

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

**Independent investigation into the  
death of Mr Joseph Davies,  
a prisoner at HMP Northumberland,  
on 12 February 2023**

**A report by the Prisons and Probation Ombudsman**

## 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



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

If my office is to best assist His Majesty's Prison and Probation Service (HMPPS) in ensuring the standard of care received by those within service remit is appropriate, our recommendations should be focused, evidenced and viable. This is especially the case if there is evidence of systemic failure.

Mr Joseph Davies died of mixed drug toxicity after taking an overdose of his prescribed medication on 12 February 2023 at HMP Northumberland. He was 27 years old. I offer my condolences to Mr Davies' family and friends.

The clinical reviewer found that the clinical care provided to Mr Davies at Northumberland was of a high standard and at least equivalent to that which he could have expected to receive in the community. However, the risk assessment which allowed Mr Davies to keep his prescribed medication did not follow procedure and important risk information was not considered.

We found that the non-clinical care provided to Mr Davies was of a good standard overall. Mr Davies' risks were identified and managed effectively by staff, who took a compassionate approach. We found no evidence that they could have foreseen an imminent risk of harm on the day Mr Davies died.

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

**Adrian Usher**  
**Prisons and Probation Ombudsman**

**November 2023**

# Contents

Summary .....	1
The Investigation Process.....	3
Background Information.....	4
Key Events.....	6
Findings .....	12

## Summary

### Events

1. On 22 June 2018, Mr Joseph Davies was remanded to prison for offences of assault and kidnap. He was taken to HMP Durham. It was his first time in prison. Mr Davies had a history of mental ill-health and received regular support from the mental health team at Durham. His antidepressant medication was continued. Mr Davies self-harmed on several occasions by making cuts to his arms. He told staff this was his way of coping. Officers monitored Mr Davies using Assessment, Care in Custody and Teamwork (ACCT) procedures for suicide and self-harm prevention. In December, he was diagnosed with epilepsy and prescribed medication to help manage his seizures.
2. On 9 January 2019, Mr Davies received an extended determinate sentence of six years imprisonment and four years on licence in the community. On 14 January, Mr Davies transferred to HMP Northumberland. He continued to see the mental health team with support from a psychologist, speech and language therapist and mental health nurse. They assessed that he had a learning disability and traits of autism, and worked with him to help him cope with this in prison. He was twice monitored under ACCT procedures, once after saying he had overdosed on his antidepressants. In September 2022, Mr Davies was discharged from the mental health team once he had completed his work with them.
3. Mr Davies told staff that he was happy at Northumberland and did not want to be considered for early release by the Parole Board. He was last subject to an ACCT for one day in October 2022 after superficially cutting his arm. In November, a nurse assessed that Mr Davies could keep seven days' worth of his antidepressant and epilepsy medications in his cell and self-administer.
4. On 12 February 2023, Mr Davies went to the visits hall in the morning for his first visit since being at Northumberland. His sister did not bring the correct identification so the visit was cancelled and Mr Davies was taken back to his houseblock. Staff said that he did not seem distressed. He went straight back into his cell, choosing not to mix with other prisoners on the houseblock.
5. At lunchtime, Mr Davies was found unresponsive, kneeling by his bed, surrounded by empty packets of medication. Staff tried to resuscitate him and, having recovered a pulse, paramedics took him to hospital. Mr Davies died later that day. The pathologist concluded that Mr Davies died as a result of mixed drug toxicity of his prescribed medication.

### Findings

6. We concluded that staff could not have predicted that Mr Davies was a risk to himself in the days leading up to his death. Staff identified and managed risks effectively and he had regular and meaningful contact with a key worker.
7. The clinical reviewer found that the clinical care received by Mr Davies was of a high standard overall. He received extensive multidisciplinary input to address his individual needs.

8. In November 2022, a nurse assessed that it was appropriate for Mr Davies to hold a week's supply of his own medication for epilepsy and depression. This was based on Mr Davies' answers to the questions asked. The nurse did not consult Mr Davies' medical record and was therefore unaware he had recently self-harmed and been subject to ACCT monitoring, or his attempted overdose in January 2019. This information might have impacted the outcome of the assessment and it is important that all available information on individual risks is considered before in-possession medication is provided to prisoners.

## **Recommendation**

- The Head of Healthcare should ensure that all staff who undertake Medication in Possession Risk Assessments (MIPRA) follow the Spectrum Medicines in Possession policy and review the prisoner's medical record as part of their assessment.

## The Investigation Process

9. We were notified of Mr Joseph Davies' death on 13 February 2023. The investigator issued notices to staff and prisoners at HMP Northumberland informing them of the investigation and asking anyone with relevant information to contact her. A prison custody officer (PCO) responded and was interviewed.
10. The investigator obtained copies of relevant extracts from Mr Davies' prison and medical records. There is no CCTV on the houseblock where Mr Davies lived.
11. NHS England (NHSE) commissioned a clinical reviewer to review Mr Davies' clinical care at the prison. The investigator and clinical reviewer interviewed nine members of staff and one prisoner in April 2023.
12. Northumbria Police investigated Mr Davies' death and concluded that there was no evidence of any suspicious or third-party involvement.
13. We informed HM Coroner for Northumberland of the investigation. The Coroner gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.
14. The Ombudsman's family liaison officer contacted Mr Davies' mother and next of kin to explain the investigation and to ask if she had any matters she wanted us to consider. She asked why there had been a delay in telling the family that Mr Davies had died, which we have addressed in our report. Other questions have been addressed in separate correspondence.
15. Mr Davies' mother received a copy of the initial report. She raised a number of issues that do not impact on the factual accuracy of this report and have been addressed through separate correspondence.
16. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS pointed out some factual inaccuracies and this report has been amended accordingly.

## Background Information

### HMP Northumberland

17. HMP Northumberland, run by Sodexo Justice Services, is a category C prison which holds around 1,350 male prisoners. Spectrum Community Health CIC provides healthcare services. Healthcare staff are on duty from 7.30am to 7.30pm, Monday to Friday. Tees, Esk, and Wear Valley Mental Health NHS Foundation Trust are contracted to provide mental health services.

### HM Inspectorate of Prisons

18. The most recent inspection of HMP Northumberland was in August and September 2022. Inspectors found that safety and respect had improved at the prison since their last inspection in 2017. Inspectors were concerned that the number of self-inflicted deaths at Northumberland was higher than at most comparable prisons. Assessment, Care in Custody and Teamwork (ACCT) documents for prisoners at risk of suicide and self-harm were poorly completed and prisoners said they did not feel supported.

### Independent Monitoring Board

19. 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 December 2021, the IMB reported that prisoners were in a safe environment, and that many of the prison's initiatives supported prisoners to feel safe.
20. The prison introduced an action plan to ensure ACCTs were monitored weekly by safer custody staff. New ACCT documentation and procedures were introduced, and staff were given additional training.

### Previous deaths at HMP Northumberland

21. Mr Davies was the seventeenth prisoner to die at HMP Northumberland since February 2020. Of these previous deaths, five were self-inflicted, ten were due to natural causes and one was drug related. None of our previous investigations raised issues relevant to this investigation.
22. Since Mr Davies' death, there have been three further deaths due to natural causes. The investigations into these deaths are ongoing.

### Assessment, Care in Custody and Teamwork

23. Assessment, Care in Custody and Teamwork (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 irregular to prevent the prisoner anticipating when they will occur. There should be regular multidisciplinary review meetings involving the prisoner.

24. 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.
25. Following the closure of an ACCT, post-closure monitoring must be completed for a minimum of 7 days in order to inform the post-closure review. A post-closure review should consider the support actions, the current feelings of the prisoner, access to support (both formal and informal) and progress since closure.

## Key Events

### HMP Durham

26. On 22 June 2018, Mr Joseph Davies was remanded to prison for offences of assault and kidnap. He was taken to HMP Durham. It was his first time in prison. Staff identified Mr Davies' history of depression and anxiety and referred him to the mental health team. He was prescribed an antidepressant (mirtazapine). Mr Davies received regular mental health input which focussed on his past trauma and low mood.
27. During Mr Davies' time at Durham, he self-harmed by cutting which he said helped him cope. He was intermittently subject to Assessment, Care in Custody and Teamwork (ACCT) procedures for suicide and self-harm.
28. Mr Davies had several unexplained seizures and, in December 2018, was diagnosed with epilepsy and prescribed lamotrigine to help manage his condition.
29. On 9 January 2019, Mr Davies was given an extended determinate sentence of six years imprisonment and four years on licence in the community. He told staff that he was happy with his sentence as he had been expecting longer.

### HMP Northumberland

30. On 14 January 2019, Mr Davies transferred to HMP Northumberland. During 2019 and 2020, he was occasionally subject to ACCT support after cutting himself. In March 2019, he said he had taken all of his antidepressant medication. He later handed in his epilepsy medication and said he was going to take an overdose. Staff assessed that Mr Davies was unsuitable to have his medication in his possession and organised for him to collect it from the medication hatch or it be delivered to his cell instead. He had regular contact with the mental health team regarding the voices he heard, his low mood and thoughts of suicide and self-harm.
31. Between December 2019 and March 2022, Mr Davies saw a Higher Assistant Psychologist 66 times. She focused on developing coping strategies for use in stressful situations as an alternative to self-harm, relationships, conflict and anger management and identifying goals for Mr Davies to work towards. They also talked about Mr Davies' past trauma, managing symptoms such as hearing voices and the feeling of abandonment he experienced.
32. The Higher Assistant Psychologist assessed Mr Davies' IQ. He scored 56 which indicated he had a learning disability. She also assessed that Mr Davies had traits of autism (a lifelong developmental disability which affects how people communicate and interact with the world) which was not formally diagnosed but prompted a referral to a speech and language therapist (SALT) in January 2022.
33. Mr Davies struggled meeting new people but once he had met and got to know staff, his engagement increased. Therefore, the Higher Assistant Psychologist joined the speech and language specialist for their first few sessions. Mr Davies and the therapist developed a good therapeutic relationship over time and completed detailed assessments between January and April. Mr Davies had 13 further

sessions with her, focusing on gaining a better understanding of his communication needs. She provided a comprehensive package of assessment and treatment to Mr Davies and shared her findings with the mental health team and offender management unit. She stopped working with Mr Davies in August 2022, when their work together was completed.

34. The speech and language therapist passed on information to wing staff about how best to communicate with Mr Davies and that he might need more time to cope with changes. She spoke to Mr Davies about how he might struggle to cope with a transfer to another prison for offence focused work. She considered that he would need adaptations to any programmes due to his learning needs, which might not have been possible.
35. Mr Davies was also under the care of a mental health nurse. Nurse A took over his care from the previous nurse in August 2021. She regularly reviewed Mr Davies' mental health care plan. She tried to arrange a social care assessment for Mr Davies to assist him on release, but his case was closed by Northumberland Social Services because of the time he had left in prison. They said they would re-open it closer to his release date. The mental health team also attended Mr Davies' ACCT reviews as appropriate.
36. A Prison Custody Officer (PCO) worked on Mr Davies' wing. She observed that his engagement with staff was variable and some days he did not want to speak to them. She said that Mr Davies struggled with his personal hygiene and keeping his cell tidy. She tried to assist and encourage Mr Davies to keep himself and his cell clean. He also seemed to struggle to communicate but never had issues with other prisoners or staff. She never had any concerns that Mr Davies was a risk to himself.
37. In March 2022, the Parole Board decided that Mr Davies should remain in prison because he had not completed any offence focused work and had indicated that he did not want to be released at that time.
38. Between 27 June and 6 July 2022, Mr Davies was subject to ACCT support after self-harming.
39. In August, once Mr Davies had completed his work with the SALT, Nurse A discussed Mr Davies' discharge from the mental health team with him. Mr Davies was reluctant to be discharged. However, she reminded him that he had a job working in visits, was compliant with his medication, seemed stable and was planning for the future by exploring a possible move to another prison. She discussed Mr Davies' discharge with the rest of the team, and they agreed that it was appropriate. He could return to them for support if he needed it. Mr Davies was discharged from the mental health team caseload on 30 September.
40. On 16 October, a report written for the Parole Board by Mr Davies' community offender manager noted that Mr Davies said he did not want to be released from prison. Mr Davies said that he felt safe at Northumberland and had good, supportive relationships with staff. Mr Davies' next Parole Board review hearing was scheduled for May 2023 at the earliest and therefore did not take place before Mr Davies died.
41. On 20 October, Mr Davies self-harmed by cutting his arm. Staff opened an ACCT. On 21 October, a Senior Prison Custody Officer (SPCO) chaired an ACCT review

with Mr Davies and the speech and language therapist. Mr Davies said he had self-harmed because he was anxious and paranoid. The therapist said that they had discharged Mr Davies from the mental health team, and he had felt let down by this. They spoke about Mr Davies' release and he said he had two years left in prison. Mr Davies said he had no thoughts of suicide or self-harm. Staff present decided to close the ACCT. On 27 October, staff held a post-closure review for Mr Davies. He said he had no concerns and was settled.

42. On 8 November, a GP at Northumberland met Mr Davies to review his epilepsy and altered his associated medication. Mr Davies requested that he be allowed to keep his medications 'in possession', for self-administration as opposed to collecting them from healthcare. The GP requested that a nurse carry out a risk assessment.
43. On 11 November, a nurse assessed Mr Davies' suitability for in possession medication. She was familiar with Mr Davies, as she had often administered his medication. She said that Mr Davies was keen to be independent with his medications. The questions that she asked when completing the assessment followed a template. She asked if he had any issues with drugs or alcohol in the last three months to which he replied yes (we found no evidence of drug or alcohol use by Mr Davies at Northumberland). She also asked Mr Davies whether he had self-harmed or attempted suicide in the last twelve months to which Mr Davies answered that he had not. She did not check Mr Davies' medical record as she should have done and was therefore unaware of his self-harm and ACCT monitoring one month prior and attempt to overdose on his medications in January 2019. She told the investigator that she had no concerns that he was a risk to himself. The assessment resulted in a score of six which meant that Mr Davies could have seven days' worth of his medication in his possession.
44. The primary care lead said that it had been difficult for Mr Davies to take his medication at the correct time after he had got a job in the visits hall, so having it in his own possession helped. She also said that this would help him when he was released in the community and responsible for his own medication. Once Mr Davies had his medication in his in possession, the frequency of his epileptic seizures reduced and he appeared to be settled and managed well. She said that he appeared happy and she had no concerns about him.
45. Mr Davies had regular key work sessions with a PCO A throughout his time at Northumberland. On 25 November, Mr Davies told him that other prisoners said he was not contributing enough at work, and it was affecting his mental health. He said staff did not have any issues with his work, and the PCO advised him to concentrate on that. Mr Davies said he had some good friends on the landing, was happy and settled and had no current issues with drugs, alcohol or debt.
46. At another key work session on 15 December, Mr Davies said that he was fine and working as a cleaner in the visits hall. He said he felt safe and again had no issues with drugs, alcohol or debt.
47. On 12 January 2023, after a key work session, PCO A noted that Mr Davies was no longer working as a visits cleaner due to his poor attendance and was looking for another job. Mr Davies told him that his mental health had been better recently and he was happy on the landing.

48. On 24 January, a nurse assessed Mr Davies and took a blood sample as his mother had contacted the prison and asked that he was assessed for diabetes. Mr Davies said he felt weak and shaky in the mornings. The blood tests showed no abnormalities or any diagnosis of diabetes.
49. On 31 January, staff submitted an intelligence report, alleging that Mr Davies and another prisoner were selling their antipsychotic medication. The intelligence assessment noted that there was no other evidence to support this allegation and that the prisoner who had made the allegations had been known to sell his own medication, so he may have been fabricating the evidence to deflect attention away from himself. Mr Davies was not prescribed antipsychotic medication and we found no evidence to support the allegation during our investigation.
50. On 2 February, the speech and language therapist saw Mr Davies on the wing. He said hello and things were "as usual" and his physical health was good. She reminded him of the support options available on the wing or through the mental health team. She had no concerns about him.
51. On 4 February and 10 February, Mr Davies rang his sister and had lengthy conversations. All calls prisoners make are recorded, a small percentage chosen at random are listened to by staff and others are listened to if there is a public protection need. There is no evidence that any of Mr Davies' calls were listened to. The investigator listened to the call on 10 February during which Mr Davies and his sister had a general conversation and discussed Mr Davies' plans for release.
52. A friend of Mr Davies said that he spoke to him most days on the wing. He said that he knew Mr Davies sometimes struggled with his mental health and described problems with other prisoners because of his poor personal hygiene. He also knew that Mr Davies sometimes harmed himself but said that he had never been concerned that Mr Davies would kill himself. He said Mr Davies seemed fine on 11 February. He helped him with a game on his game console for much of the day. He said that Mr Davies was looking forward to a visit from his sister the next day.

### **Events of 12 February 2023**

53. At 8.11am, Mr Davies tried to telephone his grandmother but the call lasted only two seconds. He was not successful in connecting.
54. At 9.00am, PCO B unlocked Mr Davies for the visit with his sister. They shared a joke. The PCO saw Mr Davies as he was waiting to leave the houseblock. She said he seemed excited and she commented on how smart he looked. However, Mr Davies' sister did not bring the appropriate identification and so she could not enter the prison and the visit was cancelled. A SPCO told Mr Davies and took him back to his houseblock at around 10.00am, where prisoners were in association (able to move around and socialise on the wing). The SPCO had no concerns about Mr Davies.
55. Mr Davies' friend said that when Mr Davies returned from his visit, he went straight back into his cell and closed the door behind him (meaning it also locked), despite prisoners on his landing being out for association at the time. He went to check on him a short time later but Mr Davies did not respond. He looked through his

observation panel and Mr Davies was lying on his bed. He told the investigator that he could see Mr Davies moving.

56. Between 11.30am to 11.45am, when Mr Davies did not come out of his cell to collect his lunch, his friend spoke to PCO C and told her that Mr Davies needed to be unlocked. Other prisoners were still in association. The PCO went to Mr Davies' cell, opened the observation panel and saw Mr Davies kneeling over his bed with his head in his hands. She could see a small amount of blood on his hands and was concerned that he might have self-harmed. She radioed for assistance from another officer who she knew was nearby and called to Mr Davies, but he did not respond. She assessed that it was safe to enter the cell so opened the door and went in. Mr Davies' lips were blue so she radioed a code blue (an emergency code indicating that a prisoner is not breathing or is having difficulty breathing). It was around 11.50am. Control room staff requested an ambulance. PCO B got to the cell and, along with PCO C, moved Mr Davies to the floor. They checked for signs of life and PCO B started chest compressions. More staff arrived to assist and they attached a defibrillator.
57. A nurse responded along with a colleague. They inserted an airway and administered oxygen while chest compressions continued. They also administered an injection of naloxone (a drug given to reverse the effects of an overdose). Paramedics attended, took over Mr Davies' treatment and administered more naloxone. Mr Davies showed signs of a pulse and, at 1.44pm, paramedics took Mr Davies to hospital. No restraints were used. Mr Davies was stabilised in hospital but his condition later deteriorated and he died at 6.00pm. Two PCOs remained outside the critical care ward while Mr Davies was being treated and staff told them that Mr Davies had died at 6.10pm.
58. Police examined Mr Davies' cell after he had died. There was a bin on his bed and next to it were several empty boxes of medication as well as empty blister packs. These were the medications that Mr Davies had been allowed in his possession: mirtazapine (antidepressant), levetiracetam (epilepsy medication), lamotrigine (epilepsy medication), folic acid and cyanocobalamin (manufactured vitamin B12).
59. The investigator saw police photos of Mr Davies' cell after he died. It was messy, with documents, torn up medication leaflets and items covering all the surfaces. The photos showed at least ten boxes of medication on the bed.
60. Paramedic documentation noted that there were several empty medication boxes and blister packs on Mr Davies bed including one month's supply of levetiracetam, three weeks' supply of mirtazapine and two weeks' supply of lamotrigine. There was also an empty ten tablet packet of paracetamol. (Prisoners are able to purchase paracetamol through the prison canteen system; there is no evidence that healthcare staff had recently dispensed paracetamol to Mr Davies.)

## Contact with Mr Davies' family

61. PCO D was one of the officers who had escorted Mr Davies to the hospital. At 3.30pm, nursing staff told him that Mr Davies did not have long to live and they wanted to inform his next of kin. He said he rang the prison at least twice to try to speak to the family liaison officer. He spoke to the Duty Governor, who said that he had four numbers for Mr Davies' mother and asked him to ring one of them, which

he tried to do but the number was unobtainable. PCO D had told the Duty Governor that he did not feel comfortable doing so as he was not a family liaison officer and did not have the appropriate skills. He suggested to the Duty Governor that they contacted Mr Davies' sister, who had visited him that morning, but was told it was against protocol as she was not listed as his next of kin.

62. A SPCO was appointed as the family liaison officer on the day of Mr Davies' death. He also tried to call Mr Davies' mother, but none of the telephone numbers on the system were in service. The prison had an address for Mr Davies' mother in Yorkshire, so the Duty Governor contacted the local police to attend her address. She no longer lived there. At 6.05pm, the SPCO telephoned Mr Davies' sister and obtained his mother's telephone number. She lived in Scotland. He telephoned Mr Davies' mother and informed her that he was in hospital. Shortly after, Mr Davies died and the SPCO called his mother again to notify her of his death. This was at approximately 6.25pm.
63. In line with national policy, Northumberland offered to make a contribution to Mr Davies' funeral expenses.

### **Support for prisoners and staff**

64. After Mr Davies' death, the Duty Governor debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.
65. The prison posted notices informing other prisoners of Mr Davies' 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 Davies' death.

### **Post-mortem report**

66. The pathologist concluded that the cause of Mr Davies' death was multiple drug toxicity. They noted that lamotrigine and mirtazapine were detected at fatal levels with levetiracetam above the therapeutic range which would have exacerbated the effects of the other drugs. Paracetamol was also detected at potentially fatal levels.

## Findings

### Assessment and management of risk

67. Prison Service Instruction (PSI) 64/2011, *Safer Custody*, lists risk factors and potential triggers for suicide and self-harm. It says all staff should be alert to the increased risk of self-harm or suicide posed by prisoners with these risk factors and should act appropriately to address any concerns. Any prisoner identified as at risk of suicide and self-harm must be managed under Assessment, Care in Custody and Teamwork (ACCT) procedures. PSI 64/2011 also states that any information that becomes available which may affect a prisoner's risk of harm to self must be recorded and shared, to inform proper decision making.
68. Over the years Mr Davies had been in prison, he had used self-harm as a coping mechanism. Staff used ACCT procedures to support Mr Davies for relatively short periods of time, on several occasions. Mr Davies said he had overdosed on his antidepressant medication just under four years before his death, in January 2019, after which his medications were removed from his possession.
69. The last time Mr Davies had been assessed as a risk to himself was in October 2022 after making cuts to his wrist. Staff used ACCT procedures for one day.
70. Mr Davies' friend told us that he had never been concerned that Mr Davies would kill himself, despite knowing that he had some struggles in prison. He said that Mr Davies got on well with staff. PCO C worked on Mr Davies' wing. She said his engagement with staff varied but she did not consider this a risk factor. He never had any issues with prisoners or officers as far as she knew. Mr Davies struggled with his personal hygiene and keeping his cell tidy, which staff reminded him to address and helped him with on a few occasions. There was no indication that this was part of a wider mental health issue. Mr Davies had several sessions with his key worker at Northumberland, PCO A. PCO A's records show regular and meaningful conversation. Mr Davies told him he felt better mentally and was happy on his landing in the weeks before he died.
71. It may be significant that Mr Davies was due to have his first family visit at Northumberland on the morning he died, which was cancelled due to his sister not bringing the correct identification. However, staff who saw him afterwards did not see any signs that caused concern and did not assess that additional monitoring was necessary. We accept that there were no obvious indications that Mr Davies was in crisis in the period before his death and do not make a recommendation.

### Clinical Care

72. The clinical reviewer concluded that Mr Davies received a high standard of clinical care which was equivalent to that which he could have expected to receive in the community. The clinical reviewer noted several areas of good practice, including the proactive referral to Social Services by Nurse A, staff ensuring Mr Davies had reports in a format that was easy for him to read, the Higher Assistant Psychologist's handover to the SALT and the generally good communication between the team.

73. The clinical reviewer was particularly impressed with Mr Davies mental healthcare at Northumberland. He was provided with a comprehensive package of mental health assessments, support and treatment and staff made efforts to ensure Mr Davies developed good therapeutic relationships with which to address his needs. We bring this to the attention of the Head of Healthcare.
74. On 11 November 2022, a nurse assessed that Mr Davies was suitable to have his medication in his possession. However, she did not review Mr Davies' medical record before completing the assessment, as she should have done, and was unaware that he had recently self-harmed and been subject to ACCT support, or that he had overdosed on his prescribed medication in 2019. In interview, she said she had focused on Mr Davies' answers to her questions when she made her decision. Mr Davies received a week's worth of medication on 12 February 2023, the day that he took the overdose. Both the paramedics who attended and the police who later searched Mr Davies' cell recorded a number of empty medication boxes and blister packs on his bed, including his prescribed medication and paracetamol.
75. The clinical reviewer found that the nurse noted no concerns about Mr Davies' compliance with medications. It is unclear what this assumption was based on, without access to the medical record. She noted that after he was given his medications in possession, which he had on a weekly basis for around three months before he died, Mr Davies' seizures reduced which was a strong indicator that he was taking his medication appropriately. However, the amount of empty medication packets on his bed when he was found unresponsive indicates that he might not have been taking his medication as prescribed in the weeks before he died.
76. The local Medicines in Possession Policy at Northumberland states that no in possession medication is allowed within 28 days of an ACCT being closed. There was a gap of 21 days between Mr Davies' ACCT being closed and him being assessed as suitable for his medication in his possession.
77. If the nurse had consulted Mr Davies' medical record, her assessment would have been informed by his history of self-harm, most recently one month prior, and his attempt to take his own life by overdose in January 2019. She would have been aware of Mr Davies' recent ACCT, and it being closed for 21 days and not the required 28 days.
78. The nurse did not follow the local procedure when assessing whether Mr Davies could hold his medication in possession. We raised this with the Head of Healthcare but have not been made aware of any particular actions taken to ensure healthcare staff are aware of their responsibilities. We make the following recommendation:

**The Head of Healthcare should ensure that all staff who undertake Medication in Possession Risk Assessments (MIPRA) follow the Spectrum Medicines in Possession policy and review the prisoner's medical record as part of their assessment.**

## **Inquest**

79. The inquest into Mr Davies' death finished on 20 May 2024. It concluded that the cause of his death was suicide due to taking an overdose of his prescription medication.

**Prisons &  
Probation**

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