, especially during night state and including that staff are trained on where to find a defibrillator and how to use one.

Clinical care

228. The clinical reviewer considered that overall, the clinical care that Mr Nikolyan received was equivalent to that which he could have expected to receive in the community. However, the clinical reviewer considered that the assessment of Mr Nikolyan’s vulnerability and the addressing of safeguarding concerns in the prison were not equivalent.

Mental health

229. Mr Nikolyan had autism and longstanding and complex mental health issues, including a personality disorder and a history of anxiety and depression. He was referred to the mental health services promptly, was closely monitored in multidisciplinary meetings and mental health nurses (who were his key workers), psychiatrists, the drug misuse team and a psychologist saw him frequently.
230. Staff found it difficult to manage Mr Nikolyan’s mental health issues as he did not consistently disclose the truth about his feelings, behaviours or use of PS. He frequently disclosed suicide or self-harm issues, only to deny them shortly

afterwards. Although he often talked about his future and support from his family, he also attempted suicide on more than one occasion. After one attempt, Mr Nikolyan said that it had frightened him and he would not try it again, yet he tried to take his life shortly afterwards. The clinical reviewer noted that the mental health team was diligent in exploring Mr Nikolyan's mental health status and used recognised assessment protocols to focus on his suicidal intent. This included appropriately prescribed antidepressants and anti-psychotic medication.

231. On the whole, staff appropriately shared information about Mr Nikolyan's mental health in a timely way and they held regular multidisciplinary review meetings which the substance misuse and mental health team attended.
232. Mr Nikolyan's offender supervisor said that he had concerns that details of Mr Nikolyan's health care plan had not been shared with staff on F Wing. There is email evidence that a SO received the care plan and confirmed that it had been passed on to F Wing staff. However, the SO had no recollection of this and an officer, who had worked on F Wing for around a year, told us that he was not aware that Mr Nikolyan had a care plan. Neither was the care plan attached to the ACCT document, when it was started on 18 February 2019. We also found that the care plan was not contained in Mr Nikolyan's prison record.
233. We therefore have a concern that although the care plan may have been passed onto F Wing, it was not easily accessible or shared widely for ease of reference to the wing staff to enable them to refer to it, to assist in their management of Mr Nikolyan. We make the following recommendation:

The Governor and Head of Healthcare should ensure that information about the management and care of a prisoner is recorded and promptly shared with the relevant staff to assist in identifying and reducing that prisoner's risk.

Inquest

234. The inquest into Mr Nikolyan's death was held in July 2023. The conclusion was that Mr Nikolyan's death was due to suicide, following failings by HMP Aylesbury in the management of Mr Nikolyan who was a vulnerable person with autism spectrum disorder.

**Prisons &
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