PRISONS AND PROBATION OMBUDSMAN
for England and Wales
Independent investigations

A Report by the Prisons and Probation Ombudsman Nigel Newcomen CBE

Investigation into the death of a man in June 2012, while a prisoner at HMP Garth

Our Vision

‘*To be a leading, independent investigatory body,*
a model to others, that makes a significant contribution to
safer, fairer custody and offender supervision’

This is the report of the investigation into the death of a man at HMP Garth in June 2012. He was found hanging in his cell. He was 33 years old. I offer my condolences to his family and friends.

The investigation was carried out by an investigator. The local PCT appointed a clinical reviewer to review the clinical care the man received in prison. Staff at Garth cooperated fully with this investigation.

The man had absconded from an open prison in 2010. He was arrested in October 2011 and charged with new offences, for which he was sentenced to a further six years' imprisonment. He suffered from depression and was prescribed anti-depressant medication in prison. He consistently said he did not have any thoughts of suicide or self-harm, and officers and healthcare staff did not think that he needed to be closely monitored.

Assessing the risk a prisoner poses to himself involves balancing the prisoner's demeanour and behaviour against known risk factors. The man had some known risk factors but he did not give any indication to staff, family or fellow prisoners that he intended to take his own life and I consider that it would have been difficult for staff to foresee or prevent his actions. There are a small number of concerns over his healthcare at Garth, including the lack of review of his depression but, overall, I am satisfied that he received appropriate care.

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.

Nigel Newcomen CBE
Prisons and Probation Ombudsman **July 2013**

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SUMMARY

1. The man was born in September 1977 in Merseyside. He had a conviction history dating back to 1994 and absconded from HMP Kirkham, an open prison, on 24 September 2010. He had a history of depression and had previously self-harmed in prison in 2005, by taking a drug overdose. He remained at large until he was arrested on 4 October 2011 and charged with further offences.

2. After his arrest, the man was remanded into custody at HMP Altcourse. He was sentenced to a further six years and eight months on 29 November 2011 and was transferred to HMP Garth on 12 January 2012.

3. During his time at Garth, the man was assessed by a member of the mental health team and prison doctors, and prescribed anti-depressant medication. He consistently said that he had no thoughts of harming himself or taking his own life. Prison staff had no concerns about his risk of harm to himself and he was not monitored under suicide prevention measures.

4. The man said he had problems with other prisoners at Garth and was concerned for his safety. Staff documented his concerns and restricted his movements in the prison to prevent him coming into contact with those prisoners he had named. However, there was no corroborative evidence to support his concerns.

5. One morning in June, an officer found the man hanging in his cell and called for emergency medical assistance. Officers and a nurse attempted cardiopulmonary resuscitation (CPR) until a paramedic arrived and assessed him. The paramedic confirmed that he had died.

6. We are satisfied that the care and medical assessment the man received at Garth was equivalent to that which he could have expected to receive in the community. While there were some indicators of risk, we do not think that staff could reasonably have predicted or prevented his death. Staff took reasonable steps to protect him after he reported receiving threats from other prisoners.

7. We make recommendations about refusal of medical appointments, mental health reviews and record keeping.

THE INVESTIGATION PROCESS

8. On 25 June, the investigator issued notices to staff and prisoners at Garth, informing them of the investigation and inviting anyone with relevant information to contact him.

9. The investigator visited HMP Garth on 2 July and obtained copies of the man's prison and healthcare records. The local PCT appointed a clinical reviewer to carry out a review of the man's clinical care. The investigator and clinical reviewer interviewed eight members of staff and five prisoners between 23 - 24 July. Written initial feedback was given to the Governor on 26 July.

10. The Coroner was informed of the investigation and a copy of the investigation report has been sent to the Coroner to assist his enquiries.

11. One of our family liaison officers contacted the man's mother to explain the purpose of the investigation and gave her the opportunity to raise any matters she wished the investigation to address. She did not have any specific issues to raise at that stage.

HMP GARTH

12. Garth is a category B training prison which can hold up to 847 adult male prisoners, many of whom are subject to indeterminate sentences for public protection (IPP) or life sentences. Healthcare services are provided by Lancashire Care Foundation Trust. The prison a nursing health care and mental health in reach teams, together with drug treatment, dental and pharmacy services.

Her Majesty's Inspectorate of Prisons (HMIP)

13. HMIP last inspection of Garth was a follow-up inspection in April 2012 of a previous inspection in April 2009. In his introduction to the report the Chief Inspector commented:

> "Garth remained a fundamentally safe prison overall and consultation with prisoners about violence reduction had improved. D1 unit, however, held a difficult mix of prisoners, including some with mental health problems alongside those needing protection from debts or gang affiliation… Investigations into serious self-harm incidents were good and few prisoners were subject to suicide and self-harm monitoring (ACCT) procedures…Personal officers and offender supervisors knew what was expected of them and there was some good personal officer work."

Independent Monitoring Board (IMB)

14. Each prison in England and Wales has an Independent Monitoring Board of unpaid volunteers from the local community who monitor all aspects of prison life to help ensure that proper standards of care and decency are maintained. The most recent IMB report for Garth is for the year ended November 2012, in which the IMB commented that the prison continued to provide a basically safe and secure environment in which prisoners were treated with decency and respect. The IMB noted that a recent survey of prisoners had shown that great majority felt safe in the prison and few had experienced actual violence, but some data indicated a recent rise in violent and potentially harmful incidents. The Board cautioned against the assumption that this was attributable to improved reporting. The IMB was positive about procedures to monitor those who were either a danger to themselves or others. The IMB noted the man's death (anonymously) and reported that there was effective liaison with official agencies, appropriate contact with his family and good support for staff and prisoners affected. The IMB commented that the death was "entirely unexpected".

Previous deaths at HMP Garth

15. There has only been one other self-inflicted death at Garth since the Ombudsman's office began investigating deaths in custody in April 2004. This was in January 2010 and there are no significant similarities between the circumstances of that death and the man's.

KEY EVENTS

16. The man was born in September 1977 in Merseyside. He had three children, was unemployed and had a history of depression. He had been in prison several times before and had attempted suicide in prison in 2005 by taking an overdose of medication.

17. On 24 September 2010, the man absconded from HMP Kirkham open prison where he was serving a sentence for causing death by dangerous driving. He remained at large until his arrest on 4 October 2011. During his time at large he committed further offences.

18. On 5 October, the man appeared at Magistrates' Court and was remanded into custody at HMP Altcourse. When he arrived at Altcourse, he told the officers completing an immediate needs assessment that he had been in custody before and had no concerns or thoughts of self-harm or suicide.

19. A nurse conducted a reception health screen (to determine any immediate physical and mental health conditions that require treatment). The man told the nurse that he had been in custody before, did not have problems with drugs or alcohol and was not registered with a community medical practice. He said that he had taken an overdose in prison in 2005. He said that he smoked, had injured his left knee four months previously and had no thoughts of harming himself.

20. The man saw doctors at Altcourse three times in October because of pain and swelling in his knee. As anti-inflammatory drugs and pain killers had limited effect, a referral to an orthopaedic surgeon was made. He was given crutches. He saw the dentist and received treatment for a loose crown and a gum abscess.

21. The man appeared at Crown Court on 19 October and pleaded guilty to absconding from HMP Kirkham. He returned to custody.

22. On 10 November, the man told a nurse he still found it difficult to cope with the guilt of killing a young girl in a car accident and was depressed as a result. She referred him to be assessed by the mental health team. Another nurse assessed him on 15 November. He said he had previously been prescribed olanzapine (an anti-psychotic medication) and zispin (an anti-depressant) when he had been in prison before, due to getting flashbacks. He also told the nurse that he had taken an overdose in 2005. The nurse recorded that he appeared relaxed and maintained good eye contact and referred him to be seen by the doctor about his medication.

23. A doctor saw the man on the morning of 22 November and noted that he had checked his prison medical records and found that he had never been prescribed olanzapine. He reiterated that he experienced flashbacks to the car accident. The doctor diagnosed him as suffering from moderate to severe depression for which he prescribed mirtazapine and arranged to see him again a month later.

24. On 29 November, the man appeared at Crown Court where he pleaded guilty to two charges of burglary and was sentenced to a total of six years eight months. Because of his previous conviction history of supplying illicit drugs to a minor he was subject to child protection restrictions which meant he was not allowed contact with children, including his own. When he return from court it was recorded that he told a PCO that he was angry about the length of his sentence but had no thoughts of harming himself or suicide.

25. On 20 December, a doctor saw the man about his depression. He told the doctor that he had experienced no side affects from taking mirtazapine although he still suffered from flashbacks and got upset easily. The doctor asked him whether he had any of thoughts of harming himself. He said that he would never do anything to harm himself as he knew it would upset his family. The doctor recorded that he was to continue to take mirtazapine and he should be reviewed in six months.

HMP Garth

26. On 12 January 2012, the man was transferred to HMP Garth as part of his sentence progression. The Person Escort Record (PER) noted that he had absconded from HMP Kirkham, had a history of violence and was associated with gangs. There is room on the PER to record details of potential risks such as self-harm and drug or alcohol issues. He was not identified as being at risk.

27. A nurse conducted the initial health screen at Garth and recorded that the man was prescribed mirtazapine, naproxen and paracetamol. He said he had no thoughts of self-harm and had no concerns that he might be bullied. The nurse referred him to the doctor and the mental health team.

28. The man told the officer who conducted his initial assessment and induction that he had been in custody before and had made a telephone call to his partner when he was in the prison's reception. He explained that he suffered from depression and was waiting for a hospital appointment about his knee. He said he had had no concerns about being in custody and no thoughts of self-harm or suicide. He said he had gang related problems with four prisoners at Garth whom he named, all of whom came from Merseyside. The officer completed a Security Information Report (SIR) about this. Because he had identified these concerns he was offered a place on the vulnerable persons' unit for his protection. He declined and said he wanted to remain on a main wing.

29. On 13 January, a prison doctor authorised the man's medication of mirtazapine, naproxen and paracetamol. The doctor did not see him and made no entry in his medical records.

30. On 15 January, a nurse completed an in-possession medication risk assessment to see if the man could keep a supply of his drugs in his cell. He was assessed as at moderate risk and on 16 January, a prison doctor authorised him to be issued with a weekly supply of mirtazapine and 28 day supply of naproxen, one to be taken twice a day, and paracetamol, one or two

to be taken four times a day. The doctor did not see him or make an entry in his medical records.

31. On 25 January, the man had an appointment with a nurse who was a member of the mental health team, but did not attend. The nurse recorded that she had contacted the wing and staff told her that he said he did not want to be seen by anyone from the mental health team. She asked wing staff if they had any concerns about his well-being and they had none. There is no record that he signed a disclaimer to say that he did not wish to have any involvement with the mental health team. The nurse told the investigator that since his death, if a prisoner refuses to attend an appointment, the nurse speaks to the prisoner face to face rather than with wing staff over the phone.

32. On 3 February, an officer recorded in the man's prison record that, because of his public protection restrictions, the telephone numbers he had been using to call his partner were no longer authorised and had to be checked first before he could continue to use them. A Senior Officer (SO), after checking with the Public Protection Office, allowed him to use the SO's office phone to call his partner.

33. On 6 February, a doctor authorised a repeat prescription of mirtazapine for the man without seeing him and did not make any entry in his medical record.

34. On 10 February, the man was moved to B Wing and an officer was assigned as his personal officer (a member of staff with particular responsibility to support and interact with nominated prisoners, help with sentence planning and resettlement issues, and act as a point of contact for any concerns). In the weeks that followed, the officer made regular entries in his prison record. He continued to maintain he was under threat from other prisoners at Garth and staff completed SIRs about this and took some protective measures such as restricting him to the wing to ensure he did not come into contact with the prisoners he felt under threat from. He was again offered a place on the VPU, which he refused. The alleged perpetrators of the threats were not on the same wing as he but were monitored to ensure they had no contact with him.

35. The man was allowed to telephone his partner but not his children. His partner (who was not the mother of his children) was under the age of 18, and was allowed to visit only when accompanied by an appropriate adult. He requested a transfer closer to Merseyside to enable his mother to visit.

36. The man's personal officer told the investigator that he liked to chat, complied with the prison regime and had friends on the wing with whom he played cards and snooker with during association periods. However, he did not work or go to the gym; he just stayed on the wing. She said that she found him pleasant and respectful. She said that he had told her that he had notes pushed under his cell door threatening him and his family but she and other staff had never seen them. She said that she had not seen anything to indicate that he was the subject of bullying by other prisoners.

37. On 2 March, a prison doctor authorised a repeat prescription of mirtazapine for the man with out seeing him or making an entry in his medical record. On 21 March, another doctor did the same.

38. On 23 April, a prison doctor examined the man's left knee after he complained of pain. The doctor recorded that it was not swollen or red and he had full movement in the joint. He told the doctor that he had been on the waiting list to see a consultant when he was at Altcourse and did not want any additional oral pain relief. The doctor prescribed Volterol gel (to reduce inflammation and reduce pain) and referred him to an orthopaedic consultant. The doctor did not record any review of his depression but authorised a repeat prescription of mirtazapine. He did not raise any other concerns with the doctor.

39. On 10 May, the man was offered a transfer to HMP Lowdham Grange, near Nottingham, as he wanted to move away from Garth because of the alleged threats against him. He refused the transfer as he said that would be too far for his partner and family to travel to visit him. Despite this, on 17 May, he applied for a transfer to the Therapeutic Community at HMP Dovegate, near Uttoxeter in Staffordshire, which he considered would help him progress his sentence. He was advised that there was a long waiting list for places at Dovegate.

40. On 19 June, the man had a scheduled telemedicine appointment (a medical consultation done via video link) with the orthopaedic consultant at Preston Hospital about his knee, but he refused to attend and told staff that he no longer wanted to be on the waiting list. There is no record that he signed a disclaimer to say he no longer wanted treatment.

41. The man made five separate telephone calls to his partner on 19 June which were recorded but not listened to by prison staff. Two calls were made at 11.53am and 12.01pm. In the first of these, he told his partner that she was rarely contactable, had not written to him for a long time and that he was no longer bothered about her. In the second, his partner told him she was no longer bothered about him. In the three subsequent calls at 5.01pm, 5.19pm and 6.29pm, he told his partner that he knew that she did not want to be with him anymore and that he would break her heart. His partner asked him what he meant by that but he said in response that he loved her and "don't blame yourself". He ended each of these calls.

42. On 20 June, at 6.40am, an officer responded to the man's cell bell. He said that he had pains in his leg and toothache and said he thought he had taken more pain relief medication than he should have, as he had been sick and coughed up blood. (He had a supply of paracetamol in his cell as well as naproxen and mirtazapine.) The officer telephoned the duty nurse, who said that he should report to healthcare at 8.00am, the usual treatment time. The officer passed this message to him and made a note of the interaction in the wing observation book. The nurse did not make any entry in his medical record and he did not report to healthcare later that morning as he had been advised.

43. The officer said at interview that when he arrived at the man's cell he was lying on the bed and there was no sign of blood or vomit. When he returned to the

cell, after speaking to the nurse, he said he did not appear anxious. He said that staff were told at the wing briefing at 7.45am that he had been advised to attend healthcare that morning at 8.00am.

44. The duty nurse told the investigator that she had advised the officer to ring healthcare when the day staff came on duty at about 7.30am as it was difficult to access cells at that time in the morning, when there was a changeover of night to day staff.

45. At 11.40am the same day, the man telephoned his partner and apologised for the calls the previous day. He asked her to visit and said that he would phone her on Friday, which was two days later. He phoned his partner at 11.44 and on Friday 22 June, but someone else answered and told him that his partner had gone to live with her grandmother for a couple of weeks. He said that he did not believe this and that he would not phone her again.

46. At 1.57pm, the man telephoned his mother. He told her that he had fallen out with his partner and was no longer bothered about her. The conversation then went on to what his mother and sister had been doing. He laughed and joked with his mother and sister during this 12 minute call.

47. At 3.57pm, the man telephoned a friend and during an 11 minute call had a general conversation about parties and drunken behaviour. He explained that he had turned down a transfer to Lowdham Grange, even though it was a good prison, because it was too far for visits. He said that he was on the waiting list for a transfer to Dovegate as he wanted to do the course there. Again he laughed and joked during the call and said he would call his friend again a week later.

48. At 4.09pm, the man called his mother again for three minutes and had a general conversation about family and friends. He ended the call by saying that it was dinner time and he would ring again the next day.

49. During both calls to his mother, and the one to his friend, the man was upbeat, cheerful and positive and gave no indication that he was depressed or had any thoughts of harming himself or taking his own life.

Day of the incident

50. An Operational Support Grade (OSG) was on duty throughout the night on B wing. She completed the required checks throughout the night and there were no concerns noted about the man, who did not use his cell bell at any time during the night. At 5.40am, she completed an end of shift roll check (a security check to ensure that every prisoner is in their cell). When she looked through the observation panel in the man's cell door, she said she saw him standing by his bed.

51. The OSG told the investigator that if a prisoner is awake at that time she goes back to their cell after a few moments to check again. She returned to the man's cell and saw him still standing by his bed. She told the investigator that

he turned and looked at her and raised his hand to acknowledge her. After completing the checks she went off duty at 6.15am and was replaced by an officer.

52. The officer then conducted a further required early morning roll check at the start of the day shift. At 6.32am she arrived at the man's cell and saw him hanging from the light fitting with a knotted bed sheet around his neck. She radioed the control room to say that she had found him hanging and was entering the cell. The control room immediately radioed a Code Blue call (an emergency call that notifies staff a prisoner had been found not breathing or with breathing difficulties). She went into the cell and cut the knotted bed sheet using her anti-ligature knife (a specially designed knife carried by all officers) and lowered him to the floor. She checked for a pulse but could not find any signs of life so started cardiopulmonary resuscitation (CPR).

53. Two more officers arrived at the cell at approximately 6.34am in response to the emergency call. One officer assisted with CPR and the other radioed to say an emergency ambulance was required. The phone call requesting an ambulance was made at 6.35am.

54. The officers were quickly joined by a SO and a nurse, who had brought emergency resuscitation equipment. The nurse took over and continued CPR, with the assistance of the SO. They attached the automated external defibrillator (AED - which monitors the heart rhythm and administers electrical shocks to the heart to restore the normal rhythm when necessary). The AED advised that there was no shockable rhythm. A paramedic arrived at 6.55am, assessed the man and pronounced that he had died.

55. As with all deaths in custody, the police undertake an initial investigation to check whether a criminal investigation is necessary. The police found a birthday card in the man's cell written to his mother, in which he said that he felt depressed and alone and found it difficult not being able to see his children. He ended with "put me by Nan please Mum so I don't feel alone anymore. I'm so sorry Mum". There were also two undated letters, one to his sister and the other to his eldest son. In both letters he said that he loved them but was unable to cope any longer. He also left a note for the Prison Service stating that he wanted his mother to be his next of kin and not his partner.

Contact with the man's family

56. That morning staff at Garth established that the man's mother was no longer at the address given in his records. The prison chaplain contacted her to confirm her current address so that he and family liaison officer could visit the family as soon as possible. They visited the family early that afternoon to break the news and circumstances of his death and offered support. In the days that followed, Garth maintained contact with the family to provide ongoing support and financial assistance towards the funeral expenses.

Support for staff and prisoners

57. A hot debrief was held at 7.35 for staff involved in the emergency incident to discuss what had happened and to offer support. The services of the care team were made available.

58. Officers and members of the chaplaincy were available to support prisoners affected by the incident. Prisoners subject to suicide and self-harm monitoring (ACCT) had their cases reviewed in case they had been adversely affected by the man's death.

Events after the incident

59. Two days after the incident, Prisoner A, a friend of the man's, told an officer that other prisoners from the Liverpool area had terrorised the man as they had said he was a "grass" and a "snitch".

60. The prisoner told the investigator that he had known the man for ten years and they had been good friends, along with Prisoner B. He described him as a quiet laid back person who kept himself to himself. He said that the man mixed with two other prisoners who were from Liverpool and they spread rumours that he was a "snitch". The prisoner said that this was "just prison politics" because the man had gang related issues with some other prisoners and these two prisoners "just jumped on the bandwagon and used his name because other people had said he was snitch". The man had told him that he was not bothered by this and the prisoner did not think he was vulnerable. However, he thought he would have benefited from a transfer to another prison.

61. The prisoner told the investigator he spoke to the man the night before he died. He said the man had used the phone, appeared his normal self and said he was fine. He gave him some chocolate and crisps and that was the last time they spoke to one another. It came as a complete shock to him that he had taken his own life.

62. Prisoner B told the investigator he classed the man as a friend. They played cards together and spoke everyday on the wing. He said that he was not aware that he was threatened by other prisoners. The prisoner believed that he was "blagging it" as he did not want to work and wanted a transfer to another prison. The prisoner also said that he appeared headstrong. He talked a lot about his children and was looking forward to when he was released. The night before he died the prisoner had spoken to him and he said he seemed his normal self.

63. Another prisoner told the investigator he had known the man for 16 years. He described him as "a happy-go-lucky lad" and "a jack-the-lad". He said that he was on the same wing as the man up to three weeks before he died and saw him everyday. He told the investigator that the man had told staff he was being threatened in the hope of getting a transfer to another prison closer to home. He went on to say that he "could not be bullied by anyone, by no-one, that's the sort of person he was".

64. The investigator interviewed one of the prisoners said to be threatening the man, who said that he did not know him though some of his acquaintances were friends with prisoners who knew him. He categorically denied that he, or his acquaintances, had threatened him.

ISSUES

Assessment of risk

65. Prisoners who are regarded as at risk of suicide and self-harm are managed under a system known as Assessment, Care in Custody and Teamwork (ACCT). Any member of staff can start the ACCT process by raising a Concern and Keep Safe form, explaining the reasons for their concern. An Immediate Action Plan is written by the manager of the wing where the prisoner is located and within 24 hours an ACCT assessment is carried out by a member of staff who has the required training. Once placed on an ACCT plan, the prisoner is subject to regular case reviews that will direct observations and conversations to be carried out at intervals determined by their perceived level of risk.

66. The investigation has considered whether prison staff missed any signs that the man posed a risk to himself and whether he should have been subject to an ACCT plan. He had been in prison before and his prison records showed that he had previously attempted suicide in 2005 and had been monitored on an ACCT plan then.

67. The man suffered from depression for which he was prescribed anti-depressants. When questioned about thoughts of suicide or self-harm on his arrival at Altcourse, he said he had no such thoughts and his first night assessment did not identify any concerns about suicide and self-harm. His mental state and risk of self-harm or suicide was also assessed by healthcare staff at Altcourse and none thought that he showed any signs of vulnerability. When he arrived at Garth he chose not to engage with the mental health team, though he continued to take prescribed anti-depressants.

68. Staff judgement is fundamental to the ACCT system. At its core, the system relies on staff using their experience and skills, as well as local and national assessment tools, to determine risk. They must balance this against the prisoner's known risk factors and their presentation.

69. The clinical reviewer considered whether staff had identified any risk factors and made the following comment:

> "Within the health care records and subsequent interviews, there did not appear to have been any key clinical suicide or self-harm indicators identified to forewarn staff that there was a high risk of self-harm."

70. The man had some known risk factors indicating that he might be at risk of suicide or self-harm, such as his history of depression and a previous suicide attempt in custody. He was not able to have contact with his children, appeared to have just broken up with his partner, and said he was under threat from other prisoners. On 20 June, there is the possibility that he took an overdose of pain relief medication.

71. However, on balance we conclude that not all the risk factors were sufficiently apparent at the time to indicate that an ACCT plan should have been opened. The man consistently said he did not have any thoughts of self-harm or suicide when he was asked directly about this and his behaviour and demeanour gave no indications otherwise, not even to those who knew him well. There was little, if anything, to indicate any change in his outlook at the time that staff could have expected to have been aware of, and we consider it would have been difficult for prison staff to have predicted his actions.

The man's contact with his children

72. In the note he left in his cell the man said he had found it difficult not to be able to see his children. He had two teenage sons and a three year old daughter from previous relationships. We understand that contact with his children was stopped because of child protection concerns, after he was convicted of supplying an illicit drug to his elder son. A note in his prison record of 2 February 2012 indicated that the local authority's children's services department had decided that he should have no contact with his children, but that this would be subject to a review. The investigator spoke to children's services, who confirmed that there had been no review by the time of his death. Decisions by local authority children's services are not within the remit of the PPO and the prison rightly implemented the decision of children's services to safeguard the children. However, it is a matter of concern that his contact was stopped for the entire time he was in Garth without the expected review taking place.

Allegations that the man was being threatened

73. When he arrived at Garth the man told staff that he had gang-related issues with other prisoners at Garth from whom he was under threat and, as a result, he did not want to leave the wing. He also told his personal officer that he had had threatening notes pushed under his cell door.

74. Between 13 January 2012 and 4 June 2012, 19 SIRs were completed by staff about allegations that threats were being made against the man. All of the allegations came from him himself and there was no corroborative evidence to support them. On each occasion, staff at Garth followed the violence reduction policy to address his concerns. He was monitored, as were the alleged perpetrators. In order to protect him, he was kept on the wing to prevent him coming into contact with any of the prisoners from whom he said he was under threat.

75. The security department liaised with the police to establish if there was any gang-related intelligence in the community that directly linked to the man to the other prisoners. There was none known and this was checked and updated frequently.

76. After the man's death some prisoners said he had been the subject of threats from other prisoners who were from his home area. It is noted that none of the prisoners who were named as the alleged perpetrators had been on his wing in

the months before his death. He said he had received notes with threats on them but never gave staff the actual notes as evidence. His personal officer said she never saw any signs that he was under threat or being bullied.

77. While bullying and threatening behaviour does occur within prisons, we are unable to conclude whether or not the man was threatened by other prisoners during his time at Garth and there is little hard evidence to support it. There is no indication that the alleged threats played any part in his actions in June. Whether or not the threats were genuine, we are satisfied that Garth acted appropriately on the allegations to help ensure his safety.

Clinical Care

78. The clinical reviewer has carefully considered the man's general physical health care and concludes:

> "He had access to dental, optical and chiropody health care in line with care available to the wider community. It was noted that he failed to attend many of these appointments."

79. On occasions, the man exercised his right not to accept medical treatment. When this happens it is good practice for healthcare staff to obtain a signed disclaimer form from the prisoner to say that they have had the reason for the treatment explained to them and, against medical advice, they refused it. It is also helpful to have a record of the reasons prisoners do not attend appointments.

The Head of Healthcare should ensure that prisoners are asked to sign a disclaimer when they decline to accept medical treatment and that where possible the reasons for non attendance at appointments are recorded.

Mental Health

80. In respect of the man's mental health care the clinical reviewer commented:

> ""On 25 January 2012 the man let the wing staff know that he did not want to attend his mental health appointment. It was acknowledged that wing staff regularly refers patients if they are concerned that there had been for example a change in behaviour, not picking up meals.
>
> "There are no local policies or procedures on how to deal with prisoners who decline mental health appointments on a single occasion."

81. We are concerned that after the man's transfer from Altcourse to Garth there was no follow up of his mental health or prescribed mirtazapine as requested by the doctor. On 13 January, 16 January, 6 February, 2 March and 21 March prison doctors repeated his prescription of mirtazapine, but on each occasion there was no review of his mental health and no entry was made in his medical record.

82. The only recorded face to face consultation between the man and a prison doctor at Garth was on 23 April, four months after he arrived at the prison. At this consultation the doctor did not review his mental health or medication but simply repeated the prescription of mirtazapine.

83. The National Institute for Health and Clinical Excellence (NICE) guidelines on the treatment and management of depression in adults states that patients who are on "long-term maintenance treatment should be regularly re-evaluated".

84. The guidance also states "For people with moderate or severe depression, provide a combination of anti-depressant medication and a high-intensity psychological intervention such as Cognitive Behavioural Therapy (CBT)".

85. We believe that the man should have been reviewed by doctors and his treatment needs fully considered.

The Head of Healthcare should ensure that prisoners being treated for depression have regular reviews that consider all treatment options.

Response to possible overdose 20 June

86. In her report the clinical reviewer commented on the events of 20 June as follows:

> "In the early hours of 20 June 2012 the man reported to wing staff that he had been unwell in the night. The wing staff noted on the wing diary that he stated that he had been coughing up blood and vomiting during the night. It was reported that he said that he may have taken too many painkillers. The wing staff contacted healthcare at approximately 06.40 and was advised to ask him to go to treatments in healthcare at 08.00 when the day staff begin to offer treatments. He was reported to have accepted this, but later declined to attend. There is no note of this conversation in the health care records and limited recollection of the facts by healthcare staff subsequently."

87. The clinical reviewer told the investigator that an overdose of more than 20 paracetamol would be considered as requiring medical attention and attendance at hospital for blood tests to see what paracetamol levels were. In addition naproxen has known side effects, even taking a recommended dose, one of which can cause a patient to bleed that would show up as vomiting blood.

88. The officer correctly contacted healthcare to report that the man said he had vomited, coughed up blood and thought he might have taken too much pain relief medication. He noted what had happened in the wing observation book. The nurse said she asked the officer to contact healthcare at 7.30am but the officer did not record this.

89. We consider that the nurse should have responded more actively to what was a possible overdose of medication. There was no check made of the man's

medical records to establish what medication he was prescribed and the potential seriousness if he had taken too much medication. The nurse did not make a note in his medical record of the symptoms described and the advice given, which meant there was nothing to prompt healthcare staff coming on duty to take any follow-up action. He himself chose not to go and see a nurse as he was advised. Nevertheless, we are concerned that more active follow up care was not provided.

The Head of Healthcare should ensure that healthcare staff assess the patient in person when there is a report of a potential overdose of medication and record any advice given or action taken.

Emergency response

90. The response to the man's need for assistance was swift and professional. Prison staff correctly started CPR and an automatic external defibrillator was used. As he did not have any cardiac rhythm, there were no instructions to administer a shock during CPR.

91. Staff continued with CPR until the paramedic arrived and took over the man's care. After he treated and assessed him, the paramedic confirmed that he had died. The clinical review commented on the attempt to resuscitate him as follows:

> "All possible care was given to the man after he was found suspended by both wing and healthcare staff … The quick response from healthcare and application of the defibrillator and additional use of oxygen did provide him with excellent care."

92. Although the man could not be revived, we believe that the emergency response at Garth was appropriate and that everything possible was done to try and revive him.

RECOMMENDATIONS

1. The Head of Healthcare should ensure that prisoners are asked to sign a disclaimer when they decline to accept medical treatment and that where possible the reasons for non attendance at appointments are recorded.

   Accepted
   In the case of Prisoners refusing treatment, there should an entry in the medical records to this effect. Any disclaimer signed to that effect should be scanned into the electronic medical records. There should also be written evidence that the likely consequences of refusal of treatment is discussed with the prisoner. There should also be an assessment of the individual's capacity to make that decision.

2. The Head of Healthcare should ensure that prisoners being treated for depression have regular reviews that consider all treatment options.

   Accepted
   Patients who are receiving medical or psychological treatment for depression will have regular reviews by GP and/or mental health team in line with stepped care protocol dependent on severity and chronicity of condition.

3. The Head of Healthcare should ensure that healthcare staff assess the patient in person when there is a report of a potential overdose of medication and record any advice given or action taken.

   Accepted
   Any patient who takes an overdose, who self-reports an overdose or who is reported to have taken an overdose, will have a full face to face physical and mental health assessment as an urgent priority.