Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Oliver Davies, a prisoner at HMP Hewell, on 31 December 2022

A report by the Prisons and Probation Ombudsman

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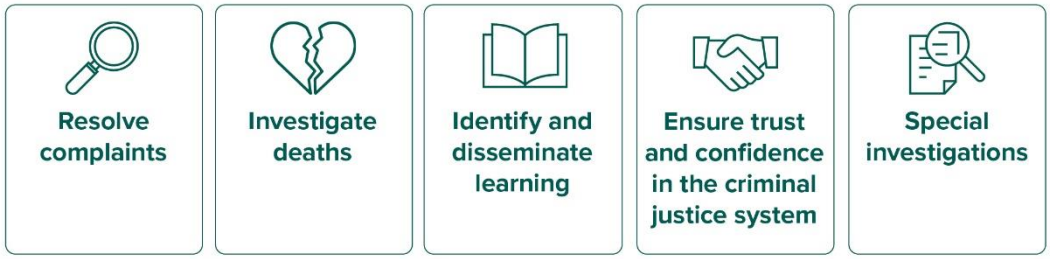
OUR VISION

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.

If my office is to best assist HMPPS in ensuring the standard of care received by those within service remit is appropriate then our recommendations should be focused, evidenced and viable. This is especially the case if there is evidence of systemic failure.

Mr Oliver Davies was found hanged in his cell on 31 December 2022 at HMP Hewell. He was 41 years old. I offer my condolences to Mr Davies' family and friends.

Mr Davies was vulnerable and arrived at Hewell with clear markers for suicide and self-harm. No one in Reception or the Induction Unit acted on this information.

Mr Davies was not prescribed the antidepressant he was on in the community nor had this medication been reviewed. This is despite a prison GP requesting a review and Mr Davies making three applications himself demonstrating his increasing distress.

Mr Davies' assigned mental health worker missed two appointments to see him. When staff eventually started ACCT procedures, Mr Davies was moved to the prison's Wellbeing Unit, but placed in a cell on his own. No one considered whether this was suitable because everyone believed it to be someone else's decision.

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 **September 2024**

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Summary

Events

1. On 20 October 2022, Mr Oliver Davies was remanded to HMP Hewell for controlling and coercive behaviour and assault. He arrived with his suicide and self-harm risk clearly flagged on his digital Person Escort Record (PER). It was his first time in prison and the alleged offence was against his father. He had been under constant CCTV supervision at some point prior to arriving at Hewell (either in police or court custody) but we do not know when.

2. No one in Reception or on the Induction Wing at Hewell recorded that they had considered the PER or beginning suicide and self-harm monitoring procedures (ACCT).

3. Between October and December, staff made referrals for reviews of Mr Davies' antidepressant medication and he himself made three healthcare applications. No review was ever carried out, so he did not receive an antidepressant while in prison.

4. In December, Mr Davies was allocated a mental health worker, but two appointments did not go ahead.

5. On 30 December, Mr Davies told a nurse he was feeling suicidal, and she started ACCT procedures. Staff set hourly observations at a case review and arranged Mr Davies' move to the Wellbeing Unit where more support could be offered. They also made a GP appointment for 3 January regarding his medication.

6. On 31 December, Mr Davies appeared to be interacting with staff and prisoners normally but at 6.10pm an officer looked through his cell observation panel and could only see Mr Davies' foot, at a strange angle, to her immediate right. Mr Davies was not responding, and the cell was dark, so the officer alerted a colleague. They got permission to go into the cell and found Mr Davies hanging in the door recess. The officers cut Mr Davies down and started cardiopulmonary resuscitation (CPR). Other staff arrived quickly to support them.

7. At 6.28pm, paramedics arrived and continued lifesaving attempts but at 6.58pm confirmed that Mr Davies had died.

Findings

8. It was obvious that Mr Davies was likely to struggle in prison. This was flagged clearly when he arrived at Hewell, but staff did not consider his risk factors or whether ACCT procedures should be started.

9. There were repeated failures in the system to ensure Mr Davies' antidepressant medication was reviewed so he did not receive any at Hewell.

Recommendations

- **The Head of Healthcare should check and ensure all staff, including agency staff, have been trained to access Person Escort Records.**

- **The Governor and Head of Healthcare should examine Reception practices and devise a plan to ensure that all relevant staff read Person Escort Records when processing prisoners.**

- **The Head of Healthcare should ensure there is an efficient process in place for continuing to prescribe pre-detention medication.**

The Investigation Process

10. HMPPS notified us of Mr Davies' death on 31 December 2022.

11. The investigator issued notices to staff and prisoners at HMP Hewell informing them of the investigation and asking anyone with relevant information to contact her. A prisoner wrote to her, stating he believed Mr Davies had probably tried to take his life at Hewell before. He also believed that staff in general and a particular supervising officer (SO) had ignored Mr Davies' distress. The investigator traced the SO, who has since left the service and did not wish to assist our investigation.

12. The investigator obtained copies of relevant extracts from Mr Davies' prison and medical records.

13. The investigator interviewed 13 members of staff at Hewell on 20 and 25 April. She obtained further information from the Ministry of Justice Security and Information Group, the Head of Safety, the interim Head of Healthcare and the Deputy Director for NHS England Midlands region.

14. NHS England commissioned a clinical reviewer to review Mr Davies' clinical care at the prison. The investigator and clinical reviewer interviewed staff together.

15. We informed HM Coroner for Worcestershire of the investigation. The Coroner gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.

16. The Ombudsman's family liaison officer contacted Mr Davies' mother, to explain the investigation and to ask if she had any matters she wanted us to consider. Her solicitor provided several comments about communications and visiting rights and asked the following questions:

    - Was the prison aware of Mr Davies' mental health issues in advance?
    - Did Mr Davies receive her email? (No specific detail given.)
    - Why had he ended up in a cell on his own?
    - What were the details around his hourly observations?
    - Was he assessed by the mental health team and not considered a suicide risk?
    - Did the prison know he was on antidepressants in the community?
    - Were there any measures in place given he was on remand?
    - Were there any unresolved issues following a previous self-inflicted death at Hewell that the prison had not acted on?

    These matters are covered within the report and in the clinical review.

17. Mr Davies' mother received a copy of the initial report. She raised questions that do not impact on the factual accuracy of this report and have been addressed through separate correspondence.

18. The initial report was shared with HM Prison and Probation Service (HMPPS). The prison's healthcare provider pointed out a factual inaccuracy in the clinical review, and the review has been amended accordingly and reissued.

Background Information

HMP Hewell

19. HMP Hewell is a large Category B local prison in Worcestershire, holding adult male prisoners. Practice Plus Group provides healthcare services at the prison.

HM Inspectorate of Prisons

20. HMIP carried out a full inspection of Hewell in December 2022. Failings in the care of early days prisoners remained a concern, and they also noted that leaders had not done enough to address previous concerns about support for those at risk of self-harm or suicide. They still considered that some of the processes to protect the most vulnerable were weak and that leaders needed to commit to following up on PPO recommendations. However, inspectors felt that in general the prison had made excellent progress and was now cleaner, more decent and safer.

Independent Monitoring Board

21. 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 30 September 2022, the IMB reported that the momentum towards improvement highlighted in their last report was still driving change. The prison was maintaining its progress and the IMB considered Hewell safer, better managed, cleaner and more humane. However, improvement was still required in certain areas.

22. The individual pathway model (seeking to provide an individualised response to prisoners' needs), and the key work model were both considered crucial to culture change – but progress was described as 'frustratingly slow'. Self-harm numbers had risen slightly and remained of concern.

Previous deaths at HMP Hewell

23. Mr Davies was the thirteenth prisoner to die at Hewell since December 2019. Of the previous deaths, five were self-inflicted and eight were due to natural causes. Up to the end of 2023, there had been one self-inflicted since Mr Davies' death.

24. In a previous investigation into the death of a prisoner at Hewell in May 2019, we recommended that the Head of Healthcare should ensure that medical records were always accessed, along with any other evidence that arrived with a prisoner. In response, the prison's action plan said: 'The Head of Healthcare will ensure that all Healthcare reception staff are reminded of their responsibility to access all available information relating to a prisoner including the Cell Share Risk Assessment (CSRA), Prisoner Escort Record (PER) and Custody Self-Harm Warning Form when a prisoner arrives at reception.'

25. In that case, the reception nurse had not made efforts to access all the information available to her (in particular a medical record) or properly consider that which she did have available (a previous Cell Sharing Risk Assessment). In Mr Davies' case,

the same nurse did not consider the Person Escort Record which clearly detailed his risks.

Assessment, Care in Custody and Teamwork

26. 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.

27. As part of the process, a caremap (a plan of care, support and intervention) is put in place. The ACCT plan should not be closed until all the actions of the caremap 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).

Key Events

28. On 20 October 2022, Mr Davies was remanded to HMP Hewell for controlling and coercive behaviour and assault against his father.

29. An unknown person or persons completed the digital Person Escort Record (PER, a document that accompanies prisoners between police custody, court and prisons, which sets out the risks they pose). Part was completed while Mr Davies was in police custody and part likely by court staff. The Suicide and Self-Harm (SASH) section had been completed. It stated Mr Davies was at risk of suicide and self-harm, had attempted suicide in the past and was currently feeling 'unwell'. He admitted to a recent act of self-harm, by cutting. Mr Davies was constantly monitored by CCTV although it is not clear if this was in police custody, at the court or both.

30. The PER also documented that Mr Davies had anxiety, depression, claustrophobia, a personality disorder and a historical brain injury. He said he took Amitriptyline (an antidepressant) once a day but did not have any with him when arrested.

31. The PER also said a member of the Liaison and Diversion in Custody Team had assessed Mr Davies along with the duty healthcare professional. They did not detect any signs of a serious mental illness, but Mr Davies said he had not felt very supported at his supported housing residence. An unknown person contacted his housing officer who confirmed Mr Davies had lived at the supported housing since mid-September 2022 and staff had completed 12-hour welfare checks on him because of his suicidal ideation. Their staff also held one to one sessions with Mr Davies to encourage him to engage with services.

32. Mr Davies' mother told us she made a statement to Hereford Police which was passed to the magistrate about Mr Davies' mental health and risk of suicide. This information was not included in the PER, and we have not seen the statement.

33. On the afternoon of 20 October, Mr Davies arrived at HMP Hewell.

34. A nurse carried out Mr Davies' first night screen. Her notes did not mention the SASH form or PER, or whether she considered opening an ACCT. Mr Davies denied thoughts of suicide or self-harm but said he was anxious as it was his first time in prison. He referred to suicidal thoughts in the past but said he had none now. At interview the nurse could not remember Mr Davies and was unclear whether she had seen the PER at all.

35. Mr Davies saw a GP in reception. Mr Davies had inflamed spots on his legs, which the doctor reviewed and prescribed an antibiotic. He placed Mr Davies on a list for a blood pressure review and had no other concerns. Mr Davies' Amitriptyline prescription was to be checked during the medications reconciliation process (where healthcare staff check which medications the prisoner was prescribed in the community).

36. An officer completed the custodial portion of the CSRA (Cell Sharing Risk Assessment) and a nurse completed the healthcare portion. The officer noted that there were no current suicide or self-harm concerns, but that Mr Davies was upset (with no further detail). He noted Mr Davies' history of self-harm and mental health

issues. The nurse ticked that Mr Davies was at no increased risk and made no other comments. It is not clear if the officer reviewed Mr Davies' PER.

37. A Supervising Officer (SO) carried out Mr Davies' first night induction. Mr Davies seemed overwhelmed but reported no thoughts of suicide or self-harm. She did not see the PER or SASH form and told the investigator she would have expected other staff (in reception) to alert her to its contents if they had seen anything concerning. She was not concerned about Mr Davies.

38. On 21 October, a pharmacy technician carried out a medication reconciliation. Mr Davies' community GP had prescribed him Duloxetine, Zapain and Amitriptyline and he had received his last prescription on 19 August. Mr Davies had said he was prescribed Duloxetine and Amitriptyline for anxiety and depression, but these medications have other uses too. (Duloxetine is also used to treat nerve pain, Zapain is pain relief and Amitriptyline is for depression, migraine, and nerve pain.) The pharmacy technician sent advice to a prison GP to continue the medications.

39. A prison GP picked up the pharmacy technician's advice and noted there had been a four week break in Mr Davies' repeat prescription. He thought the medication should be reviewed. The medication Mr Davies was on was not usually prescribed long term, and he was not sure if some of it was for antidepressant or pain relief purposes. The GP was working from home monitoring the tasks inbox at the time, and he asked the pharmacy technician to get some more information from Mr Davies. He wanted to know if Mr Davies had been taking his medication as prescribed and why there had been a four week break in his treatment. He asked that the duty doctor be updated.

40. A nurse carried out Mr Davies' secondary heath screen. Mr Davies said he also had PTSD (Post Traumatic Stress Disorder) along with the other mental health issues he had already mentioned. She made a mental health referral.

41. An administrator processed the nurse's mental health referral and placed it in the folder for a mental health nurse to pick up. She also wrote to the wing and Mr Davies confirming receipt of the referral.

42. A nurse reviewed the referral and noted that there was not a lot of information about Mr Davies in the notes and that he had said he had anxiety and depression. She noted the referral's priority level as 'routine'.

43. An officer carried out a 'Day 2 Key Worker Session'. She carried it out with a group of other prisoners and 'Insiders' (prisoners who provide information about prison life to new arrivals) and covered the practicalities of life in prison. Prisoners were told to let her know if they had any concerns, but Mr Davies did not raise anything specific. She was only responsible for key work sessions on the Induction Unit and Mr Davies did not receive any more key work during his time at Hewell.

44. On 26 October, a nurse noted she had attempted to complete a Duty Professional Assessment (to review Mr Davies' mental health history), but officers told her Mr Davies had a court video-link appointment. She noted that a member of the mental health team should see Mr Davies at their earliest convenience.

45. On 28 October, a recovery worker carried out Mr Davies' mental health review. She noted he interacted appropriately. On this occasion, he said he also had ADHD (Attention Deficit Hyperactivity Disorder). He denied any thoughts of suicide or self-harm, said his father was a protective factor and denied drug or alcohol use. He said he was feeling anxious and low in mood due to being in prison for the first time and expressed feelings of remorse for assaulting his father. He said he was mixing with other prisoners on the wing and discussed potentially attending work and education. She noted she advised he talk to officers or healthcare staff during medication rounds should he have concerns. They agreed he would be discharged from the mental health service back to the GP.

46. That day, the pharmacy technician assigned the questions the prison GP had asked about medication compliance and the reasons for the break, to a practitioner. The practitioner emailed the duty doctor inbox that day, to say he had spoken to Mr Davies, who described a lot of upheaval in his life. He was not very settled and had been unable to pick up medication regularly from his GP. He reported struggling without his medication. The practitioner told Mr Davies he may need a review before a new prescription was written. He asked that the duty doctor review and advise. He also noted that Mr Davies had not been compliant with his pain relief medication in the community.

47. On 8 November, Mr Davies submitted an application saying he needed to see a doctor as he still had no medicine for anxiety and depression. Someone added him to the GP waiting list.

48. On 9 November, an officer recorded on NOMIS (prisoners electronic record) that she had attempted to call the numbers Mr Davies had provided for his mother in order to check she was content to receive calls from Mr Davies. The landline appeared to block her call and there was no answer on the mobile number. (Prisoners are only allowed to call specified numbers that have been cleared by the prison.)

49. By 14 November, Mr Davies had moved to a different landing on the wing. He was pleased to move but concerned his new cell mate did not speak English. A member of staff told him to be patient and that his cell mate would pick it up.

50. On an unknown date, HMPPS Find A Prisoner service contacted Hewell as Mr Davies' mother wished to locate him and make contact.

51. On 16 November, a prison GP decided to prescribe Mr Davies some simple analgesia, Ibuprofen and paracetamol, together with Omeprazole for his stomach – but not the antidepressants. He had seen the practitioner's note but did not want to prescribe the other medication because Mr Davies had had a break from it, and he did not consider it wise to re-prescribe at the same doses. (Sometimes it is necessary to completely restart a medication regime where there has been a gap.) He considered a face-to-face consultation was required as the medications also had sedating risks. In interview, he said he would not have considered prescribing even just one of the medications without reassessing Mr Davies in person.

52. On 17 November, an admin assistant referred Mr Davies to the mental health team after he reported mood swings and depression. (Her role is administrative, but the Head of Healthcare explained she may have had face to face contact with Mr

Davies when booking healthcare appointments.) He said he had previously had thoughts of suicide due to it being his first time in prison. It is not clear whether the admin assistant took any action regarding the prison GP's conclusion that a face to face consultation was required or indeed if the doctor had made it clear this was his wish.

53. On 18 November, a nurse reviewed the admin assistant's mental health referral. He noted Mr Davies' issues with anxiety and depression, that he was not on an ACCT and that he had previously been seen and required a GP referral. The mental health referral was assigned as a routine assessment.

54. On 23 November, a nurse reviewed the lesions on Mr Davies' legs. He did not document why, but he also carried out a learning disabilities assessment and concluded Mr Davies had no issues.

55. On 30 November, an officer noted on NOMIS that he had spoken to Mr Davies that morning and he was very anxious and depressed because it was his first time in prison, and he felt that he should not be there. He referred Mr Davies to the mental health team as he felt he was struggling to cope and comprehend his situation. He did not record whether he had considered beginning ACCT procedures to support Mr Davies.

56. On 1 December, Mr Davies made another application asking to see a doctor saying he was extremely depressed, and his anxiety levels were really high. He said, "I'm not coping at all please help".

57. On 6 December, someone responded to Mr Davies' application saying an appointment had been booked but giving no dates. (At Hewell, prisoners are not told the appointment date until the day itself.) A nurse had sent a task to the duty doctor inbox about a prescription for antidepressants. Mr Davies had low mood and depression and she had given him a self-help booklet. She did not consider an ACCT was necessary at that time.

58. That day, a prison GP saw the task and made an appointment to see Mr Davies when he was next on duty on 12 December.

59. On 7 December, Mr Davies was discussed at the mental health allocations meeting. As a result, an administrator sent a task to mental health practitioner to see Mr Davies on 14 December.

60. On 12 December, Mr Davies' appointment with a prison GP did not take place because the GP was unable to come into the prison that day. An admin clerk should have rescheduled the appointment but did not.

61. On 14 December, the mental health practitioner did not see Mr Davies for the appointment. He noted 'No access visit for MH clinic' on the medical record, which meant the practitioner was unable to honour the appointment. The appointment had been made by an administrator and their process did not require them to check if the practitioner they had allocated an appointment to was in on that day or not.

62. On 15 December, an officer noted on NOMIS that she had attempted to call Mr Davies' mother again following his request to have her telephone numbers added to

his prison phone account, but that she had not been able to get through. She noted that she had sent Mr Davies a notification slip.

63. On 15 December, a prison paramedic saw Mr Davies for a blood pressure check. He noted that Mr Davies was feeling low, quiet, and presented as fed up with waiting to see a GP and someone from mental health. He said he had problems sleeping and some of his medication had still not been prescribed. The paramedic noted that Mr Davies was on the mental health team caseload but had not been seen the day before.

64. On 16 December, the mental health practitioner noted in the medical record that he would not be able to review Mr Davies until 28 December because of annual leave. Although there were processes to allow for another practitioner to carry out a wellbeing check in urgent cases, he did not apparently request this for Mr Davies. Custodial staff also have the option of contacting members of the mental health team who are in if they are concerned.

65. On 19 December, a SO noted on NOMIS that Mr Davies and his cell mate had had an altercation which involved shouting, and the cell mate had thrown Mr Davies' belongings out of the cell. Mr Davies was moved to share with another prisoner, Prisoner A.

66. On 21 December, Mr Davies wrote to his mother apologising for what had happened between him and his father. Mr Davies also submitted another application to the healthcare department saying he had been on mental health medication for 20 years and had not received any since arriving at Hewell. He said he was suicidal, distressed and unwell and just kept being given paracetamol.

67. That day, an officer carried out a welfare check on Mr Davies because Mr Davies had said Prisoner A had been bullying him. The officer spoke to the two men and was satisfied that Prisoner A had given Mr Davies reasonable advice regarding cleaning up after himself and taking showers. The officer was not concerned and did not consider any further action was necessary.

68. Also on 21 December, a SO noted on NOMIS that Mr Davies had been upset that afternoon when he attended a video-link appointment. She found out that a mental health referral had already been made but someone in the mental health team advised her that Mr Davies had had been allocated to a mental health practitioner who was on leave for the Christmas period. The unnamed person said they would email their manager to see if there was anybody else who could see Mr Davies. (Mr Davies did not see another practitioner.)

69. On 23 December, an unknown person logged Mr Davies' application submitted on 21 December on the system. There is no evidence that they escalated the application or took any further action in response to his saying that he was suicidal.

29 – 31 December

70. On 29 December, a SO asked a mental health practitioner if she could see Mr Davies as he was behaving bizarrely. He was invading people's personal space and staff believed he was being bullied.

71. At 11.40am, the mental health practitioner opened an ACCT after Mr Davies said he felt suicidal, was struggling to cope and started crying loudly. He said he was hearing voices telling him to harm himself and he felt like a piece of jelly in prison thinking someone may harm him. A SO completed the Immediate Action Plan straight after the mental health practitioner's conversation. She directed that staff should check Mr Davies at least once an hour.

72. At 10.20am on 30 December, a SO carried out the ACCT assessment. He recorded that Mr Davies was low, confused and scared. He reported voices telling him he was worthless. Mr Davies said he was not currently on medication but had been prescribed Amitriptyline in the community. He said he suffered from Post Traumatic Stress Disorder after an assault when he was 14. Mr Davies mentioned that he potentially had learning difficulties. Mr Davies seemed distant and as if he could not comprehend what was happening to him. He said he had never tried to harm or kill himself before. Mr Davies discussed future plans in terms of going to a hostel when he was released. He said that he wanted to speak to his father but had no contact details for him or anyone else. The SO thought that Mr Davies would benefit from a move to the Wellbeing Unit on houseblock four and a mental health assessment.

73. At 10:30am that day, a SO chaired the first ACCT review. Another SO, a mental health practitioner and Mr Davies attended. Mr Davies was polite throughout the review and engaged well but struggled at times to make eye contact. The reviewers asked Mr Davies about the voices he had said he was hearing. He said the voices told him he was worthless, and he felt a shell of his former self. He asked for support to help him feel himself again.

74. Mr Davies talked about his father and how sorry he was for what he had done to him. He wanted to be able to apologise but understood he could not contact him because of the court case. Mr Davies said he was due back in court in January and wanted it over and done with. He told the group that he had PTSD due to being assaulted in 1994. He said he was randomly attacked, and this had made him frightened and scared while in prison. They tried to assure him he was safe.

75. The SO's case review note also said that the mental health practitioner was going to make a GP appointment for Mr Davies to discuss medication. She added this to Mr Davies' care plan. Mr Davies denied any history of problematic drug or alcohol use.

76. The mental health practitioner said he would ask the chaplaincy team if they could provide some counselling to support him with his past, and Mr Davies was happy with this.

77. The SO noted that they discussed the Wellbeing Unit on houseblock four and how they all felt it would benefit him. The Wellbeing Unit provides group rooms for activities and is one of the locations for prisoners on the Wellbeing Pathway. (The Pathway provides prisoners with the opportunity to engage in meaningful interventions and activities.) Mr Davies was willing to move to the unit.

78. Mr Davies denied any thoughts of suicide or self-harm. He said he cut himself years ago and showed the staff a small scar on his arm. He said he had never attempted to kill himself and had no plans to. The SO believed him and did not challenge him.

79. The SO recorded that Mr Davies appeared frightened during the review. He said he was struggling with a few things that he needed support with, so all agreed to keep the ACCT open. Observations were kept as hourly with two conversations per day. The next review was set for 4 January 2023.

80. The SO recorded the following care plan actions: 'Move to HB4 Wellbeing Unit', (which was signed off that day by another SO) and 'see a GP regarding medication. Mental health practitioner to organise'. The mental health practitioner had made a GP appointment for 3 January and Mr Davies moved to a single cell in the Wellbeing Unit that day.

81. On 31 December, Mr Davies' mother sent two emails – one saying she had received his letter and was pleased and one referring to an email she said she sent on 21 December and that she hoped he received it. She wrote that she would put money in his account. Because of the process at Hewell for printing and delivering emails to prisoners it is not clear if Mr Davies saw these emails.

82. Records of conversations and observations in the ACCT book that day reveal Mr Davies still seemed down about his situation and did not feel he belonged on the unit, but an officer noted he was seen playing pool with other prisoners.

83. At 5.10pm, Officer A completed an ACCT check. Mr Davies was on his bed watching television. They did not have a conversation, but she did not have any concerns.

The emergency response

84. At 6.10pm, Officer A attempted to complete another ACCT check. She got no response when she knocked on his door and called Mr Davies' name. She could not see in the cell as it was dark, and she did not have a torch. A prisoner in the next cell told her that Mr Davies was in there.

85. Officer A radioed Officer B and told her Mr Davies was not responding. Officer B told her to call a Custodial Manager (CM). The CM told two SOs to go to Mr Davies' cell. In the meantime, Officer B went to the cell and tried to get a response from Mr Davies.

86. The night light outside Mr Davies' cell did not work, but Officer B thought that she could see a foot in a strange position to one side of cell. At 6.12pm, Officer A asked for permission to enter the cell and radioed a code blue (indicating a prisoner is unconscious or is having breathing difficulties). The control room staff called for an ambulance straightaway.

87. The CM gave permission for the officers to enter the cell and Officer B went in first. Mr Davies was hanging by a ligature made from a bed sheet in the door recess. Officer B held Mr Davies and Officer A cut the ligature, which was attached to the door. Officer B then removed the ligature from around Mr Davies' neck. She started CPR.

88. A SO arrived at the cell, followed by an officer and another SO. They assisted with CPR.

89. A prison paramedic, a nurse and a healthcare assistant attended and also assisted with CPR. Healthcare staff attached a defibrillator, but it did not advise they administer shocks.

90. At 6.26pm, the first ambulance arrived at the prison and the staff were at the cell by 6.33pm. They took over resuscitation attempts and continued for 20 minutes.

91. At 6.58pm, a doctor confirmed that Mr Davies had died.

Contact with Mr Davies' family

92. Mr Davies' family lived a long way from the prison and staff thought the local police would be able to break the news of his death more quickly than asking another prison to do so, given it was New Year's Eve. The police informed Mr Davies' family of his death on the evening of 31 December. On 2 January, the prison appointed a family liaison officer. She made contact with the family to offer support and advice.

93. The prison offered a contribution towards the cost of the funeral in line with national guidance.

Support for prisoners and staff

94. After Mr Davies' death, a 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.

95. 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

96. The post-mortem report concluded that the cause of Mr Davies' death was hanging. The toxicology tests did not find any evidence of drugs, alcohol or prescription medication.

Findings

Assessment of risk in Reception and on Induction Unit

97. Prison Service Instruction (PSI) 64/2011, *Management of prisoners at risk of harm to self, to others and from others (Safer Custody),* contains national requirements on the assessment and management of suicide and self-harm risks in prisons. The instruction lists risk factors and potential triggers that staff should be alert to and act appropriately to address. Any prisoner identified as at risk of suicide and self-harm must be managed under ACCT procedures.

98. No one started ACCT procedures for Mr Davies when he arrived at Hewell on 20 October 2022, despite him having markers for suicide and self-harm risk and having been constantly monitored by CCTV at some point either in police or court custody. There is no evidence that any of the staff who saw Mr Davies when he arrived at the prison considered the information about his risk or whether he needed the support of ACCT procedures. We acknowledge that it was just over two months before Mr Davies took his life, but this demonstrates poor reception screening by staff at Hewell.

99. We have raised concerns about reception practices, including the actions of the reception nurse, in a previous investigation at Hewell. The interim Head of Healthcare was unable to answer why, despite an action plan response setting out how improvements to healthcare reception processes would be made, similar issues had arisen in this investigation. However, she said that healthcare staff in reception were able to access the digital PER.

100. We are not confident that current reception practices at Hewell are effective in identifying prisoners at risk of suicide and self-harm. We make the following recommendations:

The Head of Healthcare should check and ensure that all staff, including agency staff, have been trained to access the digital Person Escort Record.

The Governor and Head of Healthcare should examine Reception practices and devise a plan to ensure that all relevant staff read and appropriately respond to information contained in Person Escort Records when processing prisoners.

ACCT

101. On 29 December, a SO appropriately alerted a mental health practitioner to Mr Davies' apparently deteriorating mental state. Staff held a case review quickly with representatives from mental health and reasonable case review actions detailing a move to The Wellbeing Unit and seeing a GP about medication were set. Hourly observations with two meaningful conversations also seem reasonable and we make no recommendations.

102. Mr Davies was moved to a single cell on the Wellbeing Unit. We have considered whether this was appropriate given that sharing a cell is recognised to be beneficial to prisoners at risk of suicide and self-harm. Staff involved in the decision could not

say whether they had considered whether Mr Davies should be placed in a shared cell. However, the landing on the Wellbeing Unit he was moved to only had single cells. Staff felt Mr Davies would benefit from being on the Wellbeing Unit and we consider that this move was in his best interests and, given he had struggled to share a cell with two previous cellmates, outweighed the potential benefits of sharing a cell.

Mental health care

103. The clinical reviewer concluded that the care Mr Davies received for his physical health was equivalent to what he could have expected to receive in the community. She did not, however, consider that his mental health care reached that standard.

104. The Deputy Director for NHS England Midlands region has provided expert opinion on elements of Mr Davies' care. She reviewed a prison GP's initial decision not to prescribe Mr Davies antidepressants until he had been seen by a GP at the prison. She considered this action was reasonable, but that the review should have happened within a couple of days.

105. Despite the prison GP's subsequent task, those sent by pharmacy staff and applications made by Mr Davies himself, Mr Davies never received a face-to face appointment to assess his medication requirements. Although antidepressants are not considered critical medications for immediate continuation, Mr Davies' applications gave a good indication of his escalating anxiety, included reference to his distress and thoughts of suicide and staff should have taken this into account.

106. The investigator asked the interim Head of Healthcare what had happened with each of Mr Davies' applications. She could not provide specific information. It is also not clear why appointments with a prison GP did not happen.

107. A process was in place to rebook missed appointments, but it was not followed. We are pleased that the process has since been improved to ensure booking clinicians take responsibility for further reviews after appointments are missed. In relation to the failure to prescribe Mr Davies relevant medication, we make the following recommendation:

The Head of Healthcare should ensure there is an efficient process in place for continuing to prescribe pre-detention medication.

108. Mr Davies was eventually allocated a mental health worker on 7 December. The worker was due to see him on 14 December but did not. At interview he said he had not had time to see Mr Davies before he started his Christmas leave. He rescheduled the appointment for 28 December. He did not see Mr Davies then either but when interviewed could not recall why. We understand he has since resigned. The mental health team has introduced a new policy so that if staff are on leave for more than one week, their cases are re-allocated. We make no recommendation.

Governor to Note

109. A SO was on duty when Mr Davies was received in the Induction Wing. She told the investigator she expected Reception staff to flag any concerns with her but that she

would not have opened an ACCT even if she had seen the PER. She was not able to adequately list SASH red flags. The investigator asked Safer Custody for comments on the SO's interview content, and they spoke to her further. They told the investigator they had spoken to her and supplied the list of features she then considered to be risk factors which was comprehensive. The Governor may wish to consider whether her initial unfamiliarity with key risks and triggers for suicide and self-harm is indicative of a wider issue at Hewell.

Inquest

110. The Coroner's inquest was held from 30 September to 11 October 2024. It concluded that Mr Davies' death was by suicide and that neglect was a contributory factor.

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