

A Report by the
Prisons and
Probation
Ombudsman
Nigel Newcomen CBE

**Investigation into the death of a man
at HMP Elmley on 2 December 2014**

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, who was found hanged in his cell at HMP Elmley in December 2014. He was 47 years old. I offer my condolences to the man's family and friends.

One of my investigators had conduct of this case and a clinical reviewer reviewed the man's clinical care at Elmley. Staff at Elmley co-operated fully with the investigation.

The man had been serving a life sentence since 1984, although he had previously been released on licence and recalled to prison. He had been at Elmley since April 2013 and was frustrated about his lack of progress. In September 2014, he appears to have engineered a move to the segregation unit, apparently in the hope he would be transferred to another prison. He refused to return to his houseblock and received consecutive punishments of cellular confinement, which meant he remained in the segregation unit, until his death.

On 27 November, after he had been in the segregation unit for over two months, an officer began Prison Service suicide and self-harm prevention procedures, as he was concerned that the man was unusually quiet and withdrawn. He appeared very paranoid and anxious about a forthcoming Parole Board hearing. The next day, prison staff ended the support procedures, without any mental health input and without fully considering or taking steps to resolve the man's identified problems. Over the following days, his mental health appeared to deteriorate and he showed significant signs of paranoia, but suicide and self-harm prevention procedures were not restarted.

On afternoon of 2 December, officers did not make the required hourly checks of prisoners in the segregation unit. Officers said that this was because they were understaffed. This meant that, as well as missing observations, segregated prisoners did not always get the opportunity to spend time in the open air, have a shower or make a phone call. In the late afternoon of that day, officers found the man had hanged himself in his cell.

I am concerned that the man spent so long segregated, with a very restricted regime, and without any support plan to help combat the long-term effects. Segregation unit staff noted that his mental health had deteriorated in the last week of his life and an officer appropriately began support procedures, but these ended prematurely the next day without any resolution of his problems. He did not have a mental health assessment and no one began support procedures again, despite clear signs that his mental health continued to decline.

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.

CONTENTS

Summary

The investigation process

HMP Elmley

Key events

Issues

Recommendations

SUMMARY

1. The man was sentenced to life imprisonment in 1984. He had been released on licence twice and was recalled to prison for a second time in 2009. He had been at HMP Elmley since April 2013.
2. Prison managers segregated the man on 25 September 2014, when he refused to go back to his houseblock from the prison's healthcare centre. He then refused to leave the segregation unit and received four separate punishments of cellular confinement. He gave different reasons for wanting to be segregated but it seems he hoped to be moved to a different prison.
3. On 27 November, an officer began Prison Service suicide and self-harm support procedures, known as ACCT. The officer who assessed him noted that the man appeared paranoid and that his upcoming parole decision might be a trigger for suicide or self-harm. He wrote a note accusing the night patrol officer of telling other prisoners about his offence and that he was an informer. He said that he now felt suicidal. No one recorded in the ACCT document exceptional reasons for holding the man in the segregation unit
4. The next day, a review panel closed the ACCT. The staff did not read the full document and were unaware of the man's allegation or a note from the night patrol officer in the ACCT document in response, recording that he was confused and paranoid. There was no healthcare representative at the review. The night patrol officer referred the man to the mental health team, but no one from the team saw him before he died and he did not have a mental health assessment within 24 hours of the ACCT being opened. Prison staff told us that he appeared paranoid for the remainder of his life, but no one began ACCT procedures again.
5. As he was serving a punishment of cellular confinement, officers should have checked the man every hour. On the afternoon of the man's death, these checks did not happen. Officers said that this often happened because the unit was understaffed. Officers found he had hanged himself in his cell, when they were unlocked cells for the evening meal. It was three hours since he had last been checked. Toxicology results showed a potentially fatal level of tramadol in his blood and a higher than expected level of his prescribed antidepressant. He had been given tramadol for back pain each day and received a week's supply of the antidepressant at a time.
6. We found that prison staff closed the ACCT prematurely without full consideration or resolution of the man's documented issues and without input from healthcare staff or a mental health assessment. Staff missed opportunities to begin ACCT procedures again in the last days of the man's life, when there were clear signs that his mental health had deteriorated. We found several failings in the management of the segregation unit, including a lack of effective care planning for those segregated for longer periods. Staff did not follow the local policy about the assessment of in-possession medication for prisoners on open ACCT plans. We make seven recommendations.

THE INVESTIGATION PROCESS

7. The investigator issued notices to staff and prisoners at HMP Elmley informing them of the investigation and inviting anyone with relevant information to contact him. No one responded.
8. The investigator obtained copies of the man's prison records and closed circuit television (CCTV) coverage of the events of that day. The investigator and another investigator interviewed 20 members of staff and five prisoners between January and March 2015. They visited the segregation unit and saw the man's cell.
9. NHS England commissioned a clinical reviewer to review the man's clinical care at the prison.
10. We informed HM Coroner for Mid Kent and Medway District of the investigation, who provided results the post-mortem and toxicology examinations. We have sent the coroner a copy of this investigation report.
11. One of the Ombudsman's family liaison officers contacted the man's ex-wife, partner and sister to explain the investigation process and to invite them to raise relevant matters for the investigation to take into account.
12. The man's ex-wife said he had attempted suicide in the past, but these incidents had always appeared to be a "cry for help". She thought he might have expected staff to have discovered him hanging earlier. He had telephoned her weekly, but his calls had stopped in September 2014. There was nothing unusual in his final call. A friend of the man had told her that he had asked to go to the segregation unit because someone had threatened to kill him. She thought that he should have been monitored more closely because he was in the segregation unit, had recently suffered a family bereavement, a threat had been made to his life, and he was due a parole decision. The man's ex-wife wanted to know whether he was taking medication when he died and, if so, whether prison staff had monitored this appropriately.
13. The man's partner told us that she had spoken to him the day before he died and he appeared his normal self. He had asked her to send him some stamps, which she felt indicated he was looking to the future. His partner said he had gone to the segregation unit because other prisoners on his wing had turned against him and hoped that the investigation might be able to provide more information about this. His partner said that he had suffered a recent family bereavement and this might have been on his mind.
14. The man's sister said that his other sister had died a few weeks before his death and she believed that prison staff should have monitored him more closely after this. She was concerned that prison staff had not informed her immediately of her brother's death, but she had learnt of this from his ex-wife the next day. As she had recently been in contact with a prison chaplain about their sister's death, she thought that the chaplain should have contacted

her after his death. She did not consider that her recent contact with her brother suggested that he intended to kill himself as he was planning for the future. She thought that something might have happened during the last day of his life to explain this. He had told her that he was concerned for his life and suggested he had been segregated for his own safety. His sister wanted to know if this had any bearing on his death. She was aware that there had been a number of recent self-inflicted deaths at Elmley and was concerned that wider failings at the prison might have contributed to her brother's death.

15. The man's ex-wife, partner and sister received copies of the draft report. They raised some issues/questions that do not impact on the factual accuracy of this report and have been addressed through separate correspondence.

HMP ELMLEY

16. HMP Elmley is a local prison on the Isle of Sheppey, which serves the courts in Kent and holds more than 1,200 remand and sentenced men in five wings, with a mixture of single, double and triple cells. The segregation unit consists of 20 standard cells, two special cells (short-term accommodation for violent prisoners to prevent them harming themselves or others or destroying property) and three cells for prisoners on 'dirty protest'.

HM Inspectorate of Prisons

17. HM Inspectorate of Prisons last inspected Elmley in July 2014. Inspectors reported that there had been a substantial increase in the number of incidents of self-harm and found that ACCT assessments and care plans were too generic and not always completed on time. They noted that relationships between segregation unit staff and prisoners were reasonably good, but the regime was poor. Segregation unit staff made poor written observations and there was little indication that they effectively monitored prisoners' emotional or mental wellbeing. Inspectors reported that most prisoners in the segregation unit were there because they refused to return to their houseblocks, mostly because they believed they would be unsafe. Plans to return prisoners to reintegrate prisoners were not adequately developed.

Independent Monitoring Board

18. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help ensure that all prisoners are treated fairly and decently. In its latest published annual report, for the year ending October 2014, the IMB reported a significant increase in prisoners harming themselves and a consequent increase in the number of prisoners being monitored under ACCT procedures. They were concerned about the number of prisoners held in the segregation unit because they refused to go back to their houseblocks in the hope that they would be transferred to another prison. They reported that prisoners in the segregation unit often missed showers, time in the open air and phone calls because of staff shortages.

Previous deaths at HMP Elmley

19. This man was the ninth prisoner to die at Elmley in 2014, the fourth self-inflicted death. A prisoner had killed himself in the segregation unit just three weeks before this man's death. Our investigation into the death of a man in March 2014 found that prison staff had missed opportunities to identify his risk of suicide and self-harm. In a number of previous investigations, we have made recommendations about the need for prison staff to use the required emergency code and call an ambulance in a life-threatening situation.

ACCT - Assessment, Care in Custody and Teamwork

20. Assessment, Care in Custody and Teamwork (ACCT) is the care planning system the Prison Service uses to support prisoners at risk of suicide or self-harm. The purpose of ACCT is to try to determine the level of risk posed, the steps that might be taken to reduce this and the extent to which staff need to monitor and supervise the prisoner. Checks should be irregular to prevent the prisoner anticipating when they will occur. Part of the ACCT process involves drawing up a care map to identify the prisoner's most urgent issues and how they will be met. Regular multi-disciplinary reviews should be held. The ACCT plan should not be closed until all of the actions on the care map have been completed. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011.

Segregation Units

21. Segregation units are used to keep prisoners apart from other prisoners. This can be because they feel vulnerable or under threat from other prisoners or if they behave in a way that prison staff think would put people in danger or cause problems for the rest of the prison. They also hold prisoners serving punishments of cellular confinement after disciplinary hearings. Segregation is authorised by an operational manager at the prison who has to be satisfied that the prisoner is fit for segregation after an assessment by a member of healthcare staff. Segregation unit regimes are usually restricted and prisoners are permitted to leave their cells only to collect meals, shower, make phone calls and have a daily period in the open air. A manager, a member of the chaplaincy team and a member of the healthcare team should visit the segregation unit daily and speak to each segregated prisoner to check their welfare. A doctor should visit at least every three days and a registered nurse on the other days to assess the physical, emotional and mental well being of the prisoner and whether there are any apparent clinical reasons to advise against continuing segregation.

KEY EVENTS

22. The man was sentenced to life imprisonment in 1984. He had been released on licence twice, but was recalled to prison each time. In 2001, he had absconded from an open prison. He was last recalled to prison in 2009. Around this time, prison doctors diagnosed him with depression for which they prescribed sertraline, an antidepressant. He also took tramadol for long-standing back pain. He was prescribed both medications for the rest of his life. An entry in his medical record in 2010 indicated that he had taken an overdose the previous year, while in the community. In January 2011, a doctor at HMP Swaleside noted that he felt paranoid and increased his dose of sertraline. He transferred to Elmley in April 2013 and a nurse assessed him as suitable to keep his medication in his cell, to take as prescribed.
23. A prison manager segregated the man for two weeks in May 2013, when he refused to move houseblocks after staff had reduced his incentives and earned privileges level (IEP, a scheme designed to encourage and reward good behaviour in prisons) was reduced. His IEP level was reduced from enhanced to standard, because he had refused to work in the prison laundry. Later that month, he told a prison doctor that his antidepressant was not working well. The doctor added amitriptyline, another antidepressant, to his prescription. The man said he did not want to see a psychiatrist.
24. The man served a further punishment in the segregation unit in September, after he refused to move to Houseblock 5. Officers did not record why he refused to move. He spent two days in the segregation unit.
25. The man did little to come to the attention of prison staff over the next year, except in May 2014, when a prisoner told an officer that the man was one of four prisoners on Houseblock 2 dealing 'spice' (a synthetic cannabis or new psychoactive substance that can be considerably stronger than cannabis). Prison staff did not obtain any further evidence of this.
26. By summer 2014, the man had moved to Houseblock 5, where he shared a cell. His cellmate told us that the man had no problems in the prison, such as bullying or debt, but was frustrated about the lack of progress he had made towards meeting his sentence plan targets at Elmley. He said that the man had planned to get himself sent to the segregation unit and would then refuse to return to a houseblock, in the hope that he would be moved to another prison, better suited to help him progress.
27. On 25 September, the man told an officer that his partner had died. This was not true but he used it as a ruse to ask for a move to the segregation unit to help him with the grieving process. He said that he was afraid he might harm someone. Prison staff took him to the healthcare centre instead and, later that afternoon, he refused to return to Houseblock 5. He was charged with a disciplinary offence and admitted to the segregation unit to await a disciplinary hearing, known as an adjudication. He was held under Prison Rule 53, which allows prisoners charged with an offence against discipline to be segregated

until the first hearing is opened. A nurse assessed that there were no health reasons to indicate that he should not be segregated.

28. An operational manager was the adjudicator at the man's disciplinary hearing on 27 September and found him guilty of disobeying a lawful order. The man wrote a note of mitigation, in which he said he was struggling to cope with his wife's death and had manipulated the move to the segregation unit for his own safety and the safety of others, as he thought he might harm someone. The operational manager told us that the man appeared genuine and wanted to have some time away from the houseblock. She punished the man with seven days' cellular confinement in the segregation unit.
29. On 2 October, the man told an officer in the segregation unit that other prisoners were planning to bring a quantity of drugs and mobile phones into the prison that day. The Head of Security arranged an operation and retrieved these items from a group of prisoners in the prison grounds.
30. On 5 October, when he was due to return to Houseblock 5, the man refused to leave the segregation unit and was again charged with a disciplinary offence of refusing a lawful order. The Head of Security was the adjudicator at the hearing on 7 October and the man told him that he could not go back to the houseblock because he was dealing with a family bereavement. The Head of Security said that he did not discuss the security information the man had provided because he did not consider this was appropriate in that forum. He told us that he thought the man had given staff the security information knowing that he could then say that he would be at risk if he returned to a houseblock and so should stay in the segregation unit. He found the man guilty and gave him a further punishment of 14 days' cellular confinement. No one assessed his fitness for segregation, before or after this further punishment of cellular confinement.
31. On 20 October, when his punishment ended, the man again refused to return to his houseblock and received a further disciplinary charge. At the hearing on 21 October, he pleaded guilty and told the adjudicator that he could not go back to any houseblock, as there was a "price on his head", because he had informed about illicit items coming into the prison. The adjudicator adjourned the hearing to investigate and corroborate the information. As the man's period of cellular confinement had expired, the adjudicator authorised his continuing segregation under Prison Rule 45, which allows prisoners to be segregated for the good order of the establishment or in the prisoner's own interests. There was no healthcare assessment.
32. On 24 October, the Head of Security chaired a segregation review board, which are held within 72 hours of first segregation under Prison Rule 45 and then at least at 14-day intervals afterwards, with the aim of returning the prisoner to standard prison accommodation. A supervising officer (SO), a member from the IMB and an unnamed nurse were present. The Head of Security noted on the review form that the man was first segregated on 21 October. (This referred only to his segregation under Rule 45 and took no account that he had in fact been segregated for over four weeks at that time.)

The Head of Security said he talked to the man for a relatively long time and thought that he came across as a man who felt worn down by the prison system. Again, they did not discuss the security information the man had provided. No one at review raised any concerns about the man's mental health or his risk of suicide or self-harm. The Head of Security authorised the man's continuing segregation under Prison Rule 45 until 7 November.

33. The Head of Security noted in response to a question on the review form that the man was to be transferred to another establishment "after 21st". He had a parole hearing scheduled on 21 November and the Head of Security explained that he meant that if the Parole Board decided not to direct the man's release, he was likely to transfer after the decision was finalised because he was "digging his heels in" and would not go to a houseblock. However, no one had made a formal decision about the move.
34. The Head of Operations was the adjudicator at the reconvened disciplinary hearing on 30 October. The record noted that an officer had spoken to the Head of Security and confirmed that the man had provided security information. The Head of Operations found the man guilty and gave him another 14 days' cellular confinement. No one assessed the man's fitness for segregation.
35. Around the end of October, the man's sister died. A prison chaplain spoke to the man's other sister to check the funeral arrangements. He told us that prison staff had offered to take the man to his sister's funeral, but he chose not to go. The chaplain thought that the length of the journey and the need to stay overnight in another prison were significant factors in the man's decision.
36. On 13 November, the man refused to return to his houseblock when the period of cellular confinement expired. At a further adjudication on 15 November, he submitted a written statement in which he said he was guilty of refusing an order to return to a houseblock but said that he could not do so as his life would be in danger. The adjudicator punished the man with 21 days' cellular confinement. Again, no one re-assessed his fitness for segregation.
37. In a conduct report for the hearing, an officer noted that the man was polite and conformed well to the segregation unit regime. Other prison staff told us that he was polite, quiet and did not cause any problems in the segregation unit.
38. On 21 November, a Parole Board panel considered the man's suitability for release at an oral hearing held at the prison. His offender supervisor spoke to the man afterwards and thought he did not appear down. She noted in his record that the hearing did not go as well as he had expected. She told us that this was because the panel had asked a lot of questions about his relationships. The Parole Board did not reach a decision about the man's release before his death.
39. The man wrote a note (not addressed to a specific person) in which he alleged that, on the night of 25 November, a female officer had told other

prisoners that he was an informer and had spoken to them about details of his offence. He wrote that other prisoners in the segregation unit then abused him and that this had made him feel humiliated, angry, depressed and suicidal. It is not clear when he wrote this note or who he gave it to. There is no reference to it in any of his prison records other than a copy left in an ACCT document, which was opened on 27 November.

40. An operational support grade was the night patrol officer on 25 November. She told us that she had known the man from when she had worked on the houseblocks and that he was quiet and polite man and she had never had any problems with him. She said that she did not know anything about the man's offence or any other security matters and did not speak to anyone about these matters. She said that she had not heard anyone in the segregation unit abusing him and that it had been a quiet week.
41. On the night of 25 November, only four of eight cells on the ground floor of the segregation unit were occupied. One prisoner was two cells away from the man and the only prisoner within four cells of him. He told us that he knew the man well and often spoke to him when they were in the segregation unit together. He said that he did not hear any prisoners or staff in the unit speaking badly of the man.
42. No one submitted a security intelligence report about the man's note and there was no investigation. The Head of Security told us that he had not been aware of the allegations. We have not been able to view CCTV footage of the night of 25 November, as all recordings from this time are corrupted.
43. The operational support grade told us that she considered that the man appeared paranoid on the night of 26 November. She said he thought there were cameras in his cell and said he could hear bells ringing. She said she could not remember if she thought about opening an ACCT document at the time, but she checked him every hour as is required for prisoners serving punishments of cellular confinement. She said she had told an officer about the man's paranoid behaviour in the morning, but there is no record of this and she did not write anything in the segregation unit observation book or in the man's records.
44. On the morning of 27 November, an officer unlocked the man's cell and thought that he did not seem to be his usual self. He said that he did not engage in conversation and did not want to come out of his cell. The man told the officer that he had heard night staff telling other prisoners about his offence. The officer was concerned about the man's state of mind and began ACCT procedures.
45. Prison Service Instruction (PSI) 64/2011 has a mandatory instruction that prisoners being managed under ACCT procedures should be held in segregation units only in exceptional circumstances. The local policy at Elmley is that when an ACCT is opened for a prisoner in the segregation unit, an operational manager speaks to the prisoner to determine whether different accommodation would be more appropriate. On the afternoon of 27

November, the Head of Residence spoke to the man who told him that he did not know why the ACCT had been opened and that he felt safe and happy in the segregation unit. He said he felt a bit paranoid but, when the Head of Residence asked him, said he had no intention of harming himself and would not move elsewhere in the prison. The Head of Residence considered that it was safe for the man to remain in the segregation unit. He told us that this was because he was open and articulate in conversation, did not appear depressed, had not harmed himself in any way, and said that he felt safe in the segregation unit. He did not record in the ACCT document the reasons for the exceptional circumstances.

46. At an ACCT assessment with an officer later that afternoon, the man persistently said he did not have any problems, except that he thought people might be talking about him behind his back. The officer told us that the man seemed extremely agitated and appeared paranoid. He said he had seen someone from the mental health in-reach team, but there is no record of this. He did not mention his sister's recent death. He spoke about his recent parole hearing and the officer thought that he put a lot of emphasis on the prospect of being released. He recorded in the note of the assessment that the man's key issues were, firstly, that he believed people were talking about him and, secondly, his parole outcome. He noted that a negative parole outcome might be a trigger for self-harm.
47. When an ACCT is opened, the local policy at Elmley is that a member of healthcare staff should review a prisoner's risk of keeping medication in possession. The man was given a supply of medication each week, including sertraline, and kept it in his cell to take as prescribed. He was not allowed to keep tramadol, which he took each day in front of a nurse at his cell. (Tramadol is an opiate-based medication, which is often traded by prisoners so is usually issued daily.) No one reviewed his risk assessment after the officer opened the ACCT.
48. The operational support grade read the ACCT document when she started her shift on the night of 27 November and saw the note that the man had written about the night of 25 November. We have been unable to establish who put this note into the ACCT document and when. The operational support grade said she spoke to the man about his allegations (which she assumed were directed at her). She wrote in the ACCT record that the allegations were not true and this was the first time she had heard of them. She said that the man had said he was very confused and paranoid and told her that he was sorry if he had been wrong about this. She told us that he did not appear his usual self and had looked around the cell for cameras. He also told her that he had a problem with his ear, which had affected his hearing.
49. At 3.00pm on 28 November, the Head of Safer Custody and a segregation unit manager held an ACCT review, around 27 hours after the ACCT was opened. PSI 64/2011 requires the first case review to be held within 24 hours of the ACCT being opened and it is mandatory that wherever possible, the assessor, the member of staff who raised the initial concern, and a member of healthcare staff should attend. The Head of Safer Custody told us that it was

not held earlier because of limited staff resources. Prison Service Order 1700, which covers segregation procedures, also requires a mental health assessment within 24 hours for a prisoner who is segregated, but this was not done.

50. The Head of Safer Custody said that he spoke to the man for a long time at the review, about his offending history, the progress he had made through the prison system and the setbacks he had encountered over the years. They talked about his previous prisons and people they both knew. The Head of Safer Custody said the man told him that the Parole Board panel had asked him questions about his relationships. The segregation unit manager recalled that the man said that he did not expect to be released and that he sometimes felt down, but was not suicidal. The Head of Safer Custody and the segregation unit manager said they did not see the note the man had written saying he felt suicidal because of hearing a member of staff talking to other prisoners about him. They did not read the operational support grade's entry in the ACCT record that referred to this note. The Head of Safer Custody said he had considered the officer's comment about the man's parole outcome but said that the man was adamant that he was okay and came across himself very well. The Head of Safer Custody said his conversation with the man had led him to conclude that it was appropriate to close the ACCT. In the record of the case review, the segregation unit manager wrote that the man said he felt paranoid when the ACCT plan was opened but these feelings had now gone. He also wrote that the man said that he did not feel suicidal and if he had wanted to take his life he would have done so much earlier in his prison sentence.
51. The operational support grade said she spoke to the man on the night of Friday 28 November and that he had apologised to her if what he had written had got her into trouble. She said that he was "up and down" over the weekend but still appeared paranoid.
52. The segregation unit manager and the prison chaplain spoke to the man on Sunday 30 November, as he appeared to be in a low mood. He said he was fine but was just not feeling talkative that day. The segregation unit manager and the chaplain discussed reopening the ACCT, but decided there was no need to, as officers were already checking him every hour as required by his segregation under Prison Rule 55. The segregation unit manager noted this decision in the segregation unit observation book.
53. On the night of 30 November, the operational support grade referred the man to the mental health in-reach team. She noted in the observation book and on the referral form that he was very paranoid, looking for cameras in his cell and hearing voices. She said she had thought about reopening the ACCT but decided not to for three reasons: firstly, the day staff had told her that he was fine now; secondly, she said that ACCTs she had opened in the segregation unit were often closed the next day; thirdly, she already checked him every hour.

54. Prisoners' telephone calls are recorded and we listened to recordings of the man's calls. Unless there are security grounds to target calls, prison staff listen to a random sample of telephone calls, but had not listened to this man's. On the afternoon of Monday 1 December, he phoned his partner. They spoke briefly about his parole hearing and he said he had not yet had the result. He said that prison staff thought he was "cracking up, they think I'm hearing voices but I can hear them videoing me in my cell ... they're trying to crack me up". The man's partner did not comment on this and the conversation returned to general matters such as his partner's work. He finished by saying that he hoped to call his partner the next day.
55. That evening, an officer responded to the man pressing his cell bell. The officer said that the man accused him of calling him a "nonce" in a conversation the officer had just had with another prisoner. The officer said that the man had said, "I'm glad to know that's what you think of me" and that he knew there were microphones in his cell. The officer told the man that he had just spoken to another prisoner about his medication and there was nothing more to it than that. He told us that the man appeared paranoid and very different from his usual self. He recorded at the time that he did not appear to be under the influence of drugs and he would refer him to the mental health in-reach team. (He told us that he did not do so when he later realised that the operational support grade had already made a referral.) The officer said that he did not reopen the ACCT because there was no sign that the man intended to harm himself. He thought his paranoia might have been related to the length of time he had spent in the segregation unit.
56. Prisoners in the segregation unit at Elmley have to indicate in the morning whether they want to spend time in the open air, have a shower or make a telephone call that day. On Tuesday 2 December, the man asked for a phone call but did not want to go out for exercise or take a shower. He had not had the opportunity to make a phone call on the day he died.
57. A nurse spoke to the man at around 9.30am as part of a routine healthcare segregation round. She said that he did not mention any problems and seemed his normal self.
58. CCTV recordings show that, at around 12.15pm, a prisoner who was in the cell next to the man, pushed something out from under his door attached to a piece of string. The man pushed some paper under his door and used this to pull the item into his own cell. He then pushed the item back outside and the other prisoner pulled it back into his cell using the string. He told us that he had asked the man for tobacco, which he gave to him.
59. At around 12.30pm, the Head of Safety Custody visited the segregation unit for the daily manager's round. He recorded in the man's daily sheet that he had "no issues or complaints", although CCTV recordings show that he did not speak to him during the visit. (Prison Service Order 1700 requires duty managers to speak to each prisoner when they visit.) He did not read the observations book and was not aware of the officer's entry about the man's paranoia the previous evening.

60. At 2.00pm, the mental health in-reach team reviewed the operational support grade's referral and listed the man for a triage assessment later that week.
61. An officer checked the man at around 2.00pm, but there were no further checks that afternoon. The usual staffing level for the segregation unit is a supervising officer and four officers in the morning and a supervising officer and three officers in the afternoon. That afternoon, one supervising officer and two officers were the staff working in the unit, one officer down from the agreed staffing level. Officers who had worked in the segregation unit in the morning had been asked to help on the houseblocks to allow their regimes to operate as planned. A number of the segregation unit staff we interviewed told us that this happened frequently – usually at weekends, but sometimes on weekdays – and this affected the delivery of the regime in the segregation unit.
62. One officer said that he was the designated adjudications officer that day and spent the afternoon preparing papers for the next day's disciplinary hearings. A second officer told us that he was very busy that afternoon and, as he was the only landing officer. He said there was a prisoner who had to be checked five times an hour, other prisoners who were persistently ringing their cell bells, and two prisoners who he had to separately escort back to their houseblock. He said that he did not have time to check the man and the other prisoners who were segregated under Prison Rule 55, who should have been checked every hour. The segregation unit was nearly full on 2 December, with just two empty cells.
63. At around 2.30pm, a Listener (a prisoner trained by the Samaritans to support other prisoners in distress) visited the segregation unit. A Listener visits the unit each day and each prisoner has the opportunity to speak to him. The Listener said that the man was asleep when he went to his cell and he therefore did not speak to him.
64. The prisoner in the cell next to him said he and the man chatted through their cell doors that afternoon about general prison matters such as how long they had served and how long they had spent in segregation. He said that they had spoken until just after 4.00pm or so. A prisoner who was in the cell on the other side of the man, said he was a quiet man who did not speak much, but said that another prisoner, who was in the cell the other side of him, sometimes spoke to the man. This prisoner told us that he had known the man for around a year in prison and knew his family in the community. He said that the man had told him to "take care", also some time after 4.00pm. None of the prisoners we spoke to thought he had any problems with other prisoners or staff in the segregation unit.
65. Two officers were assigned to the segregation unit later in the afternoon to help supervise the evening meal. In the segregation unit, each prisoner is unlocked one at a time to collect their meal and then locked back in their cell. At around 5.17pm, they unlocked the prisoner in the cell next to the man and while they waited for him to come back with his meal, one of the officers

briefly opened the observation flap on the man's flap. CCTV shows that he did not look directly into the cell but might have glanced in. He told us that he did not remember looking into the man's cell.

66. Around a minute and a half later, when he had locked the prisoner back in his cell, the other officer went to the man's cell. He looked through the observation flap and immediately unlocked and rushed into the cell, followed by two officers and a supervising officer. The man had hanged himself by a shoelace around his neck, tied to the window bars. One officer supported the man's weight while another cut the shoelace from the man's neck. The officers placed him on the floor and they began cardiopulmonary resuscitation.
67. The supervising officer left the cell and pressed the general alarm bell. He usually works in the prison's offender management unit and told us that he was not carrying the radio assigned for the segregation unit manager as he had not been given that role when he arrived in the morning and had not had the opportunity to collect it afterwards. An officer arrived at the man's cell shortly afterwards and immediately radioed a code blue medical emergency (indicating a life threatening situation) about 30 seconds after the general alarm. Both messages were recorded at 5.19pm in the communications room log.
68. Three nurses arrived around two minutes later and took over cardiopulmonary resuscitation. One of the nurses asked the officers to request an emergency ambulance. The communications room officer received the call at 5.23pm and telephoned the ambulance service. The nurses attached a defibrillator, which found no shockable heart rhythm so they continued with resuscitation. Paramedics arrived at the mans cell at 5.50pm and took over emergency treatment. At 6.18pm, the paramedics confirmed that he had died.
69. The prison chaplain was appointed as prison's family liaison officer, shortly after the man's death. He checked the chaplaincy records and found that the man had named his partner as his next of kin when he had spoken to a prison chaplain just after he had arrived at Elmley. However, the man's prison record and the ACCT document opened five days before his death, named his ex-wife as his next of kin. The prison chaplain and Head of Operations visited the man's partner that night and broke the news of his death. They visited his ex-wife immediately afterwards and informed her that he had died.
70. The next day, the prison chaplain tried to phone the man's sister twice but got no reply. His sister phoned the prison early that evening and spoke to the chaplain, after the man's ex-wife had informed her of his death.
71. Officers spoke to each prisoner in the segregation unit individually to tell them that the man had died. Staff reviewed prisoners assessed as at risk of suicide and self-harm, in case they had been adversely affected by the news of the man's death. An operational manager debriefed the officers involved in the emergency response and offered them the support of the prison's staff care

and welfare team. A nurse told us that healthcare staff were well supported by healthcare colleagues and managers.

72. The man's funeral took place on 17 December. The prison contributed to the costs in line with national guidance.
73. A post-mortem examination established the cause of death as hanging. Toxicology tests identified a potentially fatal amount of tramadol and an elevated level of sertraline in the man's blood.

ISSUES

Management of risk of suicide and self-harm

74. There are recognised risk factors that raise the risk of suicide and self-harm, which are set out in Prison Service Instruction (PSI) 64/2011. The man was segregated and had been diagnosed with, and was taking medication for, depression. Reportedly, he had harmed himself in the past. Family bereavements and parole reviews are also recognised triggers for suicide and self-harm.
75. Prison staff raised no issues about the man during his first two months in the segregation unit. Staff we spoke to thought he was getting on well and said he was a quiet man who caused no problems. Although he had some risk factors, we are satisfied that before the last week of his life, there was little to indicate that he was at raised risk of suicide and self-harm and there was a need to open an ACCT.
76. On 27 November, an officer appropriately opened an ACCT when he was concerned about the man's mental state. PSI 64/2011 states that prisoners on open ACCT plans must only be located or retained in segregation units in exceptional circumstances. PSO 1700 says that prisoners on ACCT plans should only be held in segregation units when they are such a risk to others that no other suitable location is appropriate and where all other options have been tried or are considered inappropriate. The Head of Residence assessed the man shortly after the ACCT was opened. However, his assessment focused on whether it was safe for him to remain in the segregation unit rather than on whether there was any alternative to this or whether there were exceptional reasons. We appreciate that the man was determined to remain in the segregation unit, but the Head of Residence did not record any exceptional reasons in the ACCT document as PSI 64/2011 requires.
77. We are concerned that prison staff closed the ACCT after just one day. PSI 64/2011 requires that the first case review must be held within 24 hours and must be attended by, among others, the assessor, the person who raised the initial concern, and a healthcare representative. The man's ACCT was opened on the morning of 27 November but the case review was not held until the following afternoon. Only the Head of Safer Custody and the segregation unit manager attended, not the officer who'd originally opened the ACCT, the assessor or any member of healthcare staff, which is a mandatory requirement, unless for some reason their attendance is not possible. There is no evidence that the Head of Safer Custody invited a member of healthcare staff to attend. We consider it is particularly important to have healthcare input at an ACCT review when the prisoner is segregated, as the effect of segregation on a vulnerable prisoner's state of mind can be severe.
78. Guidance in the ACCT document says that staff can close an ACCT at the first case review, if the case review team believe it is safe to do so and where all issues identified during the assessment interview have been resolved. The ACCT assessor identified two issues at the assessment: that the man was

exhibiting some paranoia and believed that staff were talking about him to other prisoners, and that a negative parole decision could be a trigger for self-harm. The Head of Safer Custody and the segregation unit manager said they had briefly discussed the man's belief that people were talking about him, but they had not read his note, in which he said he felt suicidal, or the operational support grade's related entry in the ACCT record. The Head of Safer Custody told us that they had discussed his parole outcome at the review, although they did not record this. He said that the man's presentation and the nature of the conversation led them to believe it was appropriate to close the ACCT.

79. As well as holding the ACCT review within 24 hours, PSO 1700 mandates that the man should have had a mental health assessment within 24 hours of the ACCT being opened. Even though the reason for opening the ACCT was concern about his state of mind, no one referred the man for an urgent mental health assessment. The operational support grade made a mental health referral on 30 November, but this was two days after the ACCT was closed, it was not regarded as urgent and was not prioritised.
80. We are concerned that staff closed the man's ACCT so soon, at an ACCT case review, which was not multi-disciplinary, with no healthcare representation and without the benefit of a mental health assessment. The man's location in the segregation unit, and the issues raised at the assessment interview, should have been considered with the input of the mental health team. His parole outcome was noted as a potential trigger for self-harm, but staff closed the ACCT before the outcome was known and without recording that they had discussed this at the review. Although there was very little in the ACCT document as it had been open for just a day, the Head of Safer Custody and the segregation unit manager held the review without reading and fully considering the evidence in the ACCT document and therefore missed information that should have highlighted the man's outstanding risk factors. This led them to rely too heavily on what he told them, rather than on his known risk factors. We make the following recommendations:

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

- **Prisoners assessed as at risk of suicide or self-harm are not held in the segregation unit unless all other options have been considered and excluded and there are fully documented reasons to explain the exceptional circumstances.**
- **First case reviews are multidisciplinary and always include a member of healthcare staff;**
- **First case reviews are held within 24 hours of the ACCT being opened and on the same day whenever possible;**
- **Staff read the ACCT document and familiarise themselves with all relevant issues and known risk factors before holding reviews;**

- **ACCT plans are not closed at the first case review unless all issues identified at the assessment interview have been resolved.**

The Governor and Head of Healthcare should ensure that a mental health assessment is carried out within 24 hours whenever an ACCT is opened for a prisoner in the segregation unit.

81. After the ACCT was closed, several prison staff had conversations with the man in the last four days of his life, which led them to conclude that he was paranoid or behaving unusually. He accused officers of speaking about him to other prisoners and claimed that there were microphones and cameras in his cell. Despite the evidence of his deteriorating mental health, which might have suggested he was at increased risk of suicide and self-harm, no one began ACCT procedures again. Although the operational support grade and an officer identified the need for a mental health referral there is no evidence that any of the staff mentioned this to any of the healthcare staff who visited the segregation unit daily.
82. Prison staff gave us various reasons for not opening an ACCT. These included that the man was already checked each hour (although, as we will address later, this did not always happen) that he had not harmed himself or given any indication that he would do so, and that ACCTs opened in the segregation unit were often closed the next day, as had happened on 28 November.
83. Hourly segregation unit checks, while a useful tool for monitoring the welfare of prisoners when done properly, do not replace the individual monitoring and assessment of risk that should come from a properly administered ACCT plan. A prisoner does not have to have harmed himself, or even spoken of doing so, for it to be appropriate to open an ACCT. The full range of risk factors, including significant changes to the prisoner's presentation, should be considered. It is regrettable that a manager closed the original ACCT so quickly after it was opened. We recognise that this might have indicated to junior staff that there was little point in opening an ACCT again.
84. Although the operational support grade, the manager of the segregation unit and an officer made entries in the segregation unit observation book about the man's mood and possible paranoia, other prison staff did not always review them. The Head of Safer Custody, who closed the man's ACCT on 28 November, visited the segregation unit each day but said he did not see these entries and therefore did not realise that he had ongoing problems.
85. We consider that prison staff should have identified that the apparent deterioration in the man's mental health in the days before his death might have indicated that he was at increased risk of suicide and self-harm and begun ACCT procedures again to support him and implement measures to help reduce his risk. This should have led to a reconsideration of whether the segregation unit was an appropriate place for him. We make the following recommendation:

The Governor should ensure that staff are aware of the potential effects of segregation on a vulnerable person's state of mind and begin ACCT procedures if they observe any changes in a prisoner's behaviour or circumstances, which indicate an increase in the risk of suicide and self-harm.

The man's segregation

86. The man appears to have engineered his segregation on 25 September when he refused to return to his houseblock from the healthcare centre. The reason he gave prison staff was untrue (that his partner had died) and it seems he was intent on a transfer from the prison, because he was frustrated by his lack of progress at Elmley. It also seems likely that he gave information about drugs and mobile phones being smuggled into the prison to reinforce the need for a transfer as, had this become known, this would have put him at risk from other prisoners.
87. We note that at the inspection in July 2014, HM Inspectorate of Prisons found that most prisoners in the segregation unit at Elmley were there because they had refused to return to their cells because they thought it was unsafe for them to do so. They found that planning for returning prisoners to normal location had not been adequately developed. The IMB also highlighted that a number of prisoners in the segregation unit refused to locate to a houseblock in the hope this would earn them a move to another prison.
88. Apart from a brief period in October, when an adjudication was adjourned and he was segregated under Prison Rule 45, the man spent almost all his time in the segregation unit serving consecutive periods of cellular confinement. The Prison Service Instruction on adjudications, PSI 47/2011, requires adjudicators to take account of the likely impact on the prisoner, including their health and welfare, when deciding on punishments, yet there is little indication this was done, or that subsequent adjudicators considered the cumulative effect. The PSI says that "If a prisoner appears to be committing offences with the intention of remaining in cellular confinement so as to avoid returning to normal location, the aim should be to address whatever problems the prisoner may have on the wing, rather than continually imposing punishment." There is no evidence that this was done. We are concerned that after the first segregation health screen on 25 September, there was no further health screen when each additional punishment of cellular confinement was imposed. We make the following recommendation.

The Governor should ensure that managers imposing punishments at adjudications fully consider the likely impact on the health and welfare of the prisoner and that a segregation health screen is completed for each period of cellular confinement.

89. The Head of Safer Custody and the Head of Security told us that they planned to keep the man in the segregation unit until he had the result of his parole hearing and, if the Parole Board did not direct his release, then they would try

to arrange a transfer to another prison. However, by the time of his death, he had spent over two months segregated with a very restricted regime and would probably have remained there for at least several more weeks. We consider that holding him in the segregation unit for this length of time was excessive. We accept it would have been difficult for the prison to transfer him while the parole process was ongoing. We also appreciate that he was determined not to return to a houseblock and had made such a move problematic. However, there was no staged plan to address the underlying issues behind this, mitigate the effect of his restricted regime or to reintegrate him gradually back to a houseblock. There was no structured plan to transfer him to another suitable prison, which would help him meet his sentence targets, when it was evident they could not be met at Elmley.

90. The man had an initial segregation health screen when he was first segregated in September. The purpose of the initial screen is to determine whether there are any healthcare reasons against holding a prisoner in segregation and to provide a 'snapshot' of the prisoner's mental well-being at the time of the screen. The guidance makes it clear that the screen is not intended to be a comprehensive mental health assessment and should not preclude an assessment by the mental health in-reach team. It is not intended to predict or anticipate a change in the prisoner's condition over time. Although healthcare staff saw the man on their routine daily rounds, none of them commented on his mental health and he never had any additional mental health assessment.
91. Research has shown that being held in segregation can have a negative impact on a prisoner's mental health. In some cases, this can lead to hallucinations or paranoia. Although he was not on the caseload of the prison's mental health in-reach team, the man had a history of depression and had been prescribed antidepressant medication for several years. In 2011, a doctor had increased his antidepressant dose to counter the effects of paranoia. Prison Service Order (PSO) 1700 requires that prisoners segregated under Prison Rule 45 for more than 30 days should be "subject to care plans that detail how their mental well being is to be supported". We were concerned that there was no structured plan to help combat the effects of longer-term segregation on the man. It is not usually envisaged that prisoners will be serving long consecutive punishments of cellular confinement, but we consider that there should be care plans for any prisoner segregated for this length of time. We make the following recommendation:

The Governor should ensure that prisoners held in the segregation unit have as full a regime as possible, that active efforts are made to reintegrate prisoners held in the segregation unit to standard prison accommodation and that there are effective care plans to help prevent deterioration in mental health for those who stay segregated for more than 30 days.

Management of the segregation unit

92. PSO 1700 sets out mandatory requirements and guidance to ensure the security and safety of those living and working in segregation units. It requires each prison to develop its own segregation policy to reflect its own needs as part of its local safer custody strategy. Elmley does not have its own policy.
93. Several members of segregation unit staff told us that the unit is often understaffed as officers from the unit are required to cover shortages elsewhere in the prison. We were told that this often happened at weekends, sometimes for the whole weekend, and sometimes during the week too. On the afternoon of 2 December 2014, there were two officers rather than the expected three officers and a supervising officer who did not normally work in the unit.
94. Segregation unit staff told us that this impacted on the operation of the unit. Prisoners sometimes were not able to get the showers, exercise or phone calls they had requested. Officers said they found it difficult to complete the hourly observations required for prisoners segregated under Prison Rule 55 and, worryingly, they sometimes struggled to complete ACCT observations. An officer did not check the man at any time after 2.00pm on the day of his death. He said that this was because he was the only landing officer and did not have time to do them. Other officers, who were not on duty in the segregation unit that day, told the investigator that lack of staff often meant that they could not get prisoners out of their cells or complete required checks.
95. PSO 1700 requires each prisoner to have a designated or personal officer, who is required to engage in purposeful dialogue and record this in the prisoner's history sheet, with at least three quality entries required each day. The PSO also requires that, where possible, the segregation unit officer engages in dialogue when completing hourly observations of prisoners serving punishments of cellular confinement. Prisoners in the segregation unit at Elmley do not have personal officers and we have not seen any evidence that the requirements to have conversations with prisoners were carried out consistently during the man's time in the unit. There is no record that any member of segregation unit staff had a meaningful conversation with him on the day of his death. The duty manager is required to visit every day and speak to each prisoner in the unit, but he did not speak to the man during his visit that day and he did not read the observation book.
96. Segregation units hold some of the most vulnerable prisoners and failure to provide the required regime and monitoring designed to safeguard such prisoners will increase their risks. The lack of staff engagement and monitoring the man received in the last days of his life, a time when he should have been identified as vulnerable, is a particular concern. We make the following recommendation:

The Governor should develop a local segregation policy in line with PSO 1700 to help safeguard segregated prisoners. In particular, the segregation unit should have sufficient staff at all times to provide an adequate regime and ensure that prisoners are monitored as required. Each prisoner should have a designated officer responsible for their welfare and duty managers should speak to each segregated prisoner every day and satisfy themselves of their wellbeing.

Medication

97. Toxicology tests identified that there was a potentially fatal amount of tramadol in the man's blood and an elevated level of sertraline. He had been prescribed both medications for several years. We spoke to the toxicologist, who confirmed that these levels could not have come from prescription use. It is therefore probable that the man took an overdose of these medications shortly before his death.
98. Prison staff assess prisoners to determine whether it is safe for them to keep medication in their cells, taking into account the risk of the prisoner not taking the medication, over-medicating or passing on medication to other prisoners. A prison nurse assessed the man as suitable to keep his medication in possession when he arrived at Elmley in April 2013. We are satisfied this was an appropriate assessment at the time. However, the risk assessment was not reviewed as it should have been when an ACCT was opened, albeit briefly, on 27 November. As the ACCT was closed at the first review the next day, it is unlikely that any further risk assessment would have concluded that it was not safe for him to continue to manage his own medication, which he seems to have done without a problem for some years.
99. The man was issued and collected a week's supply of sertraline at a time, which he kept in his cell in the segregation unit. He last collected sertraline on 25 November. Tramadol is a controlled drug, which prisoners are not allowed to keep in their possession and he was required to take and swallow the tablets in front of a prison nurse each day. However, some prisoners hide or regurgitate tablets during this process.
100. We do not know how the man obtained enough tramadol and sertraline to take the amounts identified by the toxicology tests. The most likely explanation is that he did not swallow the tramadol when it was issued and hoarded this and his sertraline in his cell to use later. This would suggest that he had planned to overdose. The clinical reviewer considered that the man's apparent paranoia in the last week of his life might partly have been caused by him stopping taking sertraline. Prison officers do not routinely search cells in the segregation unit and they received no intelligence that would have led them to carry out a targeted search of the man's cell. We make the following recommendation:

The Head of Healthcare should ensure that nurses safely issue medication in the segregation unit and that a prisoner's in-possession risk assessment is reviewed whenever ACCT procedures are begun.

Emergency response

101. PSI 03/2013 *Medical Emergency Response Codes*, issued in February 2013, sets out the actions staff should take in a medical emergency. It contains mandatory instructions for governors to have a protocol to provide guidance on efficiently communicating the nature of a medical emergency, ensuring staff take the relevant equipment to the incident and that there are no delays in calling an ambulance. It stipulates that when an emergency medical code is used, an ambulance must be called immediately. It should not be a requirement for a member of the healthcare team or a manager to attend the scene before an ambulance is called.
102. Elmley uses the emergency codes 'blue' and 'red' to meet the requirements of PSI 03/2013. However, at the time of the man's death, local practice was that a separate request in addition to the emergency code was required before the communications room would call an ambulance, and this was usually expected to be made by a prison nurse. A nurse had to ask for an ambulance when she arrived at the cell. We have made several recommendations to Elmley about this issue in the past. Since this man's death, in response to our earlier recommendations, Elmley has introduced new protocols that are now fully in line with national requirements. We therefore make no further recommendation.

Family liaison

103. Prison Rule 22 requires prisons to inform the next of kin immediately if a prisoner dies. PSI 64/2011 gives a mandatory instruction that, wherever possible, this must be done in person by a family liaison officer and another member of staff. The family liaison officer identified two separate next of kin in the man's prison records, his partner and his ex-wife. The family liaison officer and Head of Operations visited them both to inform them of his death.
104. The man's sister was concerned that the prison did not inform her immediately of his death, particularly as she had been in contact with the family liaison officer after the death of the man's other sister. As the man had nominated his partner and ex-wife as his next of kin, we are satisfied that the family liaison officer appropriately broke the news to both of them on the night of his death. He tried to contact the man's sister the next day, which we consider showed a commendably caring approach.

RECOMMENDATIONS

1. The Governor should ensure that prison staff manage prisoners at risk of suicide or self-harm in line with national guidelines, including that:
 - Prisoners assessed as at risk of suicide or self-harm are not held in the segregation unit unless all other options have been considered and excluded and there are fully documented reasons to explain the exceptional circumstances.
 - First case reviews are multidisciplinary and always include a member of healthcare staff;
 - First case reviews are held within 24 hours of the ACCT being opened and on the same day whenever possible;
 - Staff read the ACCT document and familiarise themselves with all relevant issues and known risk factors before holding reviews;
 - ACCT plans are not closed at the first case review unless all issues identified at the assessment interview have been resolved.
2. The Governor and Head of Healthcare should ensure that a mental health assessment is carried out within 24 hours whenever an ACCT is opened for a prisoner in the segregation unit.
3. The Governor should ensure that staff are aware of the potential effects of segregation on a vulnerable person's state of mind and begin ACCT procedures if they observe any changes in a prisoner's behaviour or circumstances, which indicate an increase in the risk of suicide and self-harm.
4. The Governor should ensure that managers imposing punishments at adjudications fully consider the likely impact on the health and welfare of the prisoner and that a segregation health screen is completed for each period of cellular confinement.
5. The Governor should ensure that prisoners held in the segregation unit have as full a regime as possible, that active efforts are made to reintegrate prisoners held in the segregation unit to standard prison accommodation and that there are effective care plans to help prevent deterioration in mental health for those who stay segregated for more than 30 days.
6. The Governor should develop a local segregation policy in line with PSO 1700 to help safeguard segregated prisoners. In particular, the segregation unit should have sufficient staff at all times to provide an adequate regime and ensure that prisoners are monitored as required. Each prisoner should have a designated officer responsible for their welfare and duty managers should speak to each segregated prisoner every day and satisfy themselves of their wellbeing.
7. The Head of Healthcare should ensure that nurses safely issue medication in the segregation unit and that a prisoner's in-possession risk assessment is reviewed whenever ACCT procedures are begun.

Action Plan: [man's name] (Elmley)

Action Plan

No	Recommendation	Accepted/Not Accepted	Response	Target date for completion and function responsible	Progress (to be updated after 6 months)
1	<p>The Governor should ensure that prison staff manage prisoners at risk of suicide or self-harm in line with national guidelines, including that:</p> <ul style="list-style-type: none"> Prisoners assessed as at risk of suicide or self-harm are not held in the segregation unit unless all other options have been considered and excluded and there are fully documented reasons to explain the exceptional circumstances. First case reviews are multidisciplinary and always include a member of healthcare staff; First case reviews are held within 24 hours of the ACCT being opened and on the same day whenever possible; Staff read the ACCT document and familiarise themselves with all relevant issues and known risk factors before holding reviews; 	Accepted	<p>Relevant managers and staff have been reminded that:</p> <p>Prisoners must not be held in segregation without considering and exploring all other options segregation will be a last resort.</p> <p>When a prisoner is held in segregation all stakeholders must be consulted to ensure that the health both physical and mental is taking into consideration to complete a care plan that ensures that a prisoners needs are met.</p> <p>Each prisoner's needs must be communicated to segregation staff and all those that visit prisoners in segregation. If the segregation unit is deemed unsuitable for a prisoner, they will be located in an area where their needs can be met.</p> <p>Staff have been reminded of the relevant requirements of the ACCT process including that the first ACCT case review must be multi-disciplinary and prioritise the needs of the prisoner, and that staff attending ACCT reviews must be familiar with the ACCT contents and not agree to closure of the</p>	Completed Head of Safer Custody	

Action Plan: [man's name] (Elmley)

Action Plan

No	Recommendation	Accepted/Not Accepted	Response	Target date for completion and function responsible	Progress (to be updated after 6 months)
	<ul style="list-style-type: none"> ACCT plans are not closed at the first case review unless all issues identified at the assessment interview have been resolved. 		ACCT until all the identified issues and related CAREMAP actions have been completed.		
2	The Governor and Head of Healthcare should ensure that a mental health assessment is carried out within 24 hours whenever an ACCT is opened for a prisoner in the segregation unit.	Accepted	Relevant managers and staff have been reminded that if a prisoner is on an ACCT document within segregation a referral must be made to the in-reach department with the aim that an assessment subject to healthcare resources being available to complete an assessment within a 24 hour period. If these facilities are not available, the on call doctor and healthcare professionals will be consulted.	Completed Head of Safer Custody	
3	The Governor should ensure that staff are aware of the potential effects of segregation on a vulnerable person's state of mind and begin ACCT procedures if they observe any changes in a prisoner's behaviour or circumstances, which indicate an increase in the risk of suicide and self-harm.	Accepted	Segregation unit staff and all those who visit prisoners in segregation have been reminded that ACCT plans must be opened for all prisoners whose behaviour indicates increased risk of suicide or self-harm, and that all prisoners in segregation must be monitored as per their care plan and any deterioration in well-being acted upon immediately, by alerting healthcare or other relevant staff of any concerns.	Completed Head of Safer Custody	

Action Plan: [man's name] (Elmley)

Action Plan

No	Recommendation	Accepted/Not Accepted	Response	Target date for completion and function responsible	Progress (to be updated after 6 months)
4	The Governor should ensure that managers imposing punishments at adjudications fully consider the likely impact on the health and welfare of the prisoner and that a segregation health screen is completed for each period of cellular confinement.	Accepted	<p>Relevant staff have been reminded of the need to ensure that a segregation health screen is completed in all cases.</p> <p>Adjudicating governors have been reminded, and will continue to be so quarterly as a standing agenda item on the adjudication tariff review meeting that the need to consider the potential impact of a punishment on the health and welfare of the prisoner.</p>	Completed Head of Safer Custody	
5	The Governor should ensure that prisoners held in the segregation unit have as full a regime as possible, that active efforts are made to reintegrate prisoners held in the segregation unit to standard prison accommodation and that there are effective care plans to help prevent deterioration in mental health for those who stay segregated for more than 30 days.	Accepted	Relevant managers and staff have been reminded that every effort must be made to reintegrate prisoners back to a normal regime as soon as possible by devising and acting on effective care plans and ensuring that regular multidisciplinary reviews take place.	Completed Head of Segregation Unit	
6			[removed as repeat of recommendation 4]		

Action Plan: [man's name] (Elmley)

Action Plan

No	Recommendation	Accepted/Not Accepted	Response	Target date for completion and function responsible	Progress (to be updated after 6 months)
7	The Governor should develop a local segregation policy in line with PSO 1700 to help safeguard segregated prisoners. In particular, the segregation unit should have sufficient staff at all times to provide an adequate regime and ensure that prisoners are monitored as required. Each prisoner should have a designated officer responsible for their welfare and duty managers should speak to each segregated prisoner every day and satisfy themselves of their wellbeing.	Accepted	The local segregation policy is in the process of being reviewed, and the revised policy will address each of the points raised within this recommendation.	1 st August 2015. Head of Safer Custody	
8	The Head of Healthcare should ensure that nurses safely issue medication in the segregation unit and that a prisoner's in-possession risk assessment is reviewed whenever ACCT procedures are begun.	Accepted	The Head of Healthcare will ensure that staff are aware of their responsibilities to ensure supervised medication is taken as indicated and measures are taken to ensure compliance from the patient. Prisoners who become subject to ACCT procedures will have the in-possession risk assessment reviewed, and in-possession medication will be dynamically risk assessed as the patient scenario, compliance, wellbeing or presentation determines.	September 2015 Head of Healthcare (IC24)	

Action Plan: [man's name] (Elmley)

Action Plan

No	Recommendation	Accepted/Not Accepted	Response	Target date for completion and function responsible	Progress (to be updated after 6 months)
			A protocol will be developed and published to guide and inform the process and staff notified.		