



A Report by the
Prisons and
Probation
Ombudsman
Nigel Newcomen CBE

**Investigation into the death of a man at HMP
Elmley in November 2012**

Our Vision

*'To be a leading, independent investigatory body,
a model to others, that makes a significant contribution
to safer, fairer custody and offender supervision'*

This is the investigation report into the death of a man at HMP Elmley in November 2012. He was found hanging from the window bars of his cell in the prison's healthcare unit. He was 66 years old. I offer my condolences to his family and friends.

A clinical review was conducted of the standard of healthcare the man received at Elmley. Staff at Elmley cooperated fully with our investigation.

The man had served more than 15 years in prison and it was expected that he would be released from HMP Standford Hill open prison after his parole hearing in July 2012. When his parole hearing was postponed, he had a severe panic attack and was moved as an inpatient to the healthcare unit at Elmley, adjacent to Standford Hill, for closer monitoring. When he was discharged from the healthcare unit, he was not returned to Standford Hill but instead was sent to a houseblock at Elmley, where he remained until his death.

This is a troubling case in which the man appears to have been unnecessarily kept in Elmley, a closed category B prison, because of his health, not a security concern, and where he appears to have lost hope. Responsibility for determining his location and managing his sentence was confused and poorly coordinated, resulting in a lack of clarity about his position.

Nor were the man's health needs well managed at Elmley. He did not receive the mental health care he required and there was insufficient understanding of the impact that moving back to closed conditions had had at a time when he had been progressing towards release. It is also of concern that his dosage of medication was increased significantly during his time at Elmley but was not reviewed to check on its effects. Despite some concern over his state of mind, it is surprising that no one at Elmley considered that he needed to be monitored as a risk of suicide. Finally, I am also concerned that it took too long for staff to enter the cell after he was found hanging.

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

Nigel Newcomen CBE
Prisons and Probation Ombudsman

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SUMMARY

1. The man was sentenced to life imprisonment on 12 November 1998 with a minimum period to serve of three years before he could be considered for release. He moved to HMP Swaleside in January 2002. After a recommendation by the Parole Board, he transferred to open conditions at HMP Standford Hill in June 2010 as part of his preparation for release.
2. During his time at Standford Hill the man got a job in the community and had periods of home leave. His next parole hearing was scheduled for 23 July 2012 and he had been recommended for release. However, on 18 July he was told that the Parole Board hearing had been postponed. He had a panic attack and his symptoms were severe so he was transferred to the healthcare unit at HMP Elmley, adjacent to Standford Hill, so that he could be monitored more closely.
3. The man spent just under a month in Elmley's healthcare unit. When he arrived, he said he had thoughts of self-harm, but had no clear plans. As a precaution he was allocated a safer cell, but suicide prevention monitoring was not started during his first night at the prison.
4. The prison's consultant psychiatrist assessed the man's mental health on the afternoon of 20 July. He remained under the psychiatrist's care for the rest of his time in the healthcare unit, and was prescribed antidepressant and antipsychotic medication.
5. His offender supervisor from Standford Hill visited the man several times while he was at Elmley and his Elmley offender supervisor saw him once.
6. The man was discharged from the healthcare unit to a residential wing at Elmley on 14 August, rather than returning to Standford Hill. There was no handover, care plan or discharge review. The psychiatrist noted in his medical record that he was to be reviewed by the prison's mental health in-reach team a week later, but no referral to the in-reach team was made. He reviewed him on 6 September. He noticed a deterioration in his mental health, so adjusted his medication, but still did not refer him to the in-reach team. He reviewed him again on 11 September and concluded that he required no further mental health treatment. However, he remained at Elmley.
7. Over the next few months, officers described the man as quiet, withdrawn and as someone who slept a lot. He was seen by several doctors because of his physical health, but he was not reviewed again by the psychiatrist or anyone else from the mental health team.
8. On 14 November, a prison psychologist became concerned about the man while she was talking to some prisoners on his wing so she referred him for discussion at the next in-reach case review meeting. He was seen by the psychologist again on 26 November, and thought he had got worse. She noted that he might benefit from returning to the prison's healthcare unit. On the afternoon of 27 November, he had chest pains, and was re-admitted to the prison's healthcare

unit for further observations and a mental health assessment.

9. The next morning an Operational Support Grade (OSG) and a nurse found the man with a shoelace tied around his neck attached to the window frame. They radioed an emergency code for assistance but did not go into the cell to try to help him until more staff arrived. Resuscitation was then attempted but, sadly, was unsuccessful.
10. We are concerned that the man, a category D prisoner, spent so long in a category B prison, without any clear plan to return him to open conditions or to keep him properly informed about his position. It is apparent that his return to closed conditions, through circumstances not related to his risk, caused him significant distress, particularly as had expected to be released. His first 24 hours in the healthcare unit at Elmley were poorly managed, and his risk of suicide was overlooked. His discharge from the healthcare unit was not communicated well, and he did not receive ongoing support from the mental health in-reach team, despite the psychiatrist's request. Finally, staff took too long to enter his cell when they found him hanging.

THE INVESTIGATION PROCESS

11. The Ombudsman was notified of the man's death on 28 November 2012. The investigator issued notices informing staff and prisoners of the investigation and inviting anyone with relevant information to contact him. No one came forward.
12. Another investigator visited the prison on 29 November on the first investigator's behalf and met the Deputy Governor and other members of staff and obtained relevant records.
13. The investigator and another investigator interviewed 18 members of staff from Elmley and Standford Hill. The investigator reviewed the man's prison records and also spoke to two prisoners, one of whom was his cell mate at Elmley. He gave written and verbal feedback to the Governor during the investigation.
14. The local Primary Care Trust (PCT) appointed a clinical reviewer.
15. The investigator informed HM Coroner for Mid Kent and Medway District of the investigation. A copy of this report has been sent to the Coroner to assist with her enquiries.
16. One of the Ombudsman's family liaison officers contacted the man's family to tell them about the investigation. We have aimed to cover a number of issues his aunt and other friends asked the investigation to address.
17. The man's family received a copy of the draft report. They raised a number of issues/questions that do not impact on the factual accuracy of this report and have been addressed through separate correspondence.

HMP ELMLEY

18. HMP Elmley is part of the Sheppey group of prisons, which includes HMP Standford Hill and HMP Swaleside. Elmley serves courts in Kent and holds both remanded and sentenced adult men, as well as unsentenced young adult men between 18 and 21. It can hold more than 1,200 prisoners in five wings, with a mixture of single, double and triple cells.
19. At the time of the man's death the local PCT commissioned healthcare services at Elmley. The healthcare centre includes a 29-bed inpatient unit. A NHS Foundation Trust provided mental health care, in partnership with a private organisation who deliver primary mental healthcare at the prison.

HM Inspectorate of Prisons

20. The most recent inspection of Elmley was in March 2012. The Inspectorate found that incidents of self-harm were lower than in many local prisons and those in crisis received good levels of care, particularly from Listeners (prisoners trained by the Samaritans to support other prisoners). However, inspectors noted that not all night staff had the confidence to deal with emergency situations and some were unable to open the cell key pouches used in an emergency.
21. The Inspectorate found that health care provision was good, but there was too much reliance on agency staff to address staff shortages. Prisoner perception of healthcare was poor. Prisoners with mental health problems had access to a large mental health team and the mental health team largely met the needs of prisoners, but there were no counselling services at the prison.

Independent Monitoring Board Report

22. Each prison in England and Wales has an Independent Monitoring Board of unpaid volunteers from the local community who monitor day-to-day life in the prison to help ensure that proper standards of care and decency are maintained. The 2012 Elmley IMB report noted that staff shortages in the healthcare team, including mental health practitioners, had affected morale. It reported a decrease in self-harm at the prison, and considered that the standard of suicide prevention documentation had improved over the previous year.

Previous deaths at HMP Elmley

23. The man's death was the second of three apparently self-inflicted deaths in the healthcare unit at HMP Elmley in 2012. In one of these cases there were concerns about medicines management and supporting prisoners at risk of suicide and self-harm, which we also comment on in this report.

KEY EVENTS

24. The man was arrested in 1998 when he attacked his psychotherapist with a knife, when he thought she had breached his confidentiality. In a report prepared for the court, a psychiatrist concluded that he was suffering from the symptoms of a depressive illness at the time of the attack: he had lost weight, slept poorly and was anxious. The psychiatrist concluded that he suffered from a somatisation disorder (when physical symptoms are caused by someone's mental health condition).
25. In November 1998, the man was convicted of attempted murder and, in December, was sentenced to life imprisonment, with a minimum term to serve of three years. From November he was monitored under suicide prevention procedures for two months after he said he had tried to hang himself. He was monitored again in February 1999, but just for three days.

HMP Swaleside

26. On 28 January 2002, the man transferred to Swaleside where it was reported he isolated himself from staff and prisoners. Over the next few years, he was repeatedly turned down for parole due to what was seen as his lack of engagement and failure to address his offending behaviour.
27. In 2007, the man joined a poetry class and began to engage more. He later told a psychiatrist that discovering poetry was the beginning of his change in his attitude and mood. In 2008, a psychiatric report concluded that he was not mentally ill. In 2009, he completed an Open University poetry course, and later his poetry was published in a national newspaper for prisoners. He participated in a number of offending behaviour courses, including enhanced thinking skills, anger management and victim awareness.
28. A psychiatric assessment completed for a Parole Board hearing in June 2010, found no evidence that the man still had a somatisation disorder. On 7 August 2010 the Parole Board recommended that he should move to an open prison as part of his preparation for release.

HMP Standford Hill

29. On 13 December 2010, the man transferred to Standford Hill open prison. He worked in the prison library and supported foreign national prisoners. Relatives visited him at the prison and accompanied him on town visits when he was released from prison for the day.
30. In October 2011, the man got a job in the community and was allowed home leave as part of his preparation for release. Reports prepared for the Parole Board recommended his release. However, on 26 October, the Parole Board deferred a decision because they thought he should be legally represented. The Parole Board wanted another psychiatric report and to have a mental health specialist on their panel. His offender supervisor noted that their decision was a

great disappointment and surprise to him.

31. In late 2011, the man started a new job with Age Concern, and it was reported that he had an excellent rapport with clients. In January 2012, an officer noted that he had had a “wonderful Christmas” spending time with family and friends in London and that he continued to wait patiently for a new parole hearing date. He won a Koestler Trust Commendation Award 2011 for one of his poems. (The Koestler Trust promotes participation in the arts in custody.)
32. During March 2012, the man continued to have regular town visits and home leave and was well supported by his family and friends. In April, it was noted that he was excited about his expected forthcoming release. He had bought a car and continued to work in the community.
33. On 17 May, the man was informed that his parole hearing was scheduled for 23 July. However, on 17 July, the Parole Board postponed the hearing as the judge who was to chair the panel was not available and there was no replacement. The next day when he was told the hearing had been postponed he became distressed. His offender supervisor described him as holding his neck saying that he could not breathe. He was shaking and had to be supported by two members of staff. A nurse attended and concluded that he was having a panic attack. He eventually calmed down and his breathing returned to normal.
34. An officer later noted that the man was very concerned that his parole hearing would not be reconvened until October and thought the Parole Board would find a reason not to release him. His offender supervisor spoke to him about the postponement and said they would discuss the situation further the next morning. He returned to his room with another prisoner and officers checked him regularly.
35. The man’s breathing got worse and a couple of hours later staff called an ambulance. A nurse recorded in his medical notes that he had had another panic attack and was to be placed under ACCT procedures, although these were not begun (Assessment, Care in Custody and Teamwork, or ACCT, is the system to identify and support prisoners at risk of suicide or self-harm). Paramedics concluded that there were no neurological factors to account for his condition and that he did not need to go to hospital. As Elmley had a 24 hour healthcare unit, unlike Stanford Hill, it was agreed that he should be taken there for a short period for monitoring.

HMP Elmley

36. The man arrived in Elmley’s reception at around 7.00pm on 18 July. A Registered Mental Nurse (RMN) said he appeared to be in shock and was trembling and shaking. The nurse noted he was incoherent but aware of his surroundings. When he was told he was being admitted to the inpatient unit he shouted that he did not want to be admitted to a mental health hospital. The nurse said he did not think he was at risk of self-harm and could not recall considering opening an ACCT.

37. The healthcare unit's daily handover sheet notes that the man was to receive a primary mental health assessment as soon as possible and that his presentation was to be reviewed before he was unlocked the following morning. The healthcare unit manager told the investigators that he came across as someone who was:

“... hyperventilating, kind of agitated. Not aggressive as such, but he was quite visually agitated. He was kind of chanting. Whatever sentence you ask him a question he kept on repeating the answer several times as if he was very, very anxious and he was also expressing suicidal ideation, thoughts of harming himself.”

38. The man was placed in one of the safer cells in the healthcare unit. (Safer cells are designed to make suicide or self-harm as difficult as possible by reducing the number of ligature points.) The healthcare manager said that he did not have a plan about how to carry out his suicidal thoughts. He thought that putting him in a safer cell would be sufficient to manage his risk. An ACCT was not opened and no level of observation was agreed.

39. Shortly before 8.00pm, a doctor prescribed the man a sleeping tablet and recorded that he needed a mental health assessment. At about 2.30am he rang his cell bell and a nurse found him shaking vigorously and uncontrollably. The nurse could not calm him down and said he was holding his throat as if he was choking. The nurse noted that the doctor was going to review him in the morning and gave him two more sleeping tablets.

40. In the morning the offender supervisor and an officer from Stanford Hill visited the man and were upset about the poor state of his cell which the officer described as disgusting. The officers said he was clearly unwell and seemed to be embarrassed about them seeing him. He moved to another cell in the healthcare unit later that day.

41. That afternoon, a Principal Officer (PO) recorded that the man had been admitted to Elmley for support, as Stanford Hill did not have the healthcare facilities to assist him. He noted that there were no discipline reasons for his move which was a temporary measure. The PO saw him and described him as confused and very distressed, but he did not think he seemed at risk of self-harm.

42. At 5.15pm, the man was noted to have been restless and anxious during the day. He appeared to hyperventilate and physically clung to staff for reassurance. His care plan included allocating a nurse to monitor his behaviour, one-to-one sessions, ensuring his dignity and privacy was respected, promoting general good health and respecting his cultural requirements. This was a generic plan for the unit and not specific to his individual needs.

43. On the morning of 20 July, the man did not go to a scheduled GP appointment, but there is no recorded reason. That afternoon the prison's consultant psychiatrist completed a psychiatric assessment with a Community Psychiatric Nurse (CPN), who was manager of the prison's mental health in-reach team and

would support the man when he returned to Standford Hill. The psychiatrist noted that he had recently been informed of a delay to his parole hearing and incorrectly recorded that he was in prison for murder. He noted his previous contact with psychiatrists and that he had been treated with diazepam for anxiety and mild depression. The psychiatrist told the investigators that the man said that he did not feel as bad as when he first arrived at Elmley, but that he was experiencing cramps in his arms and a tightness in his throat. The psychiatrist diagnosed paroxysmal anxiety (a panic attack) and prescribed 2.5mg of diazepam to be reviewed the next week, or at Standford Hill, if he had already returned there. The offender supervisor also visited him that day and was told by a member of healthcare staff that it was anticipated that he would return to Standford Hill on 23 July.

44. Over the next three days, mental health staff made daily notes in the man's medical notes. They recorded that he was calm and relaxed and kept a low profile, but still experienced anxiety. It was noted that he discussed current affairs, attended to his personal hygiene and collected his meals, but chose to spend time on his own and had little interaction with staff.
45. On 24 July, a nurse carried out a primary mental health assessment. The nurse told the investigator that he had believed that the man had been transferred from Standford Hill for observation because of the side effects of medication he was taking for anxiety. A nurse noted that he appeared settled and interacted well, but was confused about how long he would have to stay at Elmley. He said several times that he wanted to go back to Standford Hill. The nurse noted that he was suffering from mild depression. He did not say he had any thoughts of self-harm but he complained about the side effects of his medication.
46. One of Elmley's offender supervisors said she had been told by someone at Standford Hill that the man's transfer to Elmley was short-term and that he was likely to return there within a week. Although she did not record it anywhere, she said she met him in his first week at Elmley when she said he was confused about whether he wanted to go back to Standford Hill. Her next contact with him was in September, when she visited him with an officer. She said she had not started an offender supervisor contact sheet because she thought he would return to Standford Hill.
47. On 25 July, the man's offender supervisor returned from leave and discovered that the man's room at Standford Hill had been cleared because he would be staying at Elmley for longer. The next day, the offender supervisor was told that he had responded to treatment and was ready to return to Standford Hill. He said he told his manager that the man was returning to the prison. He mentioned to his manager that the man's current behaviour appeared to be similar to how he was before his offence. The manager then contacted a nurse at Standford Hill to say he was concerned that he could return to open conditions without being fully stabilised. He told the investigators that he was concerned that healthcare staff at Elmley did not know that anxiety and panic attacks had featured in the build up to his offence. The manager said he recalled the nurse he spoke to was quite alarmed by the information he had given her and agreed that he should not return to Standford Hill until his issues had been resolved.

The manager said he could not recall whether he informed the nurse of the nature of his index offence.

48. A nurse at Elmley noted in the man's medical history that she had been informed by a nurse at Stanford Hill that his current presentation was the same as when he committed his index offence, and staff should be aware that he was at an increased risk of harming others. She made no further enquiries. The nurse also noted that he was an unknown risk of deliberate self-harm.
49. At around 3.00pm on 26 July, the psychiatrist assessed the man, who said he was suffering from a swollen throat which made eating painful. He told the psychiatrist that he was worried that the police thought he had bought a flat with stolen money. He also said that prison officers were communicating through pipes in the prison. The psychiatrist noted that he was suffering from a somatic complaint, guilty ruminations and hallucinations which stemmed from his depressive episodes.
50. The psychiatrist concluded that the man should remain at Elmley. In capital letters at the end of his entry, the doctor noted that staff had been informed that his index offence, "... may have happened during a similar episode". The psychiatrist told the investigators that he diagnosed psychotic depression. He prescribed 30mg of duloxetine, used to treat depression and anxiety and 2mg risperidone, an antipsychotic. Later that afternoon, a nurse reported that he was still anxious and complained of a "drilling pain" in his head.
51. On the morning of 27 July, the man refused to take his medication and said he had a sore neck. A healthcare assistant noted he appeared confused and had said his medication was not working.
52. Over the next few days, the man was described as withdrawn, but there were no obvious signs that he was still suffering from acute anxiety. On 31 July, a nurse at Stanford Hill told the offender supervisor that healthcare staff at Elmley had told her that he had been seen by a psychiatrist and prescribed medication, but that there was no plan for him to be discharged back to Stanford Hill. On 2 August, the offender supervisor was told that he continued to make progress.
53. On 3 August, a doctor saw the man about pain in his hand. The doctor noted that an X-ray was not necessary and that there was no medical need for him to remain in the healthcare unit. The doctor suggested discharge to either a wing in Elmley or back to Stanford Hill.
54. During a ward round on 8 August, the psychiatrist noted that the man was less distressed, smiling and relatively relaxed. He told the doctor that he no longer felt problems with his "nerves", thanks to his medication. The psychiatrist agreed he should be discharged to one of the prison's wings and be reviewed by the in-reach team a week later.
55. The man remained an inpatient for another four days. In an e-mail to her colleagues at Stanford Hill on 9 August, a nurse said she had been told that he was still making slow progress and the psychiatrist had advised that he would

stay at the prison for four weeks, to integrate him back to normal location before he could be assessed for return to open conditions. On 14 August, he was discharged to houseblock five at Elmley. There was no discharge plan or recorded handover with officers on the wing.

56. On 16 August, a nurse sent another update to colleagues at Standford Hill to say that the man was still under the care of the psychiatrist, awaiting assessment. A doctor prescribed the medications already authorised by the psychiatrist without seeing him or reviewing the medications herself.
57. On 22 August, a nurse tried to see the man in his cell, but was unable to get to see him because of an operational problem on the wing. On 29 August he did not go to what was noted as an emergency doctor's appointment. Neither of these missed appointments was followed up. On 31 August, a nurse advised colleagues at Standford Hill that he was still under the care of the in-reach team.
58. On 3 September, the offender supervisor recorded that the man was now on houseblock five and was being monitored by the in-reach team. The officer noted that the nurse at Standford Hill was liaising with the healthcare team at Elmley, to arrange his transfer back to Standford Hill when appropriate. The offender supervisor noted that his parole hearing had been rescheduled to 22 October and questioned whether he would be well enough to attend.
59. The psychiatrist reviewed the man on 6 September when he told the doctor that his throat was feeling worse and thought he might have damaged it when "screaming" during his panic attack at Standford Hill. He said that during his panic attack he had felt terrified, tense and frightened of everything, but he said he had no intention to self-harm. The doctor told the investigators that he had deteriorated since he had last seen him, so he increased the duloxetine to the full dose of 30mg three times a day and prescribed diazepam again, increasing the dose from 5mg to 10mg. When asked by the clinical reviewer about the significant increase in duloxetine, and whether that would result in an increase in sedation, the psychiatrist said he did not know, adding that if a person was tolerant to 30mg without any sedation effects, he thought they would be tolerant to a full dose. He was unable to describe the side effects of the medications. Side effects of duloxetine include, dry mouth, sleepiness, throat tightness and an increased risk of drowsiness if taken with diazepam. He asked for a psychology assessment to be arranged.
60. On 11 September, the psychiatrist agreed that the man's diazepam should be dispensed only in the afternoon, at his request. The psychiatrist said that this was the last time that he saw him. He told the investigators that the man was settled and needed no further input from psychology or the in-reach team, and that any problems should be brought to the attention of the mental health team.
61. On 12 September, the man's assigned personal officer at Elmley described him as a lot better than when he first arrived on the unit but did not believe he was completely well. His two offender supervisors and an officer met him the same day to discuss his position. He said that he had asked his solicitor to request a deferral of his parole hearing, as he still had medical issues and wanted a period

of stability in closed conditions before transferring back to Standford Hill. His offender supervisor at Elmley noticed that he was unshaven, slightly unkempt and had lost weight. The offender supervisor at Standford Hill described him as “chemically-coshed” during this meeting.

62. On 18 September, the offender supervisor at Standford Hill completed a sentence planning and review report, requested by the Parole Board about why the man went back to closed conditions. The offender supervisor at Elmley also completed a sentence planning and review report. She said that she did not believe that his risk of harm to the public had increased since previous reports had been prepared, but felt unable to comment on his mental health and therefore could not recommend his release. She suggested the psychiatrist’s opinion be sought before the next hearing listed for 22 October. There is no evidence that he was contacted for his views.
63. On 3 October, the Parole Board agreed to postpone the man’s parole hearing to March 2013, in response to a request from his legal team.
64. On 8 October, the man told a nurse that he had difficulty swallowing because his throat hurt, and he had lost two stone in two months. His weight was not recorded. On 11 October, he told a doctor of the discomfort in his throat and said that he was also suffering from constipation. The doctor advised a referral for him to have an endoscopy (internal examination) to investigate his weight loss. (He died before he had an endoscopy examination.)
65. The man did not attend a doctor’s appointment on 13 November. In his absence, a doctor noted that his problems should not be managed by the long term use of buscopan (an anti-spasmodic), but he had lost weight and had missed a number of medical appointments. The doctor noted that he should be reviewed as soon as possible. The doctor told the investigators that she was not concerned about his mental health, but for his physical health.
66. On 14 November, two members of the prison’s primary care team saw the man to assess his suitability for group therapy work, unrelated to his previous contact with mental health services at the prison. One described him as unkempt, shaking slightly, lethargic and unmotivated. He told them that he had not recovered from the panic attack in July and he could not concentrate. He complained about his medication, said he found it difficult to swallow and had lost weight. He said he was waiting for a parole hearing and received support from family and friends. She requested a healthcare appointment for him and referred him for discussion at the next in-reach meeting. She said that she did not consider him at risk of self-harm.
67. The man did not attend another doctor’s appointment on 15 November, and there is no recorded explanation. On 20 November, he walked out of a doctor’s appointment and did not attend another appointment the next day. A doctor wrote in capital letters in his medical record that he needed to be seen. She told the investigators that she was not concerned about his mental health, because she (incorrectly) believed he was receiving support from the in-reach team, but was concerned about his physical health. He also did not attend a doctor’s

appointment on 21 November. There are no entries on his record to show that the healthcare team spoke to the wing to try to find out why he had not attended his appointments.

68. On 19 November, the man spoke to his aunt on the telephone. He complained about his throat pain and said doctors did not know what was wrong with him. When his aunt asked about visiting him, he said it was not worth it as he had no energy. He spoke to his aunt again an hour later, who told him his friends were worried about him. A few minutes later, he called his aunt for a third time and told her he felt he was letting people down. He said he had a physical ailment that had become psychological. His aunt repeated that people were worried about him. In another telephone call that afternoon, a friend told him that people were worried about him. He again said that he thought he was letting everyone down.
69. A doctor saw the man on 22 November and noted that he was suffering from a sore throat and was experiencing pain swallowing. The doctor prescribed antispasmodic medication, and referred him to an ear, nose and throat specialist.
70. On 23 November, the man was discussed at the mental health in-reach meeting, and it was agreed that he should be reviewed the next week for further discussion at the next meeting on 28 November. A primary mental health worker was tasked with clarifying the situation about his return to Standford Hill.
71. On 24 November, the man spoke to his aunt again on the telephone. He asked her to order a number of Christmas gifts. His aunt repeated that his family and friends were concerned about him. He told her that he had seen the prison doctor who had booked him a hospital appointment in the next two weeks. His aunt encouraged him to write poetry, but he said he could not concentrate on writing.
72. A member of the primary care team, accompanied by the mental health worker, assessed the man on 26 November. The care team member described him as dishevelled and unkempt and noticed that he was wearing prison clothing, rather than his own. (Officers told her later that he slept in his clothes. They also said that he had been seen throwing away most of his food, because he found it difficult to eat.) She noted that he was noticeably low and spent much of the time looking at the floor. He said he had no thoughts of harming himself but he was terrified about what was happening to him. He questioned why he had had a panic attack because he was ready to leave prison, and said he was anxious about his forthcoming endoscopy. When asked if he would be happy to return to the healthcare unit, he said that he would have to be and that he had felt worse since his discharge to the wing. She referred him for discussion at the in-reach meeting and planned to discuss his possible admission to the healthcare unit with the psychiatrist. She recorded in his medical record: "not for ACCT at this time, but to consider should suicidal ideation be expressed". She discussed her contact with her with his personal officer on the unit.
73. In a telephone call to a friend on 26 November, the man explained how he had reacted at Standford Hill when he had heard the news about his parole hearing

being deferred. He said his throat was “killing him” and that Elmley was a “horrible prison”. He said that he was in dire straits with regard to the problems about his throat. His friend suggested his symptoms were linked to stress and he had to break the cycle. He said he did not want to be visited in prison and was exhausted. His friend reassured him that he had his parole hearing in March to aim for. During the telephone call he explained to his friend about the medication he was taking and complained that this gave him a dry mouth. He said he could not write poetry as he could not concentrate because of the pain.

74. The man’s cell mate told the investigators that the man did not eat properly. He said he helped him with dressing, collecting his food and making sure he took his medication, which he said made him sleepy. He said that the man complained about his health but he believed that these problems were in his head. He did not think that he was suicidal, but just needed looking after.
75. On the afternoon of 27 November, the prison’s emergency response nurse went to see the man in his cell after he complained of chest pains. The nurse arranged for a doctor to see him, who requested a chest X-ray and arranged for him to be admitted to the healthcare unit for observation. The doctor noted that he had experienced previous episodes of mental confusion and took time to answer questions. At 5.10pm a nurse noted that he had been admitted for a mental health assessment and because of physical concerns. The nurse noted that his medical observations were normal. She planned for his mental health to be reviewed and for medical observations to be taken daily.
76. A doctor saw the man again at 5.30pm. The doctor noted that he felt better but although it was still painful when he breathed in, his chest was clear and an ECG showed no concerns. He told the investigators that the man expressed no thoughts of self-harm during her contact with him. She noted in his medical record that he needed to be observed every 20 minutes and if his condition worsened he should go to hospital.
77. The man’s personal officer told the investigators that in the time she had known him, he had never discussed or exhibited any signs of suicide or self-harm. Two officers said they noticed the mental health in-reach team saw him a couple of times on the wing, but officers had regular contact with him. They said he was reluctant to leave his cell, so officers made an effort to speak to him.

Events of the incident

78. A nurse arrived on the healthcare unit at about 8.30pm and during the handover was told that the man had been admitted for a mental health assessment. The nurse told the investigators he did not know him well, but said he seemed okay and gave him no cause for concern. The nurse said that he did not check on him during the night as he had not been told that he needed to.
79. An Operational Support Grade (OSG) told the investigators that she checked all of the prisoners on the unit when she started her shift, but could not specifically recall the man. The OSG said she did not check him during the night either.

80. At 5.39am on the morning of the incident, a Healthcare Assistant (HCA) noted in the man's medical record that he had had a settled night. We have been unable to establish whether or not he actually checked him at that time or whether he was simply recording that he had not requested any assistance during the night.
81. At about 5.50am the OSG started the early morning roll check and at about 6.05am, she looked through the observation panel on the man's cell door. He was slumped against the wall at the far end of the cell, with his eyes closed and his legs bent to one side. She could not see anything around his neck, but he appeared quite grey so she called to a nurse who was nearby.
82. The nurse called to the man through the observation panel, but he did not respond. The nurse noticed that a shoelace was tied around his neck, so he radioed a code blue emergency call for assistance, pressed the general alarm at 6.06am and asked the OSG to call for an ambulance. (A code blue is used to communicate a life-threatening emergency.) The OSG said that she panicked and telephoned from the wing office to call the communications room for an ambulance rather than using her radio. The control room log shows that the ambulance was called at 6.07am.
83. The nurse collected the emergency response bag from the treatment room next to the wing office. He then waited outside the locked cell until the duty manager and two officers arrived a couple of minutes after the code blue had been called.
84. One officer opened the cell, cut the shoelace from around the man's neck and laid him on the cell floor. The nurse checked for a pulse and other signs of life, but could find none. An officer started cardiopulmonary resuscitation (CPR), while the nurse attached the defibrillator, which advised to continue with CPR. He used an ambu-bag to administer oxygen. Resuscitation efforts continued until the paramedics arrived at 6.28am. The senior paramedic examined the man and pronounced him dead at 6.30am.

Staff support

85. A debrief was held at 7.45am before staff went off duty. No concerns were identified about what had happened or how the emergency incident had been managed. A member of the prison's care team was at the meeting to offer support to staff.

Family liaison

86. The man's aunt was on holiday, so the news of his death was broken to his cousin at her home, at about 1.00pm. His cousin later informed his aunt of his death and the prison maintained contact with her. The funeral took place on 24 January, led by the prison chaplain. The prison offered to contribute to funeral expenses in line with national guidance.

Prisoner support

87. The Governor issued a notice to prisoners about the man's death, reminding them of the support available in the prison. All prisoners being monitored as at risk of suicide and self-harm were reviewed in case they had been adversely affected by his death. A memorial service was held on 29 November.

ISSUES

Transfer to closed conditions

88. Prison Service Order (PSO) 4700 for indeterminate sentenced prisoners sets out the requirements for life sentenced prisoners who are transferred from open to closed conditions, but does not specifically cover the circumstances when the transfer is for health reasons. The national Public Protection Casework Section (PPCS) must be notified of the reason for the transfer and the prisoner's offender manager should be contacted, preferably before the prisoner is transferred. It was Stanford Hill's responsibility to record the reason for his transfer and inform those involved in his offender management.
89. The man moved to Elmley on 18 July, originally for a few days to monitor his mental and physical health. His offender supervisor and a colleague from Stanford Hill visited him several times at Elmley. On 26 July, a psychiatrist concluded that he should remain at Elmley for mental health treatment. When he was discharged to the wing in August, the psychiatrist suggested that he needed four weeks on a houseblock to stabilise his condition before he was transferred back to open conditions. As he did not need hospital or inpatient treatment it is not clear why his health could not have been monitored at Stanford Hill. The psychiatrist discharged him from his care on 11 September and he remained on houseblock 5 for more than three months after that.
90. The man's offender supervisor at Elmley said that the other offender supervisor maintained oversight of his case. She said she visited him within a week of his arrival at the prison, but did not record their meeting on a contact sheet because she thought he would return to Stanford Hill. She said that her next contact with him was in September, when she visited him with an officer from Stanford Hill. She did not see him again. Throughout his time at Elmley, she understood that he would eventually return to Stanford Hill because he had not failed in open conditions and was at Elmley only temporarily.
91. The offender supervisor said that she had told the man to contact her when he felt well enough to return to Stanford Hill, and that she would not have further contact with him until he was ready to do so. She explained that she was only required to see prisoners every three months, and would have followed up with him if she had not heard from him before December. The psychiatrist was never consulted about his return to Stanford Hill.
92. Healthcare staff and offender supervisors at Stanford Hill often contacted Elmley to discuss the man's return to Stanford Hill and recorded these conversations. They were incorrectly advised that he was being supported by the mental health in-reach team. The investigators asked whether there was a formal risk management meeting after his transfer to Elmley, but no such meeting took place. Correspondence between the offender supervisors was informal and often not recorded. There is no evidence in the records that his offender manager was ever involved in the decisions about his initial move or his subsequent stay at Elmley. Nor did the prison recall informing the Public Protection Casework section.

93. The responsibility for the man's offender supervision was unclear, which meant he remained a category D prisoner in a category B prison, with a much more secure regime and reduced privileges. No one appeared to take overall responsibility for his management and his return to open conditions. When his immediate healthcare concerns had been addressed, a transfer back to Stanford Hill should have been sought, yet he remained at Elmley with no clear care plan either in relation to his health or his sentence progression. His offender supervisor did not contact the psychiatrist about his suitability to return to open conditions. No assessment of risk was made which indicated that he was no longer suitable for open conditions.

The Governor of Stanford Hill should ensure that the national guidance for transferring indeterminate prisoners to closed conditions is followed when such prisoners transfer to Elmley and that transfers should be for the shortest possible time, with the reasons fully justified, recorded and monitored.

Assessment of the man's risk of suicide and self-harm

94. When the man arrived at Elmley, he was described by the healthcare manager as hyperventilating, agitated, mentally disturbed and thinking about suicide. He decided to locate him in a safer cell, but did not open an ACCT. At interview, the nurse manager explained that he talked about suicide, but did not have a plan, so he considered that his risk could be managed by locating him in a safer cell without additional suicide prevention monitoring. He said that he did not record anything in his medical record that evening, because he considered that record-keeping was a task to be delegated to more junior nurses.
95. Prison Service Instruction (PSI) 64/2011 - Safer Custody requires that:
- “Any member of staff who receives information, including that from family members or external agencies, or observes behaviour which may indicate a risk of suicide/self-harm must open an ACCT.”*
96. The PSI also points out that safer cells cannot deal with the problems underlying a prisoner's self-harming or suicidal behaviour and cannot replace the individualised and multi-disciplinary care plan for prisoners at risk of self-harm. We consider that when a safer cell is used to manage a prisoner's risk an ACCT should always be opened. Officers from Stanford Hill visited the man the next day and were upset by the condition of his cell. He had no personal belongings with him, and nothing to do at that particularly vulnerable time. He was observed only once during the night, when the nurse responded to his cell bell after he had another panic attack.
97. At no time during his time at Elmley did staff open an ACCT to support the man. The healthcare manager noted he talked about suicide but considered an ACCT was not necessary. Life sentenced prisoners who are returned to closed conditions are at an increased risk of self-harm, but there is no evidence staff considered this as a specific risk factor. PSI 64/2011 suggests that parole

hearings are a time of heightened risk, and yet staff did not identify his distress at the continued postponement of his parole hearing as an additional risk factor combined with his poor mental health. As his risk factors were not identified, staff did not put effective support measures in place to mitigate those risks.

98. We consider that the man would have benefited from the case management approach of the ACCT process, so that a named individual would have been responsible for oversight of his support plan. A multidisciplinary approach to his care would have ensured he had appropriate mental health and other support, while his return to open conditions was managed with appropriate urgency.

The Governor and Head of Healthcare at Elmley should ensure that all staff are aware of their responsibility to open an ACCT if there is any information that a prisoner has thoughts of suicide and take account of all known risk factors.

Mental health assessments

99. The clinical reviewer considers that the man required a primary mental health assessment as soon as possible after his transfer from Stanford Hill. The assessment was not made until 24 July by a nurse. The clinical reviewer describes the corresponding entry in his medical record as so generic, as to be on the verge of meaningless and was of little clinical value. When interviewed, the nurse was unable to explain the psychiatric rating scale he had used in the assessment.
100. We agree with the clinical reviewer that all healthcare staff undertaking primary mental health assessments should receive training to ensure their quality and that the assessments are completed in a timely manner. We make the following recommendation:

The Head of Healthcare at Elmley should ensure that primary mental health assessments are completed promptly by staff who are qualified and trained to undertake such assessments.

Discharge from the healthcare unit

101. When the man was discharged as an inpatient from Elmley healthcare unit on 14 August, there was no discharge plan. He did not return to Stanford Hill and there is no evidence that healthcare staff contacted wing staff to brief them about his position in advance of his arrival on the houseblock. Oxleas Mental Health Referral Pathway requires that healthcare staff should speak to officers on the houseblock and give them a copy of the discharge plan in these circumstances. The guidance goes on to say that a post-discharge appointment should also be made.
102. PSI 64/2011 also recommends that healthcare staff should explain to officers how to manage a prisoner who has an ongoing mental health problem when they are discharged to the care of residential staff.

The Head of Healthcare should ensure that there is an appropriate handover when a prisoner is discharged from the healthcare unit.

Mental health in-reach support on the houseblock

103. On the 8 August, the psychiatrist assessed that the man could be discharged from the healthcare unit and recommended that he was reviewed by the in-reach team the next week, but did not refer him. He saw him again on 6 September, and still did not refer him for in-reach support, even though the psychiatrist said that he had deteriorated since their last meeting. Less than a week later, the psychiatrist thought he had settled so well that he needed no input from the in-reach team and scheduled no more psychiatric reviews. The clinical reviewer considers that the psychiatrist's initial treatment plan that the man should be seen by the in-reach team was appropriate, but is concerned that he became "lost" when this did not happen.
104. The man was discharged from the healthcare unit on 14 August. Apart from his three appointments with the psychiatrist, he did not have any other mental health support until he was noticed by members of the primary care mental health team who happened to assess him for group therapy on 14 November. The psychiatrist mistakenly thought he was receiving support from the mental health in-reach team for the first month on the wing, and that he would be seen by the mental health in-reach team on the wing after that.
105. On 6 September, the psychiatrist suggested that the man should have a psychology assessment, but no referral was made. At this time access to psychology services was limited. The clinical reviewer notes that it is not acceptable that a psychology assessment requested by a consultant psychiatrist did not take place.
106. The clinical reviewer suggest that there is a need for regular meetings involving the consultant psychiatrist, the mental health in-reach team and the primary care mental health team to improve communication and discuss all referrals to ensure that none are missed. We agree with the clinical reviewer's findings and make the following recommendation:

The Head of Healthcare should ensure that mental health referral processes are clear and fully discussed by mental health clinicians to provide effective support for prisoners with mental health needs.

The man's medication

107. When asked to comment specifically on the medication that the man was prescribed the clinical reviewer concluded that he was prescribed medication that was appropriate to his symptoms. On 6 September, the psychiatrist increased the levels of his medication. The dose of risperidone remained the same, but the dose of duloxetine was increased from once a day to three times a day and the level of diazepam from 2.5mg to 10mg. The clinical reviewer suggests that when a patient's medication is increased so significantly, there should be regular reviews to see how he is responding, but this did not happen.

108. When interviewed, the psychiatrist could not identify the side effects of the medication he prescribed. The side effects of duloxetine and risperidone are similar: drowsiness, dizziness and tremors and tightness of throat and dry mouth. During his time on the wing, the man was drowsy and spent a lot of time in his cell sleeping. His offender supervisor described him as “chemically coshed” when he saw him in September, which the clinical reviewer suggests might have been the result of his depression but could also have been a side effect of his medication.
109. The clinical reviewer concludes that regular reviews would have helped identify the extent to which the man was responding to his medication or had side effects. We consider that it was a significant omission that such reviews did not take place and make the following recommendation:

The Head of Healthcare should ensure that prisoners prescribed medication for mental health problems are regularly reviewed.

Missed medical appointments

110. The man did not go to seven doctors’ appointments, and walked out of one. A number of these missed appointments occurred in the weeks leading up to his death and there is no recorded explanation for his absence. The clinical reviewer considers that these were further missed opportunities to monitor his wellbeing and arrange support from the mental health in-reach team. We agree with the clinical reviewer that when a patient does not attend a healthcare appointment the reasons should be clearly recorded and followed up.

The Head of Healthcare should ensure that reasons for missed appointments are recorded and rebooked. Where appointments are not rebooked, the reason should be entered on the clinical record.

Overnight observation on night of the incident

111. On the evening of the incident, the man was admitted to the healthcare unit when he complained of chest pains, for monitoring and a mental health assessment. Despite a doctor’s request that he should be checked every 20 minutes there was no record of any observations overnight. The level of observations was recorded in his clinical record but a nurse said he had not been told about them.
112. There appears to have been a lack of clarity and understanding about the purpose of the man’s admission to the healthcare unit on 27 November. When the nurse arrived on the healthcare unit at around 8.30pm, he said he was told that he had been admitted to the unit for a mental health assessment. The nurse said he seemed okay, responded normally, and gave him no concerns. He said that he did not check on him during the night as there was no reason to do so. We agree with the clinical reviewer that observations should have been taken in line with the doctor’s request:

The Head of Healthcare should ensure that nurses are briefed and carry out

required observations in line with each prisoner's care plan.

Delay in entering the man's cell

113. When the man was seen to be hanging in his cell, the OSG had a key in a sealed pouch, which is carried to ensure that staff can have immediate access to a cell in an emergency. Despite this, she and a nurse waited for assistance from other staff before going into his cell. The OSG said that she was not trained to go into a cell in an emergency and the nurse said it was protocol to wait for officers to arrive before going into a cell.
114. Elmley's local instruction for unlocking a prisoner during the night states:

"A night patrol may, exceptionally, unlock a cell in the case of a serious emergency (e.g. fire or suicide) without awaiting the arrival of a second officer provided that in their judgement immediate action is imperative to save life."
115. The OSG saw that the man was grey, and shortly afterwards, the nurse saw that he had a shoelace tied around his neck. We are concerned that neither the nurse nor the OSG knew they had the authority, or felt confident to go into the cell in such a situation.
116. It is important that staff are not only aware of the protocols to be followed in entering a cell in an emergency but also have the confidence and training to do so. Senior managers need to take responsibility for ensuring that staff fully understand their responsibilities to enter cells promptly and that in an emergency the preservation of life should come before security concerns. We note that at the last inspection of Elmley HM inspectorate of Prisoners commented on night staff's lack of confidence to intervene and respond to emergency situations and the need for training and monitoring their competence. We make the following recommendation.

The Governor must ensure that all staff understands that, subject to a personal risk assessment, they should enter a cell at night when there is potentially a risk to life.

RECCOMENDATIONS

1. The Governor of Standford Hill should ensure that the national guidance for transferring indeterminate prisoners to closed conditions is followed when such prisoners transfer to Elmley and that transfers should be for the shortest possible time, with the reasons fully justified, recorded and monitored.
2. The Governor and Head of Healthcare at Elmley should ensure that all staff are aware of their responsibility to open an ACCT if there is any information that a prisoner has thoughts of suicide and take account of all known risk factors.
3. The Head of Healthcare at Elmley should ensure that primary mental health assessments are completed promptly by staff who are qualified and trained to undertake such assessments.
4. The Head of Healthcare should ensure that there is an appropriate handover when a prisoner is discharged from the healthcare unit.
5. The Head of Healthcare should ensure that mental health referral processes are clear and fully discussed by mental health clinicians to provide effective support for prisoners with mental health needs.
6. The Head of Healthcare should ensure that prisoners prescribed medication for mental health problems are regularly reviewed.
7. The Head of Healthcare should ensure that reasons for missed appointments are recorded and rebooked. Where appointments are not rebooked, the reason should be entered on the clinical record.
8. The Head of Healthcare should ensure that nurses are briefed and carry out required observations in line with each prisoner's care plan.
9. The Governor must ensure that all staff understands that, subject to a personal risk assessment, they should enter a cell at night when there is potentially a risk to life.

ACTION PLAN: The Man – HMP Elmley

No	Recommendation	Accepted/Not accepted	Response	Target date for completion	Progress (to be updated after 6 months)
1	<p><u>HMP Stanford Hill</u></p> <p>The Governor of Stanford Hill should ensure that the national guidance for transferring indeterminate prisoners to closed conditions is followed when such prisoners transfer to Elmley and that transfers should be for the shortest possible time, with the reasons fully justified, recorded and monitored.</p>	Accepted	<p>The Head of Offender Management (HMP Stanford Hill) will brief all Offender Supervisors that the Offender Manager and PPCS (Public Protection Casework Section) will be notified whenever an indeterminate sentenced prisoner is transferred to another prison, no matter how short or temporary the arrangement is.</p>	End June 2013	
2	<p>The Governor and Head of Healthcare at Elmley should ensure that all staff are aware of their responsibility to open an ACCT if there is any information that a prisoner has thoughts of suicide and take account of all known risk factors.</p>	Accepted	<p>All providers will ensure that regular staff working within the establishment receive ACCT training and are updated as necessary. Notification has been sent to all staff of all Healthcare providers as follows (including a copy of PSI64/11): South East Health Minster Medical Group Oxleas Mental Health Trust Central and North West London – (Drug misuse).</p>	Complete	

3	The Head of Healthcare at Elmley should ensure that primary mental health assessments are completed promptly by staff who are qualified and trained to undertake such assessments.	Accepted	A template has been devised and published to enable staff to carry out a more standardised and robust primary mental health assessment. Training in the completion of this template has been carried out. The completion of this assessment is included in the admissions/discharge policy and it has been shared with all healthcare providers.	Complete	
4	The Head of Healthcare should ensure that there is an appropriate handover when a prisoner is discharged from the healthcare unit.	Accepted	Admissions/discharge policy has been reviewed and published. System-one templates have been altered to address the recommendation. A hardcopy of any recommendations is provided to house block staff regarding any follow up with health care. Any discharges to the Mental Health provider are communicated via an electronic referral and provides an auditable trail.	Complete	
5	The Head of Healthcare should ensure that mental health referral processes are clear and fully discussed by mental health clinicians to provide effective support for prisoners with mental health needs.	Accepted	The Mental Health Services are now one service provider. There are robust referral systems in place and were at the time of the man's death. These are and were available to health care and non health care staff to enable referral. Further training and notifications have been sent to staff to ensure the protocols in place are followed. The Mental Health Team has a daily multi-disciplinary meeting to discuss referrals and ongoing management.	Complete	
		Accepted	The psychiatrist has built in sessions as part of	Complete	

6	The Head of Healthcare should ensure that prisoners prescribed medication for mental health problems are regularly reviewed.		the contract, to enable reviews of patients under their remit, which includes medication reviews.		
7	The Head of Healthcare should ensure that reasons for missed appointments are recorded and rebooked. Where appointments are not rebooked, the reason should be entered on the clinical record.	Accepted	Health care do not have the resources to indentify why each offender doesn't attend. Health care work in conjunction with the Heads of Residence to reduce the numbers of DNA's. Health care staff provide lists to each house block each day of all the offenders required and this is published. Similarly with community provision no chase up is conducted. The new Health care provider is contracted to open clinical rooms on each house block which will enable access to a nurse on a daily basis thus making this recommendation easier to fulfil.	Complete	
8	The Head of Healthcare should ensure that nurses are briefed and carry out required observations in line with each prisoner's care plan.	Accepted	Handovers are built in to each nursing shift, which includes the patients current care plan and any observations required.	Complete	
9	The Governor must ensure that all staff understands that, subject to a personal risk assessment, they should enter a cell at night when there is potentially a	Accepted	Training specific to OSGs on night shifts has been rolled out. This has included cut down knife training, emergency response and ACCT refresher. Governors (during night visits) supplement this by ensuring staff can present an awareness of their actions in an emergency.	Complete	

	risk to life.				
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