Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Thomas Oleisky, a prisoner at HMP Wealstun, on 11 September 2022

A report by the Prisons and Probation Ombudsman

Third Floor, 10 South Colonnade
Canary Wharf, London E14 4PU

Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk

T I 020 7633 4100

OUR VISION

To deliver high quality and timely independent investigations and work closely with partners to achieve tangible benefits for the safety and confidence of those in custody and under community supervision.

WHAT WE DO

WHAT WE VALUE

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

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

Mr Thomas Oleisky died on 11 September 2022, four days after he was found with a shoelace tied around his neck in his cell at HMP Wealstun. He was 32 years old. I offer my condolences to Mr Oleisky's family and friends.

Staff started suicide and self-harm prevention procedures (known as ACCT) for Mr Oleisky on 5 September 2022, after he harmed himself. He told staff he was at risk from other prisoners on B Wing as he owed them money for hooch (illegally brewed alcohol). He was moved to the segregation unit at his request.

Two days later, when Mr Oleisky could not cope on the segregation unit, staff moved him back to B Wing because there was nowhere else to move him. That afternoon, a family member contacted the prison to say that Mr Oleisky had called his father to say goodbye as he was going to end his life. Staff found him with a dressing gown cord around his neck, but he was unharmed. He then made a cut to his wrist. Staff moved him to G Wing and increased checks to four an hour. Around an hour later, an officer found Mr Oleisky unresponsive with a shoelace tied around his neck and attached to the window. He was taken to hospital but never regained consciousness and died four days later.

I am concerned about the decision to move Mr Oleisky back to B Wing, the location that had triggered his initial act of self-harm. The decision appeared to have been taken unilaterally by a prison manager. I consider that there should have been a multidisciplinary discussion about the best location for Mr Oleisky.

While staff considered placing Mr Oleisky on constant supervision on 7 September, I am satisfied that the decision to increase observations to four an hour was reasonable in the circumstances.

The investigation found that while staff held multidisciplinary ACCT reviews and set appropriate care plan actions, the care plan was not completed correctly which potentially led to confusion about whether actions had been completed or were still outstanding.

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

Susannah Eagle
Deputy Prisons and Probation Ombudsman **March 2024**

Contents

Summary 1

The Investigation Process.....4

Background Information.....5

Key Events.....7

Findings 13

Summary

Events

1. On 23 June 2022, Mr Thomas Oleisky was sentenced to 27 months in prison for controlling and coercive behaviour and sent to HMP Doncaster. It was his first time in prison. On 12 July, he was moved to HMP Wealstun.

2. On 2 September, staff found hooch (illegally brewed alcohol) in Mr Oleisky's cell and saw that he was under the influence of alcohol. They confiscated the hooch. On 4 September, Mr Oleisky barricaded himself in his cell and told staff that he was in debt to other prisoners due to the hooch. Staff began violence reduction procedures to support him.

3. On 5 September, Mr Oleisky told staff that he had swallowed some paracetamol because he was at risk from other prisoners. When an officer left to get help, Mr Oleisky cut his arm. Staff moved Mr Oleisky to the segregation unit at his request. Staff also started suicide and self-harm monitoring (known as ACCT). Mr Oleisky told staff that he was scared that he would be assaulted by other prisoners on B Wing and had self-harmed to get off the wing. When Mr Oleisky arrived at the segregation unit, staff checked him five times an hour but at the first case review, the frequency of checks was reduced to one an hour.

4. Staff planned to keep Mr Oleisky in the segregation unit for 72 hours and then move him to a different wing. However, Mr Oleisky became paranoid that prisoners from B Wing were in the segregation unit and on 7 September, he said he could not cope with another night on the unit (there was a prisoner there who was very noisy and on a dirty protest). The only cell available to move Mr Oleisky to, was his old cell on B Wing. Mr Oleisky said he would rather go there for one night than stay on the segregation unit, so staff moved him back to B Wing.

5. At around 1.00pm, Mr Oleisky's grandfather telephoned the prison to say that Mr Oleisky had called his father to say goodbye as he was going to end his life. Staff went to Mr Oleisky's cell and found that he had tied his dressing gown cord round his neck. He was unharmed. He then cut his wrist. Healthcare staff dressed and then stitched his wound.

6. Staff held an urgent ACCT case review and considered placing Mr Oleisky under constant supervision, but Mr Oleisky said he did not want this. Instead, they increased staff checks to four an hour. At around 3.40pm, staff moved Mr Oleisky to G Wing.

7. During an ACCT check at 4.35pm, an officer found Mr Oleisky unresponsive with a shoelace tied round his neck, which he had also tied to the window. The officer went into the cell, cut the ligature and then called a medical emergency code. Mr Oleisky was taken to hospital but never regained consciousness and died there on 11 September.

Findings

8. While staff held multidisciplinary ACCT case reviews and set appropriate care plan actions, the care plan was not completed correctly which meant it was unclear whether actions had been completed or were still outstanding. Also, some staff were unaware that they had been allocated care plan actions.

9. We consider that the decision to reduce observations from five an hour to one an hour, very soon after Mr Oleisky arrived in the segregation unit, was premature. Also, consideration should have been given to increasing observations the next day when Mr Oleisky's behaviour deteriorated, and he appeared paranoid that prisoners from B Wing were in the segregation unit. We are satisfied that the decision on 7 September not to place Mr Oleisky under constant supervision but on four checks an hour instead was reasonable in the circumstances.

10. We are concerned that a prison manager in the segregation unit appeared to make a unilateral decision to move Mr Oleisky back to B Wing, a location which had triggered his initial act of self-harm. We consider that there should have been a multidisciplinary discussion about the best location for Mr Oleisky.

11. We are concerned that the officer who found Mr Oleisky with the shoelace around his neck on 7 September did not call an emergency code immediately. We accept that this was a short delay but nevertheless, the code should have been called first, before going into the cell and cutting the ligature.

12. The clinical reviewer found that Wealstun provided reasonable care to Mr Oleisky for his substance misuse and mental health issues although she identified issues with record keeping and information sharing.

Recommendations

- The Governor should ensure that staff manage prisoners at risk of suicide and self-harm in line with policy guidance, in particular that they:
    - fill out the ACCT care plan correctly so that it shows the date by which the care plan action is due and when it has been completed;
    - ensure that staff who have been allocated ACCT care plan actions are aware; and
    - set the appropriate level of observations in line with the prisoner's risk.
- The Governor should ensure that where a prisoner on ACCT is moved from segregation and there is a concern regarding a potential risk created by a return to normal location, then wider consultation should be sought prior to the move taking place and an ACCT review arranged as soon as possible.
- The Governor should ensure that staff are aware of their responsibilities during medical emergencies and that staff who discover the emergency should call the appropriate medical emergency code immediately.

- The Head of Healthcare should ensure healthcare staff keep accurate and timely records of significant contacts.
- The Head of Healthcare should ensure that significant information is shared promptly between healthcare services and where appropriate with wider prison staff.

The Investigation Process

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

14. The investigator received copies of relevant extracts from Mr Oleisky's prison and medical records.

15. The investigator interviewed 16 members of staff during November and December 2022.

16. NHS England commissioned an independent clinical reviewer to review Mr Oleisky's clinical care at the prison. She jointly conducted interviews with the investigator.

17. We informed HM Coroner for West Yorkshire of the investigation. We have sent the Coroner a copy of this report.

18. The Ombudsman's family liaison officer contacted Mr Oleisky's family to explain the investigation and to ask if they had any matters they wanted us to consider. They asked how Mr Oleisky's risk was assessed and what measures were put in place to try to keep him safe, which we have addressed in this report. They also raised several issues that were outside the remit of our investigation, which we have addressed in separate correspondence.

19. Mr Oleisky's family received a copy of the initial report. They did not provide any further comments or information which impacted on the report's findings.

20. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS pointed out some factual inaccuracies and requested a recommendation be re-worded. This report has been amended.

Background Information

HMP Wealstun

21. HMP Wealstun is a category C prison near Wetherby, West Yorkshire, which holds more than 800 men. There are ten residential units and a segregation unit. Practice Plus Group provides health care services.

HM Inspectorate of Prisons

22. The most recent inspection of HMP Wealstun was in October 2022. Inspectors reported that the prison had reasonably good outcomes on all the healthy prison tests apart from purposeful activity which was not sufficiently good. These results indicated an overall improvement in the prison since the last inspection in 2019.

23. HMIP's priority concerns included the high levels of self-harm and lack of any strategy to combat the problems. Although the prison had a safer custody hotline, for families and friends concerned about a prisoner's wellbeing, calls made out of hours were unanswered and there was no voicemail facility.

24. Inspectors' overall impressions of health care was of professional, resilient staff delivering essential services. However, they considered staffing to be extremely constrained, with the small primary care and pharmacy teams carrying several vacancies, which resulted in regular agency staff use.

Independent Monitoring Board

25. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report, for the year to 31 May 2022, the IMB reported that their main concerns included the lack of time prisoners spent out of cells and staffing shortages. They considered ACCTs to be well managed but that the new ACCT process, introduced in 2021, seemed complicated and took a while to bed in. The segregation unit was reasonably well maintained and, on the whole, relationships between staff and prisoners on the unit appeared to be good.

Previous deaths at HMP Wealstun

26. Mr Oleisky was the second prisoner to die at HMP Wealstun since September 2020. There are no similarities between the findings in our previous investigation and those following our investigation into Mr Oleisky's death.

Assessment, Care in Custody and Teamwork

27. ACCT is the Prison Service care-planning system used to support prisoners at risk of suicide or self-harm. The purpose of ACCT is to try to determine the level of risk, how to reduce the risk and how best to monitor and supervise the prisoner. After an initial assessment of the prisoner's main concerns, levels of supervision and interactions are set according to the perceived risk of harm. Checks should be

carried out at irregular intervals to prevent the prisoner anticipating when they will occur. Regular multidisciplinary review meetings involving the prisoner should be held.

28. As part of the process, a care plan (a plan of care, support and intervention) is put in place. The ACCT plan should not be closed until all the actions of the care plan have been completed. All decisions made as part of the ACCT process and any relevant observations about the prisoner should be written in the ACCT booklet, which accompanies the prisoner as they move around the prison. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011, Management of prisons at risk of harm to self, to others and from others (Safer Custody).

Segregation Unit

29. Segregation units (sometimes called Care and Separation 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 must be satisfied that the prisoner is fit for segregation after an assessment by a member of healthcare staff.

30. 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 wellbeing of the prisoners and whether there are any apparent clinical reasons to advise against continuing segregation.

Key Events

31. On 23 June 2022, Mr Thomas Oleisky was sentenced to 27 months in prison for controlling and coercive behaviour and sent to HMP Doncaster. It was his first time in prison.

32. Mr Oleisky had a history of alcohol and drug misuse. When he arrived at Doncaster, staff identified that he had alcohol withdrawal symptoms. He was prescribed appropriate medication and monitored. He was also prescribed pain relief for back pain following a fall a few weeks before. He told staff that he was prescribed mirtazapine (an antidepressant) in the community. However, this was not prescribed at Doncaster because of potential interactions with his pain medication (both medications suppress breathing).

33. On 5 and 6 July, Mr Oleisky was assaulted by other prisoners and was taken to hospital on both occasions. He told staff that he had been seeing a woman who was connected to a gang which may have been the cause of the assaults.

HMP Wealstun

34. On 12 July, Mr Oleisky was moved to HMP Wealstun. A nurse booked a GP appointment to review his back pain medication and he was prescribed co-codamol in the meantime.

35. On 26 July, a prison GP prescribed dihydrocodeine in place of the co-codamol. He prescribed duloxetine (for low mood and pain) and a five-day course of promethazine (to treat anxiety and sleep issues).

36. On 27 July, following a self-referral by Mr Oleisky, a Drug and Alcohol Rehabilitation Service (DARS) worker recorded that she had seen Mr Oleisky (although she told us she probably saw him the day before). She spoke to him about ‘hooch’ (illicitly brewed alcohol) as she was aware it was in the prison. Mr Oleisky agreed to attend Alcoholics Anonymous (AA) for peer support and she added him to the waiting list. Mr Oleisky told her he had dyslexia and she assisted him with a workbook.

37. On 4 August, a mental health nurse saw Mr Oleisky following his self-referral on 27 July. He said he was having negative thoughts and was struggling to sleep at night. He wanted to go back on mirtazapine, and she told him to discuss it with a GP (he did not put in an application to see a GP). She suggested he do some ‘anxiety work’ and use distraction material. She added Mr Oleisky to her caseload. (This would normally mean reviewing the prisoner every fortnight, but the mental health team was short staffed at the time.)

38. On 12 August, Mr Oleisky attended AA and engaged well, according to his new DARS worker.

39. On 23 August, the DARS worker saw Mr Oleisky on the wing and introduced herself officially as his DARS worker. They worked through an alcohol in-cell pack. He agreed to keep an urge and trigger diary. He implied he was using substances and she gave him advice about substance misuse.

40. On 2 September, staff found hooch in Mr Oleisky's cell and found that he was under the influence of alcohol. A nurse saw Mr Oleisky, but no one informed the DARS team. Staff downgraded him to the basic level of the Incentives and Earned Privileges (IEP) scheme and put him on a disciplinary charge.

41. On 3 September, Mr Oleisky told a Supervising Officer (SO) that he felt low. He had self-referred to the mental health team and to DARS but felt at a loss. She contacted a nurse in the mental health team, who said he would see Mr Oleisky the next day.

42. On 4 September, Mr Oleisky barricaded himself in his cell. He said he was in debt over the hooch and wanted to move wings. The SO noted he seemed very unwell and submitted a Challenge Support Intervention Plan (CSIP) referral. (A CSIP is used to manage prisoners who pose a risk of violent behaviour with the aim of encouraging more positive behaviour. It can also be used to support victims of violence.)

43. The nurse visited Mr Oleisky in his cell for a welfare check, but Mr Oleisky declined to engage.

5 September: ACCT opened and move to segregation unit

44. On 5 September, the Head of Residence carried out Mr Oleisky's adjudication following the hooch find. She suspended the punishment because Mr Oleisky showed remorse and his behaviour had been out of character.

45. Later that morning, Mr Oleisky told an officer that people were trying to get him, and he had swallowed paracetamol. He was very agitated and, when the officer went to get help, Mr Oleisky cut himself. Staff restrained him for his own safety, and then at around 11.30am, moved Mr Oleiskey to the segregation unit at his request.

46. A nurse carried out the segregation health screen (which assesses whether there are any health reasons why the prisoner should not be segregated) and recorded no concerns. A different nurse recorded that healthcare staff should check Mr Oleisky once an hour.

47. An officer started suicide and self-harm monitoring (known as ACCT). The Head of Residence completed the Immediate Action Plan and set observations at five an hour (the standard frequency for prisoners entering the segregation unit on an ACCT until their first case review.) Staff gave Mr Oleisky an in-cell phone and reminded him about Listeners (prisoners trained by the Samaritans).

48. A member of the safer custody team carried out the assessment interview. Mr Oleisky said he was frustrated and annoyed with his circumstances, felt overwhelmed and needed some quiet time. He said that he struggled with obsessive compulsive disorder, dyslexia and dyspraxia, was being assessed in the community for autism and needed to be on a quieter unit. She noted that she would speak to the mental health team and GP and consider relocation to another wing.

49. The same day, the Head of Residence held the first case review. A mental health nurse attended. The member of the safer custody team and a Custodial Manager

(CM) (who was managing the CSIP) did not attend but spoke to the Head of Residence ahead of the meeting to give their thoughts.

50. Mr Oleisky said he was relieved to be off B Wing as this had triggered his self-harm. He said he had never considered harming himself before but was so scared of being assaulted on B Wing that he thought it was his only choice. He said that he had been holding the hooch for other prisoners and was now at risk from them because he had drunk it and then been caught with it. He said that he had drunk the hooch because he had looked at a photo of his children, which made him sad as he was estranged from them. He thought the segregation unit would give him the opportunity to sleep and refresh but he knew it was a short-term solution and he would be expected to leave.

51. The review team reduced observations to one an hour. They concluded that it was not currently necessary to remove any items, including razors, from him. The Head of Residence noted that Mr Oleisky would remain in the segregation unit for 72 hours, to enable him to sleep and engage with support services. She created a care plan which included that the CSIP was in place, and for the mental health team to work alongside DARS and Mr Oleisky to maintain contact with his family.

52. A CM created plans to support Mr Oleisky through the CSIP process and emailed details of the named perpetrators on B Wing to security. She was due to review the CSIP plan on 8 September, once Mr Oleisky had moved to a new location (probably F Wing).

6 September

53. On 6 September, a CM carried out a wellbeing check in the segregation unit. She noted that Mr Oleisky's behaviour was erratic, agitated and anxious. He thought there were prisoners near him from B Wing and described someone who was not there who he said had been outside his cell and had keys. She assured Mr Oleisky this was not the case. She called a mental health nurse and asked her to check on Mr Oleisky.

54. The nurse went to see Mr Oleisky. He was concerned about who was in the cell next to him and seemed paranoid. She did not document the incident on Mr Oleisky's medical record but told the clinical reviewer she had asked another nurse to check Mr Oleisky's observations.

55. Later that day, the Head of Residence held the second case review. A nurse and a SO attended. The Head noted that Mr Oleisky said he felt safe in the segregation unit but had not managed to get the sleep he expected due to the environment and him worrying. He was vague about his worries but asked if he was returning to a standard wing that day. She thought this might be one of the things worrying him.

56. The Head of Residence noted that Mr Oleisky continued to say he had no thoughts of self-harm but said he could not guarantee he would not do so again. She maintained observations at one an hour.

57. A nurse saw Mr Oleisky that day. He was agitated and said his heart was pounding. She booked him a blood pressure appointment and planned to recheck in the

afternoon. She tried to see him later, but he was very hostile so could not be unlocked. He told her he felt physically better.

58. That night, Mr Oleisky behaved strangely and claimed he was talking to someone called 'Ratio'.

7 September

59. On the morning of 7 September, a prison manager held Mr Oleisky's adjudication hearing (for not following a lawful order prior to being taken to the segregation unit). Mr Oleisky admitted the charge and the manager suspended the punishment.

60. Later that morning, an officer noted in the ACCT observations log that Mr Oleisky had to be helped to his feet in the exercise yard after feeling unwell and had been checked by a nurse.

61. Mr Oleisky was upset and tearful and told a SO repeatedly that he could not stay in the segregation unit. He said he could not spend another night there and that he was not coping. (There was a prisoner on the unit who was making a lot of noise and on a dirty protest.)

62. The SO told the manager of the segregation unit that Mr Oleisky said he was struggling to cope.

63. The manager found out that the cell on F Wing was not going to be ready until the next day and that the only available cell was Mr Oleisky's old cell on B Wing. The SO told Mr Oleisky, who said that he would rather go back to B Wing temporarily than stay in the segregation unit.

64. Later that day, a CM came down to the segregation unit and someone told her that Mr Oleisky was being moved back to B Wing. She told the manager of the segregation unit that she did not think he should be moved, particularly to B Wing, as he would self-harm there. She said that the plan was to hold him in the segregation unit for 72 hours (until 8 September) before considering F Wing as a new location.

65. The manager of the segregation unit told her that Mr Oleisky had said he would prefer to go to B Wing than stay in the segregation unit for another night. He was moved to B Wing at around 12.10pm. The plan was for him to spend one night there before being moved to F Wing.

Move back to B Wing

66. That afternoon, at approximately 1.00pm, Mr Oleisky's grandfather called the prison and told them that Mr Oleisky had contacted his father to say goodbye because he was going to end his life. A member of the safer custody team alerted staff on B Wing, who found Mr Oleisky with his dressing gown cord tied around his neck. Staff called a code blue (a medical emergency code used when a prisoner is unconscious or having breathing difficulties) and a nurse attended. Mr Oleisky was unharmed.

67. After the incident, an officer spoke to Mr Oleisky and encouraged him to tell his family he was okay. She left the cell to give him some privacy, but he then cut his wrist with a razor (she saw him do this through the observation panel). She called a code red (a medical emergency code used for severe loss of blood) and the nurse attended again. She dressed the wound but assessed that it needed stitches.

68. A SO held an ACCT case review which a nurse, a CM, the member from the safer custody team and a manager attended. Mr Oleisky said he had not been sleeping and did not know what was real anymore. He said he had told staff that he had wanted to be moved back to B Wing so that he could hang himself.

69. The review panel considered whether to place Mr Oleisky under constant supervision, but Mr Oleisky said he did not want this, and, over the course of the review, his presentation became much calmer. Staff increased observations to four an hour with staff expected to have three meaningful conversations with him a day. Staff also decided Mr Oleisky should be moved to a cell on G Wing overnight before moving to F Wing the next day. Staff decided that Mr Oleisky should have supervised shaves but did not consider that any other measures, such as removal of other items he could use to self-harm, were necessary. They considered that his presentation had improved and there were enough other measures in place to keep him safe.

70. A CM took Mr Oleisky to the healthcare unit to have his wound stitched. On the way, he asked her if she could hear prisoners threatening him. She did not hear anyone threaten him and tried to offer reassurance, but he said it felt very real. They discussed his location, and he expressed an interest on the Residential Support Unit on A Wing. She said staff would need to assess him.

71. After a nurse had stitched Mr Oleisky's wounds, the CM took him to G Wing.

G Wing

72. At 3.40pm, the CM handed Mr Oleisky to an officer on G Wing. Mr Oleisky asked to be locked in his cell because he did not like the noise on the wing and the officer agreed. Staff checked on him at 3.45pm and there were no issues.

73. Around 20 minutes later, the officer took Mr Oleisky his bedding pack and had another conversation with him. He asked if staff could bring him his meals as he did not like the noise levels on the landings and got nervous around other people. She agreed and he thanked her for everything she had done for him so far. She had no concerns about his presentation.

74. At 4.10pm, an officer carried out a check and saw Mr Oleisky sitting on his bed looking out of the window. At 4.25pm, the officer checked him again. Mr Oleisky was slumped by the window in an odd position and the officer went into the cell. Mr Oleisky had tied a shoelace around his neck and attached it to the window.

75. The officer cut the shoelace with his anti-ligature knife. He radioed a code blue at 4.26pm but was on the wrong channel so had to call it again. Staff in the control room logged that they called the ambulance service at 4.27pm. The officer could not find a pulse on Mr Oleisky's wrist or neck so started chest compressions. Two CMs took over when they arrived. Another member of staff brought a defibrillator.

76. A nurse arrived at Mr Oleisky's cell around six minutes after the officer called the code blue. She assisted with resuscitation attempts by inserting an airway provided by her colleague.

77. Paramedics arrived at the prison at 4.47pm and took over Mr Oleisky's care. At 5.26pm, they left to take him to hospital.

78. Mr Oleisky did not regain consciousness and died in hospital at 12.30pm on 11 September.

Contact with Mr Oleisky's family

79. On 7 September, the prison appointed a family liaison officer, and he telephoned Mr Oleisky's partner to tell her he was in hospital. He stayed in contact with the family to offer support and advice. In line with national policy, the prison made a financial contribution to Mr Oleisky's funeral.

Support for prisoners and staff

80. After Mr Oleisky's death, a prison manager debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support. Welfare checks were offered to relevant staff on 11 September and further debriefs were held for staff who were on leave.

81. The prison posted notices informing other prisoners of Mr Oleisky's death and offering support. Staff reviewed all prisoners assessed as being at risk of suicide or self-harm in case they had been adversely affected by Mr Oleisky's death.

Post-mortem report

82. The Coroner has provided the post-mortem report which concludes that Mr Oleisky died from 1a) hypoxic brain injury 1b) cardiac arrest and 1c) hanging. Toxicology tests were not carried out.

Findings

Management of Mr Oleisky's risk of suicide and self-harm

83. Prison Service Instruction (PSI) 64/2011, *Management of prisoners at risk of harm to self, to others and from others (Safer Custody)*, sets out the procedures (known as ACCT) that should be followed when a prisoner is identified as being at risk of suicide and self-harm.

84. Staff started ACCT procedures on 5 September after Mr Oleisky cut himself. They were still in place when he died.

85. We are content that staff opened the ACCT appropriately, that there were multidisciplinary case reviews and that staff identified appropriate care plan actions.

86. However, we found that the care plan had been completed incorrectly which meant that it was unclear whether actions had been carried out or were still outstanding. Dates had been entered in sections where the status of the action (required or completed) should have been recorded so it was unclear whether that was the date an action was required, or the date completed. It is possible that anyone looking at the care plan would have assumed the latter. We also note that a CM was unaware that she had been allocated some actions. Clearly, it is very important that anyone responsible for carrying out an ACCT care plan action is aware of what is required and by when.

87. Staff set ACCT observations at five an hour when Mr Oleisky first arrived in the segregation unit, which is the standard frequency of observations when a prisoner is segregated, and an ACCT is opened. At the first case review later that day, staff reduced observations to one an hour. We consider that observations were reduced too quickly. Mr Oleisky had been in the segregation unit for only three hours at this point. The Head of Residence told us that she was satisfied that Mr Oleisky's risk had reduced significantly following his move away from B Wing and to the segregation unit, which had more staff available to keep him safe. However, Mr Oleisky told staff at the first case review that he could offer no assurance that he would not self-harm again. Given this, and Mr Oleisky's very recent arrival in the segregation unit, an environment that can be difficult for prisoners to cope with, we consider that the reduction of observations to one an hour was premature.

88. At the second case review the next day, on 6 September, the review panel maintained observations at one an hour. We note that staff were concerned about Mr Oleisky's erratic behaviour earlier that day and that he appeared to be paranoid that prisoners from B Wing were in the segregation unit and near to his cell. At the case review, he said he had not slept much as he was worried. Again, he said he could not guarantee that he would not self-harm. While we accept that Mr Oleisky had not self-harmed between the first and second case reviews, there were concerns about increased paranoia and his general behaviour. We consider that observations were set too low in the circumstances.

89. On 7 September, after his move back to B Wing, Mr Oleisky was found with a dressing gown cord tied around his neck. The prison had been alerted that Mr Oleisky had called his father to say goodbye as he intended to end his life. At the

subsequent case review, the panel considered whether to place Mr Oleisky on constant supervision. However, Mr Oleisky did not want this and instead, staff set observations at four an hour. We consider this was reasonable in the circumstances. Constant supervision can be oppressive for the prisoner and should be used sparingly. Staff considered that the highest level of observations (four an hour) was preferable, and we consider that this was a reasonable decision.

90. We note that staff did not remove any items, such as shoelaces or clothing, from Mr Oleisky after he tied the dressing gown cord around his neck when he returned to B Wing. It is a difficult judgement call as it can be distressing to prisoners to have personal items removed and it should be reserved for prisoners at very high risk. Staff told us that Mr Oleisky's mood calmed significantly during the final case review and apart from withholding razors, they did not consider that removal of any other items was necessary given the frequency of observations in place and the move to G Wing. We consider this was reasonable in the circumstances.

91. We recommend:

The Governor should ensure that staff manage prisoners at risk of suicide and self-harm in line with policy guidance, in particular that they:

- **fill out the ACCT care plan correctly so that it shows the date by which the care plan action is due and when it has been completed;**
- **ensure that staff who have been allocated ACCT care plan actions are aware; and**
- **set the appropriate level of observations in line with the prisoner's risk.**

Location

92. Mr Oleisky first self-harmed on 5 September and said he did this because he was scared of being assaulted on B Wing and needed to get off the wing. It is generally not advisable to hold people under ACCT supervision in the segregation unit because it is a more stressful environment and offers less staff support. Mr Oleisky asked to move to the segregation unit because he was fearful of reprisals on B Wing. A nurse carried out the segregation health screen and the Head of Residence completed the defensible decision log to support the decision to hold Mr Oleisky in the segregation unit. We are satisfied that it was reasonable to conclude Mr Oleisky could be safely located in the segregation unit.

93. On 7 September, he was moved back to B Wing after he said he could not cope on the segregation unit. Very soon after, he tied a dressing gown cord around his neck and then cut himself. He was then moved to G Wing, where he tied a shoelace around his neck, which resulted in his death.

94. We accept that prison staff were in a difficult position with regard to where to place Mr Oleisky. On 7 September, he told them that he could not cope on the segregation unit, and he was tearful and upset. We consider that it was appropriate to consider moving him from the segregation unit. According to the manager of the segregation unit, the only option available was Mr Oleisky's original cell on B Wing and Mr Oleisky said he would rather move there than stay on the segregation unit.

A CM said she was strongly opposed to a move back to B Wing, given that this location was the original trigger for his self-harm.

95. We are concerned that the manager of the segregation unit appeared to take a unilateral decision to move Mr Oleisky to B Wing. We consider that there should have been a multidisciplinary discussion to decide on the best location for Mr Oleisky. While this may have taken longer, it is likely to have resulted in a more informed decision and staff could have placed Mr Oleisky on a higher level of observations to keep him safe in the meantime. Given the background, we consider that the move to B Wing was inappropriate, and alternatives should have been considered.

96. It is also the case that Mr Oleisky later told staff he had contrived to get back to B Wing so that he could self-harm again (possibly because he would have access to more things and the staffing ratios are lower).

97. We recommend:

The Governor should ensure that where a prison on ACCT is moved from segregation and there is a concern regarding potential risk created by a return to normal location, then wider consultation should be sought prior to the move taking place and an ACCT review arranged as soon as possible.

Delay in calling medical emergency code

98. PSI 03/2013, Medical Emergency Response Codes, requires all prisons to have a medical emergency response code protocol in place, the purpose of which is to ensure a timely, appropriate and effective response to medical emergencies. When a medical emergency is discovered, staff should call the appropriate medical emergency code straightaway so that relevant staff, including healthcare staff, are alerted, the correct equipment is brought, and an ambulance is called immediately.

99. There was a delay in calling the medical emergency code when staff discovered Mr Oleisky unresponsive. The officer entered the cell and cut Mr Oleisky's ligature before calling the code. While we understand that the officer focused on removing the ligature and there was only a short delay in calling the code, it should nevertheless have been done straightaway. We make the following recommendation:

The Governor should ensure that staff are aware of their responsibilities during medical emergencies and that staff who discover the emergency should call the appropriate medical emergency code immediately.

Clinical care

100. The clinical reviewer found that the physical and mental health care Mr Oleisky received was of a reasonable standard overall, and with the exception of some instances of poor information sharing and record keeping, was equivalent to that he could have expected to receive in the community.

101. The clinical reviewer noted that a nurse did not share information about the hooch incident on 2 September with the DARS team.

102. On 6 September, two nurses both saw Mr Oleisky at different times. His behaviour was unusual, and the clinical reviewer considered that the reasons for it, in particular the potential for it to be due to intense fear or his reaction to hooch, could have been explored further and passed on to other staff. We make the following recommendations:

The Head of Healthcare should ensure healthcare staff keep accurate and timely records of significant contacts.

The Head of Healthcare should ensure that significant information is shared promptly between healthcare services and where appropriate with wider prison staff.

Inquest

103. The inquest, held on 20 March 2025, reached the following narrative conclusion:

"Tom deliberately did the act that ended his own life but his probable intent cannot be ascertained. The causative issue was the decision at the ACCT Review on the 7th September 2022 not to remove items which could be used as a ligature."

Prisons & Probation Ombudsman
Independent Investigations

Third Floor, 10 South Colonnade
Canary Wharf, London E14 4PU

Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk

T I 020 7633 4100