Investigation into the death of a man whilst in the custody of HMP Gartree in October 2010

Report by the Prisons and Probation Ombudsman for England and Wales

January 2012

This is the report of an investigation into the circumstances of the death of the man, a prisoner at HMP Gartree. He was found in his cell with an apparently self-inflicted wound on his neck. I would like to offer my sympathy and condolences to his family and friends for their loss. I am sorry that my report has been delayed and apologise for the distress which this may have caused.

The investigation was carried out on my behalf by my colleague. I would like to thank the Governor of Gartree and his staff for their co-operation during the course of our enquiries.

Leicestershire County & Rutland Primary Care Trust (PCT) was commissioned to conduct a clinical review into the standard of healthcare the man received whilst in custody at HMP Gartree. The PCT appointed the clinical reviewer. I would like to thank him for his review.

The man came into prison experiencing drug problems, and with a number of physical problems associated with old injuries. He was a popular prisoner with staff and peers alike. However, it seems that he was frustrated by his prison sentence and, although keen to undertake his offending behaviour course, found it challenging. From 2009 onwards, he began to exhibit unusual behaviour which was treated with anti-psychotic medication. However, despite being on the waiting list, he did not see a psychiatrist until he cut his wrist on 5 September 2010. He was subject to suicide monitoring procedures and I am pleased to see the range of staff involved in his care. However, he took his life shortly after the monitoring procedures came to an end.

I am concerned by the management of his psychiatric care and aspects of the suicide monitoring procedures and I make related recommendations. However, I am satisfied that staff sought to protect him as best they could.

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

Thea Walton
Deputy Ombudsman **January 2012**

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SUMMARY

1. The man entered HMP Nottingham on 21 October 2004, having been charged with a serious offence. When he arrived at prison, he was assessed as suffering from a drug dependency problem. He was prescribed detoxification medication which resolved his opiate usage. The man also suffered from pain caused by a number of historical injuries. Throughout his time in custody, he frequently sought to manage his pain using different medication either on prescription or illicitly from other prisoners.

2. The man transferred to HMP Gartree on 14 September 2006. He settled in and began to address his offending behaviour. In early 2009, he began to complain of feeling stressed and hearing voices. Staff initially thought that this was a result of the pressure of undertaking the offending behaviour courses.

3. By August, his symptoms had increased and the mental health nurse reviewing him made a referral to a psychiatrist. The nurse also suggested that, until the man could be assessed by a psychiatrist, he should be prescribed Olanzapine (an anti-psychotic drug) to manage his symptoms. Following the nurse's recommendation, Olanzapine was prescribed by a prison GP under the assumption that it would go on to be reviewed by a psychiatrist. However, he did not see a psychiatrist until he harmed himself in September 2010. Until then, he continued to be prescribed Olanzapine, and was regularly reviewed by the mental health team.

4. The man was found in his cell on 5 September having cut himself badly on his arm. He was taken to hospital and treated. Upon his return, suicide and self-harm monitoring procedures were begun, and he was under the constant supervision of a member of staff, 24 hours a day. He told staff that he had harmed himself for a number of reasons, including the stress of his course. He complained of hearing voices and was afraid of people coming into his cell and harming him. The prison investigated but found no evidence that his fears were grounded in reality.

5. A range of staff were involved in the care of the man at this time, and there were regular reviews to determine the best way to support him. Constant supervision was gradually reduced to intermittent checks, and he slowly returned to his wing for short spells. Although keen to continue his course, it was decided to reintegrate the man slowly into the course through one-to-one sessions. Suicide prevention measures were ended on 28 September.

6. Although the man was described as seeming quite positive in early October, he was found early in the morning on 10 October in his cell with a deep wound to his neck. The nurse on duty tried to resuscitate him, but the paramedics judged that he had died. Following the man's death, the prison broke the news to his family, who visited the prison, and

accepted the Governor’s offer to contribute to the cost of the funeral. His property was then returned to his family.

7. I make 11 recommendations regarding healthcare and some aspects of the suicide monitoring procedures. I also identify several examples of good practice.

THE INVESTIGATION PROCESS

8. I appointed one of my investigators to undertake the investigation into the man's death. The investigator and a colleague opened the investigation at HMP Gartree on 15 October 2010. They met senior prison managers and took copies of the documentation relating to the man. Notices of the investigation were issued to staff and prisoners, inviting those who wished to provide information regarding his death to make themselves known to the investigator. No-one came forward with regard to the notices.

9. The investigator wrote to the Chief Executive of Leicestershire County & Rutland Primary Care Trust (PCT) to commission a clinical reviewer. Leicestershire County & Rutland PCT asked the clinical reviewer to carry out a review of the care received by the man whilst at HMP Gartree. They also arranged for the Head of Forensic Services at Northamptonshire Healthcare NHS Foundation Trust, to assist the clinical reviewer by providing mental health expertise. The clinical reviewer received a copy of the relevant medical documents upon which he based his findings. The clinical review was delayed by the need to speak to a number of individuals.

10. One of my Family Liaison Officers (FLOs) contacted the man's family at the beginning of the investigation. He explained the investigation process and offered the opportunity to raise any questions or concerns they would like addressed. During this conversation, the man's sister asked the following questions:

    - How long was the man subject to suicide prevention measures?
    - What was the frequency of observations on the man during this time?
    - When did the suicide prevention measures end?

11. I trust that my report answers her questions, and provides further information about the man's time in custody. The man's family did not provide any further feedback following the publication of the draft report.

12. The investigator, clinical reviewer and the Head of Forensic Services met on 18 November to discuss the emerging issues in the investigation. They visited the prison on 7 and 10 December and 13 January to interview staff and prisoners. The investigator provided verbal feedback to senior staff, and written feedback to the Governor on the progress of the investigation.

13. The National Offender Management Service (NOMS) responded to the draft report in December 2011. The response to each recommendation is included at the end of the report, and reference is made to additional comments made by NOMS in the report, where relevant.

HMP GARTREE

14. HMP Gartree is a Category B prison that accommodates life sentenced prisoners. Prison Service Order (PSO) 0900 (Categorisation and Allocation) explains the reason for categorising prisoners:

> *"Prisoners must be categorised objectively according to the likelihood that they will seek to escape and the risk that they would pose should they do so*."

15. Category B prisoners are defined in the PSO as:

> "Prisoners for whom the very highest conditions of security are not necessary, but for whom escape must be made very difficult."

Her Majesty's Chief Inspector of Prisons

16. Her Majesty's Deputy Chief Inspector made a full announced inspection of Gartree between 10 and 14 May 2010. In the foreword of the report, the Deputy Chief Inspector said:

> "Gartree has improved considerably since our last visit. It now has a more settled population of life-sentenced prisoners, and our previous concerns over safety have largely been assuaged. Relationships between staff and prisoners remained generally good, although minority groups had more negative perceptions of the prison."

17. With regard to suicide and self-harm the report said:

> "There were low levels of self-harm, with around four incidents a month involving two to three prisoners and, we were told, no near-fatal incidents in recent years. On average, eight ACCT [that is the prison's suicide monitoring procedures which I describe overleaf] documents were opened each month. Only one was open during the inspection. The prisoner involved, who was waiting for transfer to a specialist mental health unit, spoke positively about the help he had been given."

18. However the report did acknowledge some concern with the range of staff involved in some of the reviews. The section on healthcare said:

> "The governor provided strong leadership and support to the health care team and was active in the development of health services. A new building due to open in June 2010 would provide much improved facilities. Primary care services were satisfactory and included a good GP service, life-long conditions management and visiting specialists. Mental health services were very good, with effective joint working between the primary and secondary mental health teams. The primary mental health team was led by a senior registered mental nurse (RMN) with a mixture of RMNs and health care officers who were also RMNs."

Independent Monitoring Board (IMB)

19. Each prison is monitored by an Independent Monitoring Board (IMB), members of which are drawn from the local community. They have full access to prisoners and every part of the establishment. In its latest annual report, covering the year ending 30 November 2009, Gartree's IMB said: "The Board is well aware that the prison is served by a very able Healthcare team." However, they raised concerns about the dental service:

> "The present two sessions per week by the Dentist and Nurse and one by the Hygienist, are proving woefully inadequate for nearly 700 prisoners. However emergencies are usually seen within one week. Otherwise prisoners can wait for 50 weeks for a non urgent appointment."

20. The report said, with regard to suicide and self harm:

> "During the year 99 ACCT documents were opened, sometimes several for the same prisoner. All documents are now quality assessed and with the exception of some small minor short comings are of a generally high standard."

Mental health provision

21. Responsibility for mental health treatment at Gartree passed from Leicestershire Partnership Trust to Northamptonshire Healthcare NHS Foundation Trust on 1 April 2010.

Assessment, Care in Custody and Treatment

22. Assessment, Care in Custody and Treatment (ACCT) is a care planning tool used by prisons to help support and monitor those prisoners

identified as being at risk of suicide or self harm. The ACCT is a multidisciplinary process that encourages staff to work together to provide individual care to prisoners in distress and help to diffuse circumstances where self harm or suicide may occur.

Personal officer scheme

23. Each prisoner is assigned a personal officer who acts as a point of contact should they need help. This officer is required to have regular conversations with the prisoner and record these interactions.

Offending Behaviour Programmes

24. The prison provides programmes to help prisoners to address their problems. They include Enhanced Thinking Skills (ETS), (a general offending behaviour programme exploring problem-solving skills) and the Cognitive Self-Change Programme (CSCP). (This programme targets high risk violent offenders and includes group and individual sessions. It equips prisoners with skills to help them control their violence and avoid reconviction.)

Incentives and earned privileges (IEP) scheme

25. The IEP system is intended to encourage and reward good behaviour in prison. Prison Service Order (PSO) 4000 describes it as follows:

> "The IEP scheme complements the discipline system by rewarding good behaviour. In addition to any local aims, it is intended to encourage prisoners and YOs [young offenders] to behave responsibly, to participate in constructive activity, and to progress through the system. This will foster a more disciplined and controlled, and therefore safer environment for prisoners and staff. It should also contribute to the reduction of re-offending by encouraging prisoners to lead law-abiding, productive and healthy lives."

26. Prisoners are able to move up a level (basic, standard or enhanced) and earn various privileges. Poor behaviour can result in moving down a level or losing privileges. Privileges include association time and extra visits.

Listener

27. A Listener is a prisoner trained by the Samaritans to provide emotional support to other prisoners. It is confidential, but is not a counselling service.

Previous deaths at Gartree

28. Since the Ombudsman was given responsibility for investigating all deaths in prison custody for England and Wales in April 2004, there have been four self-inflicted deaths at HMP Gartree (including that of the man). The first two deaths both involved periods of constant supervision. In the second case, the deceased died six weeks after ACCT procedures were ended by cutting his throat. There are no relevant similarities in the third death. The man's death was the first since May 2009.

KEY FINDINGS

29. The man was arrested and subsequently remanded into the custody of HMP Nottingham on 21 October 2004. Although he told staff that he had suffered from schizophrenia (a mental disorder), they checked with his GP in the community who confirmed that no mental illness had been diagnosed or treated. He was charged with a serious offence. He underwent drug detoxification treatment due to chronic drug usage prior to his arrest.

30. A psychiatric report was produced for the court in June 2005 which referred to childhood sexual abuse and a serious car accident at 14 which resulted in serious injury to his head. His problems with short term memory and severe alcohol and substance misuse were also noted. Nevertheless, he was deemed fit to appear in court, and the man was convicted and sentenced to life imprisonment with a minimum tariff of five years at Nottingham Crown Court on 1 July 2005.

31. While at Nottingham, the man received a number of written warnings which resulted in him being downgraded to the basic level on the incentives and earned privileges (IEP) system. There is no record of the man suffering any mental health problems, or being prescribed anti-psychotic medication, while at Nottingham.

32. The man transferred to HMP Gartree on 14 September 2006. He was referred to the mental health team on 18 September due to his memory problems and because he said that he had previously been diagnosed with schizophrenia. However, he was not assessed as suffering from any mental illness.

33. In April 2007, the man spent seven days in the segregation unit as a punishment for having unauthorised medication in his possession. At his sentence planning board that month, it was recommended that he undertake the Cognitive Self-Change Programme (CSCP). (This programme targets high risk violent offenders and includes group and individual sessions. It aims to equip prisoners with skills to help them control their violence and avoid reconviction.)

34. The man suffered from two bereavements in June and July 2007. He was seen by several members of the healthcare team and chaplaincy who explained the support available. Healthcare staff prescribed short-term sedation medication to help him sleep.

35. In May 2008, the man began the Enhanced Thinking Skills course (ETS) (a general offending behaviour programme exploring problem-solving skills). He was granted enhanced status on the IEP scheme at the end of the month. The man completed the ETS course on 18 June. In his post-programme report, it was written that he engaged well with the course. It suggested that he would benefit from increasing his

awareness of the consequences of his actions and controlling his impulses.

36. The man referred himself to the CARATs team on 9 December. (CARATs stands for Counselling, Assessment, Referral, Advice and Throughcare, and the team works with prisoners with drug problems.) Due to staff sickness and the Christmas period, he did not meet the member from the CARATs team until 15 January 2009. He told her that he had last used drugs in Nottingham prison in September 2006. She undertook the Comprehensive Substance Misuse Assessment with him on 10 February. He then told her that, since he used drugs in Nottingham, he had taken some heroin in December 2007.

37. The member from the CARATs team recorded in his CARATs file that the man was mentally struggling. She referred him to the mental health department and healthcare department as he complained of suffering pain related to the car crash in his youth. He claimed to have been diagnosed as a borderline schizophrenic at the age of ten or 11, but had not been prescribed any medication. A mental health nurse attempted to see him but he was unavailable. However, on the basis of good reports from his workshop instructor, it was decided that no further intervention was needed.

38. The man was also referred for the STOP (Straight Thinking on Probation) programme on 12 February. This course aims to cover elements such as problem solving, social skills and management of emotions.

39. Prison staff referred the man to the mental health team on 8 June, as he had complained of feeling low and hearing voices. He was seen four days later by Registered Mental Health Nurse A. He told the nurse that he felt stressed because of pain related to historical injuries, and was hearing voices. The man was referred for a further mental health assessment, and wing staff were asked to observe his sleeping patterns. Nurse A explained that he would agree with each prisoner on his caseload how often they would meet.

40. The man completed the STOP programme on 18 June. He received positive feedback regarding his involvement, including the group discussions and his written work. On 29 June, it was recorded in his CARATs file that he complained of hearing voices. He was told that it could be stress-related as the STOP course had made him address some difficult issues. He was referred again to the mental health team in late June by the prison GP as he was hearing voices but, when seen, the mental health nurse again attributed it to stress. A follow-up appointment was arranged for four weeks time.

41. He underwent a further mental health review on 29 July with Nurse B where he spoke further of hearing voices. The meeting ended abruptly due to a fire alarm, but further assessment from a psychiatrist and GP was recommended. (Nurse A told my investigator that he thought he

must have been unavailable on this date. In order to ensure continuity of care, the man would have continued to see Nurse A had he been available.)

42. Having been referred by a prison GP, the man was seen in a hospital headache clinic on 18 August, where the hospital prescribed him Nortriptyline.

43. The man saw Nurse A for his monthly check-up at the end of August, when he disclosed that the voices were becoming more intense and telling him to harm other people. The nurse referred him to a psychiatrist. He explained to my investigator that the man needed more expert input as his symptoms were increasing and required further assessment. The mental health team were responsible for adding prisoners to the psychiatrist's waiting list and would be seen in the order in which they were listed unless there was a reason to prioritise the appointment. My investigator was told that that there might have been some time before he would have been able to see a psychiatrist.

44. Nurse A noted in the man's medical record that he suggested a prescription of Olanzapine until he saw a psychiatrist. He also noted that the man said that he had previously been taking the same medication although the nurse had no access to earlier records and could not verify the information.

45. Nurse A explained to my investigator that Olanzapine could help control the symptoms, and provide some assistance in sleeping. On 1 September, Prison Dr A prescribed 10mg of Olanzapine once a day, and again referred him to the psychiatrist.

46. On 18 September, Prison Dr B recorded in the man's medical record that the prison was unable to dispense Nortryptilene (an anti-depressant medication) for headaches due to security reasons and was writing to the specialist to determine an alternative. (The man suffered from headaches related to his historical head injury.) Two days later, Officer A noted in the man's records that he was frustrated that the prison would not prescribe the Nortryptilene as recommended by the hospital. The officer helped the man complete a formal complaint regarding the matter.

47. According to the prison records, the man was scheduled to see the psychiatrist on 7 October following the two referrals made more than month earlier. However, this appointment did not take place. (It was unclear exactly why he had been unable to see a psychiatrist, but staff told my investigator that it might have been because the preceding appointment overran.) The man was placed back on the waiting list, but was not listed as a priority.

48. On 8 October, Nurse A reviewed the man's symptoms. The man said that he had improved somewhat since being prescribed Olanzapine, but still suffered from headaches and tiredness. He said that he would like to be

reviewed by a psychiatrist. The nurse confirmed to my investigator that the man was on the waiting list to see a psychiatrist at this point.

49. The next day, the man told his CARATs worker that the medication provided by the healthcare department was insufficient. The same day, on the advice of the hospital, Prison Dr B prescribed Propanolol to treat his headaches. On 16 November, the doctor reviewed the man's medication and, as he did not tolerate Propanalol, advised him to use paracetamol to control his pain. On 3 December, Prison Dr C added Diclofenac (pain relief) and lansoprazole (stomach problems) to his prescription.

50. The man finished the pre-programme CSCP session (Cognitive Self Change Programme) on 9 December and then attended a pre-course group session for the programme.

51. The substance misuse work with the CARATs team came to an end on 29 January 2010. On 8 February, the man undertook an interview regarding the CSCP. Entitled the 'assessment protocol for treatment readiness and responsivity interview', the man replied in response to question 37:

> "Do you anticipate that participating in the CSCP will result in having to deal with difficult emotions?"
> "Yeah, because I've forgot a lot of what's happened."

52. On 25 February, the man was referred to the CARATs team as he had failed a voluntary drug test (VDT).

53. Responsibility for mental health services passed to Northamptonshire Healthcare NHS Foundation Trust on 1 March. The man had a further mental health review with Nurse A on 2 March. He asked for an increase in his medication as he was hearing the voices more, which he said was distracting. He said that he had lost his job as a wing cleaner because he had taken medication from another prisoner to treat the pain which he was experiencing. The nurse referred him to the GP because of his pain, and to the psychiatrist regarding his prescription of Olanzapine.

54. The man saw his CARATs worker again on 1 April because he had taken other prisoners' medication. He said that he had done so because healthcare had not given him the correct medication. He admitted that he had done this a few times over the last two months. On 14 April, the man failed a mandatory drugs test (MDT) again because he had taken another prisoner's medication.

55. An assessment report for CSCP was written in April by a Forensic Psychologist in Training. The CSCP psychologists contacted the mental health team to confirm that the man was fit to undertake the course. Nurse C and Nurse A confirmed that the prescription for Olanzapine was

a relatively low dose and should not preclude the man from undertaking the CSCP course.

56. A further mental health review was held on 4 May with Nurse A. The man was reported to feel well, despite voices telling him to kill someone. He did not want his Olanzapine medication to be changed. They discussed the forthcoming CSCP and the issues that it could bring up. The man was recorded to be keen to undertake the course, and Nurse A offered him support to do so. He began the CSCP on 21 May.

57. Nothing further of note is in the man's record until August.

58. The man saw a nurse on 9 August, as he had broken a tooth. He was given an appointment to see the dentist. It was recorded in his medical record on 31 August that he had been prescribed paracetamol and brufen for his toothache, and remained on the list to see the dentist.

59. At approximately 5.30pm on 5 September, the man cut his right wrist with a razor blade and proceeded to squeeze blood out of the wound. He was found by the night staff slumped over the toilet when they performed their checks. (The note in the medical record is timed at 11.06pm.) There was a lot of blood in the cell, and healthcare staff were called. The man was placed in the recovery position and given oxygen. The paramedics took approximately 30 minutes to reach the man, after which he was taken to hospital. He was discharged from hospital in the early morning of 6 September, and returned to the prison with seven stitches. ACCT procedures were begun and the man was referred for a mental health assessment. He had still not been assessed by a psychiatrist, over a year after his first referral.

60. Healthcare staff were called to the wing at approximately 9.30am as the man had collapsed while walking to the healthcare centre. Nurse D recorded that the man was pale, with a blood pressure of 118/70. (This is a low reading. 130/80 is the optimal average blood pressure reading.) The nurse asked a prison doctor to review the man. Nurse E recorded, when she saw the man later that morning he said that he had been feeling low, and matters had "come to a head". He said the course was a factor as he felt he was struggling with it, and also said that he had pain in his back. However, it was recorded that he also said that he felt better and was not intending to harm himself again.

61. The ACCT assessment interview was undertaken by a psychologist, at 4.10pm. She said that there seemed to be many factors involved in his actions, rather than one single trigger. She recalled of the meeting:

> "I think my impression from the assessment was that I didn't really know what was behissnd it [cutting his wrist]. He came across as quite confused and quite bizarre. He talked about people on the wing talking about him. He talked about people questioning previous sexual offences that he didn't have but he thought that

people thought he had so he certainly did mention CSCP but it was among a list of other factors as far as I remember."

62. The first ACCT case review occurred after the assessment interview. Wing staff, psychology, safer custody and healthcare departments were all represented. The man said that his mood was very low, and acknowledged that he might be paranoid. He wanted to know if A wing prisoners would accept him back on the wing as he was concerned that his actions may have changed their view of him.

63. Wing staff called the healthcare department at approximately 7.20am the following morning to report that the man had reopened his wound. It was thought that the wounds would need re-stitching in an outside hospital, but instead sutures were applied in the healthcare department. He was reviewed by Prison Dr A, in the company of Nurse E and a prison officer. The doctor recorded in the man's file that he said that he had reopened the wound because of frustration about not receiving the correct analgesia for his back pain. He also stated that he found the CSCP demanding. The doctor recorded that the man appeared calm and well, and said that he did not have any current plans to harm himself again. The doctor decided that the man should be placed on constant supervision because he had harmed himself twice. (Constant supervision involves a member of staff sitting outside the cell and supporting the individual. They watch the prisoner at all times to witness and prevent any attempts to harm themselves.) He was also referred for a psychiatric review and to be reviewed regarding his back pain.

64. The man was taken to the constant supervision cell located in the therapeutic community above F wing. (Therapeutic communities provide a long term, residential, offending behaviour intervention for prisoners who have a range of offending behaviour risk areas, including emotional and psychological needs.) The man said that he had heard people shouting at him during the night, calling him a "bacon" (sex offender) and threatening to "have his jaw as a trophy".

65. At the morning case review on 7 September, the man was told that a referral had been made for him to see a psychiatrist. He said that he had not had his medication for two days and Nurse F noted in his medical record that she would investigate what had happened. A further case review was undertaken at 4.15pm, where the man said he: "feels better, having spoken to the psychologist about his pre-cons [previous convictions] and having drunk a lot of coffee". The psychologist told my investigator that she personally twice took the man a list of his convictions to show that no sexual convictions had been added. She said that this momentarily calmed him, but he became worried again. He said that there was no specific threat against him, but he still felt threatened.

66. Senior Officer (SO) A recalled seeing the man at the second ACCT review which was the first time they had met since he harmed himself:

> "He was a totally different man when I saw him. He obviously hadn't slept at all. You could see it in him he'd struggled to sleep. He seemed very paranoid, very untrusting. He did seem very different. He seemed as if he had gone through something very traumatic, well, yes he did go through something very dramatic really, it was quite a serious incident that he went through but yes he was quite pale … he believed that people were out to get him and he felt as though people would be coming through his door and if he went to sleep someone would come through his door and get him."

67. SO A told my investigator that this potential threat and the man's worries that other prisoners were shouting about him were taken seriously by staff and Officer B, the violence reduction coordinator, looked into whether there was a genuine threat from other prisoners. When they asked the man about this, the SO recalled his response to my investigator:

> "He said 'no there's no one', he said 'there's no one, I just feel as though someone's going to do it'. He said 'no one's threatened me I just feel as though someone's after me' so there was no identifiable threat."

68. SO B, the initial ACCT case manager and SO for F wing, also recalled the man claiming to hear voices that did not appear to be there:

> "I think probably on two occasions I was playing darts with him and he said he'd heard things and I was in the room with him and just nothing there unless my hearing was very bad but that was a common theme, yes, he said he heard voices but there was no back-up for it I'm afraid."

69. SO B, as the ACCT case manager, was aware that the man was engaging with the mental health team.

70. On the morning of 8 September, whilst being supervised constantly by staff, the man broke his glasses in an attempt to use them to remove the stitches. His wound was cleaned and redressed. He underwent a further mental health review that afternoon with Nurse F. Concerns were raised about his ability to cope on CSCP although his tutors had reflected that he was managing the programme material well. He spoke of feeling paranoid and felt that he had let his peers down. He said that he had not slept for 11 nights due to paranoid thoughts and pain from his back, arm and teeth. Nurse F recorded that his regular medication had been reinstated. The man was still awaiting a psychiatric appointment.

71. Ongoing from 8 September was an email exchange between the Forensic Psychologist, CSCP Treatment Manager, and Nurse F. They discussed the man's ability to have a phased return to the CSCP, his motivation to

re-engage and reflections from the man about the impact of the programme and his realisation of the impact of his offending behaviour.

72. The man had a further ACCT review on 9 September where it was noted that he had made some progress, although he was still being supervised constantly. His risk of harming himself was still assessed as high.

73. He saw a covering psychiatrist who increased his prescription for Olanzapine to 7.5 milligrams. (This appointment took place over a year after the man was first referred to a psychiatrist.) The psychiatrist was not forensically trained, and the man was the first patient he saw that morning. The ACCT documentation was not available for the covering psychiatrist to review.

74. Nurse F explained to my investigator that the man needed to see a psychiatrist at this time as the self harm was thought to be "totally out of the blue". The nurse said that the man had not made an attempt in the past which raised concerns. Also, prior to the referral on 6 September, the nurse wanted to obtain a second opinion " for my peace of mind" as well as his benefit.

75. The man had daily ACCT reviews over the next few days where he disclosed that he thought about suicide when he woke up. (He was also seen daily by a member of the mental health in-reach team.) He said that he did not have the means to carry out these suicidal ideas, but would take his life if given the opportunity. He remained subject to constant supervision by staff. He had attempted to leave the constant supervision cell and return to the wing on 10 September, but had found it 'too hectic'. (SO A explained that it was a very busy time when he came back to the wing, and he found it too much to cope with.) His risk level of self harm remained high. (Risk levels are assessed as low, raised or high.)

76. The following day, the man had a visit from his brother. He said at the review that he was still thinking of killing himself in the mornings but had no method of doing it. However, he did say that he found the day became easier as it went on and he interacted with more people. His risk remained high and constant supervision continued. The SO recalled to my investigator his impressions of the man at this time:

> "I think I remember noting when I walked into the review and saw him I said wow you've got some colour back in your cheeks, you look as though you've had a good night's sleep and he said yes the sleepers as they call them are working, he's sleeping, he's getting fluids, he's getting some fuel inside him to get through the day and he said his sleeping's coming on, he said he's going to sleep and he's feeling physically a bit better in himself, stronger, but mentally he was still a bit, he was struggling a little bit still."

77. On 14 September, it was noted that the man had a visit from his mother and sister. Staff considered whether it was safe to reduce the level of ACCT checks from constant supervision to frequent but irregular observations. There were representatives at the review from the safer custody team, A wing, the mental health team and one of the constant supervision officers. No changes were made to his observation level at that point. At the review the following day, further good progress was noted although the man said that he still struggled at night and in the morning. It was decided to reduce constant watch during the day from 16 September. The review included staff from the psychology department, A wing and safer custody. He was to be subject to four observations per hour in the day, and then returned to constant supervision at night. At the review, he said that this had been helpful and he felt more settled as his concerns about his medication had been resolved.

78. A support plan was developed to help the man, and was included with his ACCT paperwork. SO C recalled this being developed in collaboration with the mental health team, psychology unit and himself to aid the man's return to the wing. It included giving the man a job with the cleaners on A wing to keep him busy on his return. Pain relief was given to the man for his dental pain. On 16 September, the man went to A wing in the day to clean it.

79. At his case review on 17 September, the man said that things were going well on a wing and he had received good support from other prisoners. SO A said to my investigator that staff were surprised by the number of prisoners who came to ask about the man, and wanted to go and see him. However, he did not want to return to the wing full-time as he still felt low in the mornings. His risk level was reduced from high to raised.

80. The man said at the ACCT review on 19 September that he felt that his return to the wing had helped him. He asked for the ACCT observations to be reduced to one an hour. His level of risk was reduced to low. He thought that he was now back to full health. He said at a subsequent ACCT review on 21 September that the CSCP programme had been the trigger for his low mood. Present at this review were representatives from the mental health team, psychology department and wing staff. The man felt positive and suggested the ACCT procedures should be closed, but it was decided to keep it open for another week. The psychologist explained that the way forward with the CSCP course would be initial one-to-one meetings, and the man was content with this approach.

81. The note of the meeting in the ACCT document said:

> "We spoke about the man's current state of mental health. He feels positive and suggested the document should be closed. The psychologist discussed the way forward regarding CSCP and an initial one to one being arranged. The man was

supportive with this. The Forensic Psychologist in Training highlighted his ability to identify his triggers and his positive attitude; agreed that meds [medication] could be issued on a weekly basis. … the obs [observations] were lowered to three obs per day and three obs per night."

82. In interview for this investigation, Nurse F recalled the man's attitude at that review:

> "I remember that as time was progressing he was becoming more positive and wanting things to return to normality. He was getting a lot of support from his peers … He was back on A wing and he'd had a job as a cleaner on the wing just for a bit of further support and he was quite keen to move back to the workshops and resume his usual employment."

83. SO C said, during interview, that he was unable to arrange for everyone he wanted to come to the next ACCT review on 28 September. Only SO C, Officer C and the man were present. At the review, the man was described as 'far more settled'. He said that he had spent a good week with positive contact with his family. In interview, the SO described the review:

> " … we reviewed all aspects of his care map; we analysed the reasons for his acts of self-harm and the man was far more settled. He had a really good week on the wing, he was sleeping, he said he was sleeping really well, he was working well and he'd had some positive contact with his family. And it was decided by all of us … there was no need for the document to remain open anymore."

84. The ACCT procedures were therefore closed on 28 September, having been in place for three weeks.

85. Later the same day, Nurse F noted in the man's medical record that the man was receiving good support on the wing and coping well. The nurse decided to review the man's contact with the mental health in-reach team in two weeks with a view to discharging him from their caseload.

86. On 30 September, a one-to-one CSCP session was held to check on the man. He said that he was coping but was worried about his peers' views of him. He was unsure about rejoining the group as he thought that hearing other prisoners talk about violence was not relevant to him. They decided to schedule another one-to-one session.

87. A post-closure ACCT interview was held on 5 October involving SO C and another member of the wing staff. The SO said that, although the man seemed more positive, there were still things that needed attention. He was still waiting to return to the workshop, waiting for his parole

paperwork from his solicitor and needed to send out some visiting orders to his family. A further post-closure interview was therefore scheduled for 13 October. Overall, SO C said that, at the 5 October review, the man was not going to harm himself again. There did not seem to be any major concerns and he seemed to be quite positive.

88. A further one-to-one CSCP session was held on 6 October by Officer D, a facilitator for the programme. (The officer told my investigator that the man had been engaging well with the programme prior to 5 September, and he had no concerns that he might harm himself again.) The officer described the purpose of this meeting to my investigator:

> " … it was just to see how he was fitting in, how he was getting on. It's like a fact finding to see how he's settling in, what sort of support he's having, what's he engaging with and sort of like just to do, we didn't do much stuff to do with his offending, but just to sort of touch on some of the skills that we used so he didn't lose it. So if he did come back he's not rusty basically."

89. Officer D explained that this was not the usual process if someone dropped out of the course, but it was decided that one-to-one meetings were the best way to continue to engage with The man:

> " … it was a slow building back up to see, I presume it was to see if he could re-engage in the programme on a full–time basis but they weren't going to put him in and we weren't going to talk about his violence and stuff, it was just to slowly bring him back."

90. Officer D and the man discussed the support which was available to him. The officer recalled to my investigator that the man seemed reasonably positive as he had spoken to his solicitor and had applied for a new job. The officer's overall impression was that the man was keen to rejoin the CSCP group. The officer also said to my investigator that he thought it was positive that, during their conversation, the man spoke about his future plans:

> "He's talked about things that he's currently engaged with and he's been trying to get some things sorted out. So to me that was, again to me, it was like positive kind of things he was talking about."

91. According to Officer D the intention was for the man to continue having weekly one-to-one sessions with a CSCP facilitator until it was decided that he was capable of safely rejoining the wider group. However, the man died before the officer saw him again and this could happen.

92. The next day, whilst on the wing, the man asked a member of the mental health in-reach team about his glasses that he had broken. He was advised that they were irreparable and he was referred for an eye test.

The man was scheduled to meet the in-reach team on 10 October for a follow-up appointment.

10 October

93. At approximately 5.00am on 10 October, 12 days after the ACCT procedures were closed, the Night Operational Support Grade looked into the man's cell when conducting her morning roll check. She saw the man lying on the floor, and believed that she could see blood in the cell. She alerted the Night Orderly Officer, who immediately asked the communications room to send a message asking the assistant night orderly officers and the healthcare staff to come to the cell.

94. Nurse D said that he heard a message over the radio saying "urgent message – healthcare required." He collected his emergency equipment (including an ambu-bag, defibrillator and oxygen) and went to the end of the corridor to be met by the Night Orderly Officer. At night the nurse is locked behind double gates in the healthcare centre and does not carry keys. Therefore, if needed in the prison, the nurse has to be escorted there by staff carrying keys. (Defibrillators deliver a brief electric shock to the heart, which can enable the heart's natural pacemaker to regain control and establish a normal heart rhythm.)

95. The communications officer then called the duty governor, at home to ask his permission for the staff to enter the cell. He granted this request. The cell was opened. Nurse D went into the cell first and was immediately aware of blood on the blanket that the man was lying on. The nurse turned round and asked for an ambulance to be called. He told my investigator that he examined the man who felt cold to the touch. The nurse checked for a pulse (there was none) and removed a ligature from around the man's neck. Having covered a wound in the man' neck with gauze, the nurse began cardio pulmonary resuscitation (CPR). He also applied the defibrillator but there was no shockable rhythm in the man's heart at any point. The nurse recalled that he continued CPR for approximately 45 minutes until the paramedics arrived. When the paramedics arrived they confirmed that the man had died and CPR was stopped at 5.56am.

96. The care team was available for staff who wished to speak to them. Nurse D told my investigator that he was offered the chance to stay off work the next day, but he said that he wanted to get back to work as normal. A hot debrief was undertaken in the morning with the staff involved. (This is a meeting of all the staff who were involved in finding and attempting to resuscitate the prisoner. The meeting should focus on reassurance, information sharing and how staff can support each other.) A critical incident debrief was undertaken a week later.

97. Support was also available to prisoners, and the chaplain led a service that afternoon for prisoners to attend should they have wished to.

Liaison with the man’s family

98. The officer appointed as the prison’s family liaison officer travelled to Nottingham with the reverend to break the news to the man’s family. The officer returned two days with the duty governor to discuss funeral arrangements.

99. The man’s family visited the prison on 21 October. They went on to the wing where the man had lived, spoke to staff and spent time in his cell. The prison’s family liaison officer arranged for them to spend time with some of the man’s friends. She gave the family flowers on behalf of the Governor and staff, and also a plaque for the man's grave that the prisoners had made.

100. The prison contributed to the cost of the funeral and the chaplain conducted the service. The prison’s family liaison officer and the duty governor attended the funeral. They later visited the man’s family to return his property to them. I understand that the family sent a letter of thanks to the prison, and I am pleased that the prison was able to support them at such a difficult time.

ISSUES

Referrals to the mental health team

101. The man began exhibiting concerning behaviour in 2009, and was referred to the mental health team for assessment. However, staff initially judged the symptoms to be the result of stress. The clinical reviewer writes of this in the clinical review:

> "Many of the symptoms that the man complained of were too easily attributed to stress relating to his CSCP course. It may be true that the course was causing him some genuine stress but stress is also a risk factor for developing more serious illness."

102. The clinical reviewer makes a recommendation concerning training for mental health nurses regarding psychotic illness that I encourage the Head of Healthcare to consider. In their response to the draft report, NOMS wrote that:

> "We reject the belief that training for mental health nurses regarding psychotic illness is required. There is considerable specialist expertise with both the Primary Mental Health and In-reach teams to offer all prisoners specific assessment, input, and treatment options when presenting with a psychotic illness."

Referrals for a psychiatric assessment

103. At a mental health meeting at the end of August 2009, Nurse A recommended that the man should be prescribed Olanzapine (an anti-psychotic medication) by the GP until he could see a psychiatrist. The nurse explained to my investigator that the man had told him that he had taken Olanzapine previously. The nurse suggested that Olanzapine might help control the man' symptoms and help him sleep. He explained that the wait to see a psychiatrist could be a few weeks so the prescription would benefit the man in the meantime.

104. However, the man did not see a psychiatrist until September 2010, over a year later. My investigator was told that there was a long waiting list and those who were not deemed to need urgent attention had to wait for their appointment, which could take some time. It is disappointing to learn that prisoners were waiting such a long time to see a psychiatrist. However, I understand that since the transfer of mental health functions, the position has improved and more psychiatric appointments are available for prisoners. I hope that the head of healthcare continues to assure herself that the new procedures provide appropriate support to the prisoners who need it. In these circumstances, despite the detrimental effect that the delays had on the man, I do not make a recommendation about the matter.

Prescribing psychotropic medication

105. During the time when the man waited for the appointment with a psychiatrist he took Olanzapine without the prescription ever being reviewed by a psychiatrist despite his ongoing contact with the mental health inreach team. The clinical reviewer summarises the situation in his review:

> "The man was therefore commenced on medication without a clear diagnosis being made by a person appropriately qualified to do so. Assumptions were made about previous long term use of this drug which were fuelled by uncorroborated statements from the man himself."

106. I understand that long-term prescription of psychotropic (mood-altering) medication without an appropriate prescription is inappropriate and is clearly concerning. I recommend:

The head of healthcare should ensure that the prescription of mood-altering drugs is only undertaken following, or in expectation, of an appropriate assessment.

107. The clinical reviewer writes that staff need to be aware of the need to check the histories given by prisoners:

> "The records were not checked for previously known information and if this had been done staff would have been aware that they were dealing with a new presentation – not a long term problem as presented by the man. Staff need to be made aware of the importance of double checking records, including records held outside the prison if necessary, before starting long term medication and psychotropic medication in particular."

108. It should be made clear that staff need to check with prison and community records where appropriate, particularly prior to prescribing mood-altering medication.

The head of healthcare should ensure that staff check records appropriately and do not rely on information from prisoners before prescribing long-term or psychotropic medication.

109. The clinical reviewer believes that the problem with the man’s continued prescription of Olanzapine without an appropriate psychiatric assessment is explained by “the lack of cohesion amongst the various agencies responsible for mental wellbeing within the prison”. The psychiatrists were not involved in decisions about prioritising the prisoners on the waiting list. This meant that they were unable to influence who was given an appointment or the priority given to each referral. There was no formalised process to urgently prioritise cases which the clinical reviewer considers may have led to the man’s prescription of Olanzapine. I make the following recommendation:

The head of healthcare should work with the psychiatrists to establish a means of prioritising referrals. The psychiatrists should be informed about the new referrals which are assigned to them, and assist healthcare staff to prioritise those cases effectively.

110. Prison GPs saw the man many times during the year when he was prescribed Olanzapine but, as the clinical reviewer points out, the prescription system at Gartree is paper-based and entirely separate to the prisoner’s clinical record. This impaired the ability of the GPs to recognise the significance of the ongoing prescription of Olanzapine. He makes a recommendation regarding the use of an electronic prescription system that I would encourage the prison to consider:

The head of healthcare should investigate provision of a computer based prescribing system that is fully integrated with System One.

111. The clinical reviewer writes that he is concerned that taking Olanzapine may have masked potentially psychotic symptoms:

> “My concern is that the man may well have been suffering from an unrecognised psychotic illness (schizophrenia) during the 20 months prior to his death.”

112. Many of the man’s symptoms, such as the feeling of pressure in his head, hearing voices and believing others were talking about him, could well have been caused by a psychotic illness. The clinical reviewer also suggests that omitting the man’s medication in the first few days after he harmed himself in September may have been a reason for his heightened symptoms:

> “These paranoid feelings seemed to become more florid during the first few days of supervision under the ACCT process which may have been because he was not given any of his usual medication (including the Olanzapine) for the first two days. The symptoms that he had would have been masked to an extent by

> taking Olanzapine which, although prescribed with good intent, meant that the imperative for psychiatric assessment was removed and in his case the opportunity for diagnosis was lost."

113. Given that the man was prescribed Olanzapine without any form of psychiatric assessment, it is feasible that there could be other prisoners in a similar situation to him. I join with the clinical reviewer in suggesting that the prison may wish to check that all prisoners on psychotropic medication are appropriately diagnosed.

   The head of healthcare should carry out an audit to ensure that all prisoners prescribed psychotropic medication have had an appropriate diagnosis made by an appropriate person, and that their treatment is properly supervised.

The man's initial act of self-harm

114. Prior to harming himself on 5 September 2010, the man was regularly seen by Nurse A, from the primary mental health team. However, after he cut his wrist on 5 September, he was taken on to the mental health in-reach team's caseload instead. This meant that his continuity of care was broken, and a nurse with no previous experience or knowledge of the man was asked to assess him. More importantly it meant that, a time of crisis, a constructive relationship with a nurse was disrupted and the man had to get to know someone else. I agree with the clinical reviewer's suggestion that it might be better to try to maintain continuity as far as possible by moving prisoners on to the in-reach team caseload if they are deemed to require psychiatric assessment. (He suggests that the primary mental health team member could remain involved as long as deemed necessary if the transfer happens at a time of crisis.) I encourage the head of healthcare to consider this suggestion.

115. The clinical reviewer also notes that the psychiatrist who eventually saw the man after he harmed himself on 5 September was a covering consultant, with no experience of working in prison, and without access to the ACCT documentation. The ACCT document contained lots of detail on the man's symptoms at the time, and may have proved useful for the psychiatrist. He makes two recommendations, that I endorse:

   The head of healthcare should ensure, as far as practicable, that psychiatrists involved in the care of prisoners have appropriate forensic training.

   The Governor should ensure that ACCT documentation is available for review by all relevant staff, including visiting psychiatrists.

Provision of medication to the man

116. The man was moved from his usual cell after he harmed himself on 5 September. He later reported that he had not received his usual medication since moving location. This was followed up by healthcare staff and Nurse F noted on 8 September that the problem had been resolved. After the man harmed himself on 5 September, he was taken to and from hospital, had moved cells, ACCT procedures began and various referrals were made. However, arrangements had not been made for his medication to go with him. Given his complex medical history, I think that this was an unfortunate oversight. I have recast the clinical reviewer's recommendation as follows:

    The head of healthcare must ensure that prisoners have access to their regular prescribed medication if their accommodation is changed or they are relocated to another part of the prison.

Attempted resuscitation of the man on 10 October

117. I was concerned to hear that the communications officer telephoned the duty governor to ask permission to enter the cell (which was granted). In my experience, this is unusual. Prison Service Order (PSO) 2710 (Follow-up to a death in custody) says:

    > "If the apparent death has taken place in a cell, the first person on scene must enter the cell as soon as possible, following the local strategy for safely doing so. Local protocols must contain clear instructions covering cell entry, especially for Night Patrols."

118. I am surprised to hear that authority was sought from the duty governor before the cell was entered. The man was alone in a single cell and the OSG correctly believed that she could see blood in the cell. Although I understand that some staff are concerned about the risks about entering a cell at night, given that the man appeared to be in a vulnerable position, I would have expected quick entry to the cell. My investigator has asked Gartree for a copy of the night instructions but has not received it yet. Although I do not believe the delay in entering the cell had any impact in the man's death, this would clearly not be so in every case. I am sure that that the Governor will wish to ensure that the night instructions are in agreement with the PSO. Any delay in entering a cell

could have serious consequences in a similar situation in the future. Therefore, I recommend:

The Governor must ensure that staff are aware of their responsibilities regarding entering a cell at night where a suspected act of self-harm has occurred.

119. The clinical reviewer writes of the efforts made by Nurse D to resuscitate the man:

> "The ambulance service crew was again able to gain rapid access to the man after his fatal episode of self harm. While waiting for the ambulance to arrive prison officers made strenuous efforts to resuscitate him. However, it was clear to the ambulance crew when they arrived that on this occasion that he was beyond resuscitation."

120. I endorse the clinical reviewer's comments. It is most unfortunate that, despite Nurse D's strenuous efforts, the man was beyond saving.

Whether the care provided to the man was equivalent to what he would have received in the community?

121. The clinical reviewer provides an overall opinion on the clinical care provided to the man which I share. He writes:

> "I would conclude that, apart from the deficiencies in his psychiatric care which I have previously described, his general medical care was of a comparable standard to the care that he would have received in the community."

122. He goes on to comment positively on many aspects of the man's care:

> "Notwithstanding the recommendations above it is clear from the records and from the interviews carried out that the man had good and appropriate care for many of his presentations to the healthcare staff. In particular the multidisciplinary management of his physical problems and appropriate involvement of secondary care resources was good. His immediate management after the first episode of self harm was good. The ambulance service was able to access the prison and transfer him to secondary care without hindrance."

Support for prisoners undertaking the Cognitive Self-Change Programme (CSCP)

Assessment for the course

123. The CSCP is a long (approximately 12 months) course that makes considerable demands on the prisoners undertaking it. The psychologist at Gartree, explained that it could be difficult for some prisoners because it involved looking at prisoners' offences and the feelings they had at that time.

124. It is important to consider whether the CSCP was appropriate for the man and whether he was adequately supported by the course leadership following his harming of himself in September 2010. The man was advised to undertake the course at his sentence planning board in 2007, but was unable to do so until he had completed the Enhanced Thinking Skills course in 2008. Once he had done so, he was eligible to apply for assessment for the CSCP. She explained the assessment process to my investigator:

> "When a prisoner first refers we have quite a lengthy assessment process for CSCP. So we do a screening interview first of all which looks at, generally, the likelihood that they will need to do the programme in terms of their level of risk. So we ask about their violent convictions and that sort of thing but there are also questions in the screening interview about things like mental health, about things like substance use if there are any current concerns, a couple of other questions about other factors that might impact on their ability to undertake treatment at that time. So any concerns will be flagged up at a very early stage and then that will trigger us to go and liaise with the healthcare. The full assessment which we then do if someone is assessed as eligible from the screening interview is a full risk assessment by a psychologist which would involve a complete collateral review, which would include gaining consent for access to medical records and speaking to any relevant staff."

125. The man completed the assessment interviews and he was considered appropriate for the course. The psychology staff also considered his medical suitability for the course. The forensic psychologist in training, explained to my investigator that, having received consent, they would check the medical records of each prisoner to ensure that there were no medical reasons why they should not undertake the course.

126. In the case of the man, the prescription of Olanzapine was noted and advice was sought from the mental health team. Nurse C and Nurse A responded by saying that the dosage was quite low and should not preclude him from the course. I am pleased to see the attention paid to such matters by the CSCP team, and find no fault in this regard.

Support from the course leaders after 5 September

127. Having harmed himself on 5 September, the man said that part of the reason for his actions was pressure caused by the course, although the psychologist (who also acted as the ACCT assessor) recalled that a number of other factors were mentioned as well. The forensic psychologist training said that she was surprised to hear that the man said the course had contributed to his actions because he had not come across as seeming depressed during the course.

128. Despite this claim, it is clear that the man was very anxious to remain on the course, and continue to undertake his offending behaviour work. The psychologist recalled:

> "I think he was concerned that he needed time off physically because he'd been to hospital and physically couldn't attend sessions so I think he did come across as worried that we might thrown him off the course because of that."

129. It was good practice for the officer who held one to one session and Officer D to meet the man in one-to-one sessions in order to keep him in touch with the CSCP course, without reintroducing him to the group sessions. Officer D recalled that the man was keen to engage with him, and asked when he would be able to rejoin the group. He said that the intention was for the man to continue with the one-to-one sessions until he was settled enough for the group sessions. This approach is sensible and proportionate, and I think it important to note that, although the man wished to rejoin the group immediately, the CSCP facilitators intended to support him more closely. This is a constructive approach and I welcome the support provided to the man.

The Assessment, Care in Custody and Teamwork (ACCT) process

Constant supervision

130. Constantly observing a prisoner is the highest level of observation and a method that is only used with prisoners deemed to be at very high risk of harming themselves. The man was subject to constant supervision for over a week after he reopened the wound on his arm on 7 September. I am satisfied that this was the correct decision given the vulnerability of the man at this time.

131. When a prisoner is deemed to require constant supervision authorisation must be sought. PSO 2700 (Suicide prevention and self-harm management) requires the first case review to be held immediately prior to unlock the following morning in cases where the prisoner is placed under constant supervision during the night.

132. PSO 2700 explains:

> "Acute suicidal crisis may be temporary and one aim of the case reviews should be to reduce the level of supervision progressively, substituting alternative supports, as the prisoner's condition improves. This will involve some degree of risk-taking as it involves the prisoner being allowed to gradually take more responsibility for him/herself. Constant supervision must only be for the shortest time possible and how the prisoner will be returned to normal location and/or a lesser level of conversations and observations, must be reflected in the CAREMAP."

133. Gartree clearly followed this advice, and developed a support plan to allow the man to accept the ending of constant supervision. He went to A wing in the day, with frequent, but not constant observations, before returning to constant supervision during the night (when he said he felt most vulnerable). This, again, is an organised and sensible way of reducing the man's reliance on constant supervision whilst minimising the risk of him harming himself again.

Treating pain when a prisoner is being monitored by the ACCT procedures

134. When the man was subject to ACCT monitoring procedures, he frequently complained of being unable to sleep. He said that one of the causes of this was pain in his teeth. This originated from 9 August 2010 when he was referred to the dentist due to pain from a broken tooth. On 15 September, the ACCT documentation reveals that he was still suffering from pain from his tooth. The clinical reviewer writes, with regard to this issue:

> "At this point he had been on the dental waiting list for over a month and expedition of his dental appointment would have been appropriate. This would have been appropriate under the

terms of the ACCT as pain had been listed as one of his sources of stress."

135. One of the benefits of the ACCT process is that the caremap allows staff to document all of the ongoing concerns and issues a prisoner has at their time of vulnerability. It should be remembered that physical pain can have a close relationship with emotional distress and attempts should be made to mitigate it in the same way as other concerns listed in the ACCT documentation. The man's caremap did not include any reference to his physical pain.

136. All sources of stress to the prisoner should be included on the ACCT caremap, and this includes physical pain. Omitting issues, which may seem unrelated increases the chance that a person's risk will not be appropriately managed.

The Governor should ensure that ACCT caremaps include all relevant issues.

Closing the ACCT

137. PSO 2700 says:

> "The ACCT Plan can only be closed once all the CAREMAP actions have been completed and the Case Review Team judges that it is safe to do so … The Case Manager must enter in the record of the final Case Review why the Case Review Team feel it is safe to close the ACCT Plan, and enter the date closed and date for a post closure interview ..."

138. SO C explained that at the case review of 21 September, the man wanted the ACCT closed, but the staff members at the review wished to keep it open for an extra week to check how he coped.

139. PSO 2700 states that at all case reviews, the membership of the team should be:

> "One of the attendees must be the named Case Manager (and failing that, the Manager responsible for the prisoner's location), one a residential officer who works in the area where the prisoner is located and the other an appropriate member of non-discipline staff."

140. However, at the following meeting on 28 September, only SO C, Officer C and the man were present. The SO explained that he was unable to gather everyone he wanted for the review, but decided to undertake it anyway.

141. For the vast majority of case reviews undertaken for the man, a good mix of multidisciplinary staff were involved. Staff from healthcare, the psychology department, wing staff and safer custody team were all involved. At the penultimate review there were representatives from psychology and the discipline staff, but the final review when the ACCT was closed only included wing discipline staff. This is disappointing as the combined expertise from different departments could only have benefited the review. The man was a man with mental health needs, and was concerned about his involvement with the CSCP course. Staff involved in these areas may have been able to offer further insights and suggestions for support.

142. However, given the discussions at the review on 21 September, I think that it is possible that, even if the 28 September review had been multi-disciplinary, the same decision to close the ACCT would have been reached. The mental health in-reach team subsequently told my investigator that, had they been present at the ACCT review, they would not have objected to the closure of the ACCT. The clinical reviewer writes in the clinical review:

> "The members of the in-reach team agreed that, had they been present at the meeting they would not have objected to closing the ACCT. Nevertheless it would have been good practice record the fact that they had been consulted in the ACCT document the decision."

143. Although I accept that the decision may well have been the same, this might not be so in every case. In the man's case, the ACCT was closed 12 days before he took his life. I consider that closing the ACCT was reasonable. I have found in other investigations that knowledgeable staff from different working areas who know the prisoner are vitally important for the ACCT process to work effectively, and it is also necessary for such discussions to be recorded. I therefore make the following recommendation to remind the Governor of this:

The Governor should satisfy himself that multidisciplinary staff are involved ACCT case reviews in accordance with the requirements of the PSO.

144. Having said this about the review which closed the ACCT procedures, I am pleased to learn that an additional post closure review was scheduled as the staff realised that some practical issues remained unresolved. This was another example of good practice.

CONCLUSION

145. The man was a man with a complicated personal history affected by physical and mental health concerns and a substance misuse problem. However, upon entering custody, the man got on well with staff and his peers and undertook offending behaviour work. His subsequent mental health problems and death are very sad for all concerned.

146. I believe that, overall, the man was well looked after during his time at Gartree. His concerns were clearly listened to, and staff attempted to help him where they could. However, certain problems with the psychiatric care system led to the man being prescribed psychotropic medication for over a year without any psychiatric overview. The support offered to him following his initial act of self-harm was again impressive, and there is clear evidence of staff genuinely attempting to allay his fears. However, I have highlighted a number of issues with the ACCT process that I believe the prison should consider further.

147. This was a tragic death of a well-liked young man. I hope that the improvements already made to Gartree's processes and implementing my recommendations will reinforce the commitment demonstrated by staff and help to prevent a similar death in the future.

RECOMMENDATIONS

1. The head of healthcare should ensure that the prescription of mood-altering drugs is only undertaken following, or in expectation, of an appropriate assessment.

   The National Offender Management Service accepted this recommendation and wrote in their response to this report:

   > "The prescribing of medication is always undertaken by recognised professionals – whether it be Medical or Non-Medical prescribers – all of whom will possess the necessary competencies to make such decisions. However, all psychotropic medication initiated by GP's should be reviewed at the earliest opportunity by the Psychiatrist and this system is now firmly embedded."

2. The head of healthcare should ensure that staff check records appropriately and do not rely on information from prisoners before prescribing long-term or psychotropic medication.

   The National Offender Management Service partially accepted this recommendation and wrote in their response to this report:

   > "The prisoners at HMP Gartree possess extensive medical notes – both paper and Systm One - which are easily accessed by all relevant professionals. During any assessment, it is appropriate to consider anecdotal as well as historical symptomatology to aid a definitive diagnosis. Taking account of all these processes, it is considered that this constitutes an appropriate check of records by staff."

3. The head of healthcare should work with the psychiatrists to establish a means of prioritising referrals. The psychiatrists should be informed about the new referrals which are assigned to them, and assist healthcare staff to prioritise those cases effectively.

   The National Offender Management Service accepted this recommendation and wrote in their response to this report:

   > "The referral list for the Psychiatrist is a fluid process based on need – urgent cases can replace others following risk assessments and clinical discussions between all relevant Mental Health Professionals and the Psychiatrist. This system was in place prior to the new Provider but further attention has been given to ensure all referrals are seen within a specific timeframe."

4. The head of healthcare should investigate provision of a computer based prescribing system that is fully integrated with System One.

The National Offender Management Service partially accepted this recommendation and wrote in their response to this report:

> "The recent HMIP also recommended the use of computer based prescribing. However, the software that enables all Systm One users to prescribe/dispense safely is still undergoing quality control measures by the Health Informatics Team in conjunction with LLR PCT. As yet, there are no firm plans to introduce this within the Leicestershire prisons."

5. The head of healthcare should carry out an audit to ensure that all prisoners prescribed psychotropic medication have had an appropriate diagnosis made by an appropriate person, and that their treatment is properly supervised.

The National Offender Management Service accepted this recommendation and wrote in their response to this report:

> "This has been completed by the visiting Forensic Psychiatrist."

6. The head of healthcare should ensure, as far as practicable, that psychiatrists involved in the care of prisoners have appropriate forensic training.

The National Offender Management Service did not accept this recommendation and wrote in their response to this report:

> "Forensic Psychiatry primarily focuses on criminogenic behaviour and the legal aspects of mental disorders. General Psychiatry primarily focuses on the diagnosis, treatment, and prevention of mental and emotional disorders. Therefore, it is appropriate that a General Psychiatrist can assess and review a prisoner presenting with mental health concerns with supervision provided by a Forensic Psychiatrist if that assessment takes place in a secure environment."

7. The Governor should ensure that ACCT documentation is available for review by all relevant staff, including visiting psychiatrists.

The National Offender Management Service accepted this recommendation and wrote in their response to this report:

> "The Case Manager and relevant professionals will provide any visiting specialist access to the ACCT document to assist in assessment, treatment and evaluation."

8. The head of healthcare must ensure that prisoners have access to their regular prescribed medication if their accommodation is changed or they are relocated to another part of the prison.

The National Offender Management Service accepted this recommendation and wrote in their response to this report:

> "A system to ensure that prisoners who cannot access their medication through the Pharmacy receive their medication is now in place.''

9. The Governor must ensure that staff are aware of their responsibilities regarding entering a cell at night where a suspected act of self-harm has occurred.

The National Offender Management Service accepted this recommendation and wrote in their response to this report:

> "LSS instructions for nights include both non emergency and life threatening situations and safety of staff and authority levels needed."

10. The Governor should ensure that ACCT caremaps include all relevant issues.

The National Offender Management Service accepted this recommendation and wrote in their response to this report:

> "Daily management checks are conducted by the Orderly Officer and Wing Senior Officers. A further weekly review is conducted by a Governor to ensure correct procedures have been followed. Ad hoc checks are carried out by the Safer Custody Manager. A complete review of all closed documents is conducted and findings and recommendations of improving practices are forwarded to the Wing management."

11. The Governor should satisfy himself that multidisciplinary staff are involved ACCT case reviews in accordance with the requirements of the PSO.

The National Offender Management Service accepted this recommendation and wrote in their response to this report:

> "PSO is followed. Where ever possible a multi-disciplinary review is conducted. Management checks conducted by weekly Governor checks ensure reviews are appropriately attended. Safer Custody close off reviews also highlights issues relating to appropriate attendance of the case reviews."