PRISONS AND PROBATION OMBUDSMAN
for England and Wales
Independent Investigations

Investigation into the circumstances surrounding the death of a man, at HMP Northumberland in March 2012

Report by the Prisons and Probation Ombudsman for England and Wales

May 2013

This report considers the circumstances surrounding the death of a man at HMP Northumberland in March 2012. He was found in his cell with cuts to his neck and with razor blades in the immediate vicinity. I offer my condolences to his family and all those who knew him.

The investigation was conducted by an investigator. A review of the man's clinical care was provided by a clinical reviewer on behalf of the local PCT. HMP Northumberland cooperated fully with this investigation.

The man was sentenced to eight years imprisonment in August 2010, for a well publicised conviction related to handling a stolen copy of Shakespeare's First Folio. He spent the majority of his time in prison at the Castington site of HMP Northumberland. During 2010 and much of 2011 he appeared to settle well at the prison and participated positively in the regime.

Several members of prison staff noticed a decline in the man's mood, demeanour and appearance in early 2012. This coincided with his anti-depressant medication being discontinued in January, although it was reinstated the following month. He became preoccupied with the time he had left to serve in prison and was worried about a pending appeal against his conviction and sentence. During much of February, he was subject to suicide and self-harm monitoring procedures. He received support from members of staff on his residential unit, as well as a mental health nurse and the prison chaplains.

The investigation has identified a number of deficiencies in the operation of the suicide and self-harm monitoring. Reviews of the man's risk did not sufficiently involve all the relevant people responsible for his care and it is of concern that a decision was made, by one member of staff alone, to stop monitoring him, without clear evidence that he was no longer at risk. There was no follow up of this decision as there should have been. There were also weaknesses in the treatment provided for his depression, including an inconsistent approach by a number of different doctors about the prescription of anti-depressant medication.

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 **May 2013**

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SUMMARY

1. The man was sentenced to eight years' imprisonment on 2 August 2010. He had been convicted of charges relating to the handling of a stolen copy of Shakespeare's First Folio. Because of the offences and his flamboyant appearance at court, his trial received extensive media coverage.

2. After he was sentenced, the man was taken to HMP Durham and then HMP Acklington. On 29 September 2010, he moved to what was then HMP Castington. (In 2011, Acklington and Castington merged as HMP Northumberland.)

3. The man was seen for a standard health screening when he first arrived at Castington. He was already prescribed fluoxetine for depression but declined a referral to the prison's mental health team.

4. On 4 January 2012, a large quantity of medication was found in the man's cell during a search. For the next week, his prescription medication was taken off him and he was issued with it as required rather than being allowed it in his possession. His fluoxetine prescription was discontinued because the doctor thought his need for it had reduced.

5. In early 2012, several members of prison staff noticed that the man's mood, demeanour and appearance deteriorated. On 6 February, he saw a doctor and his fluoxetine prescription was reinstated. However, his low mood did not improve. He saw a mental health nurse for an assessment on 9 February, and the next day suicide and self-harm prevention measures began. He remained low in mood and distressed about being in prison and called the Samaritans several times. He saw the mental health nurse on several occasions and spoke to the chaplains almost every day.

6. On 13 March, the man saw one of the prison chaplains. He talked about the difficulties of being in prison and the length of his sentence. The chaplain said he came across to him as usual and that he had no reason to be unduly concerned. However, on the same day, another prisoner said that he told him that he intended to take his life that night. The prisoner said he reported this conversation to a member of staff, but there is no record of this.

7. One morning the man was found in his cell with wounds to his neck and it was evident that he had lost a lot of blood. Nurses who attended found no signs of life and resuscitation was not attempted.

8. The investigation has covered mental health support, the suicide and self-harm monitoring process, the conversation that the man had with another prisoner the day before his death, the events of the morning of his death and aspects of his clinical care. We make five recommendations regarding improved management of depression, better prescribing of medication and the adherence to proper procedures for suicide and self-harm monitoring.

THE INVESTIGATION PROCESS

9. The investigator issued notices about the investigation to staff and prisoners at HMP Northumberland asking anyone with information to contact him. One prisoner came forward and was subsequently interviewed.

10. The investigator visited the prison on 20 March 2012 and saw the areas where the man had spent time and collected relevant records. He returned on 10 May, and 26 and 27 June, and conducted interviews with 13 members of staff and one prisoner.

11. The local PCT commissioned a review of the man's clinical care in custody to determine whether the standard was equivalent to what might have been expected in the community. A clinical reviewer conducted the review, which was received on 21 August 2012. He had access to the man's clinical record, suicide and self-harm monitoring documents, and transcripts of the interviews conducted by the investigator.

12. The coroner for North Northumberland was informed of the investigation and he provided copies of the man's post-mortem and toxicology reports. This report will be sent to the coroner to assist with his enquiries.

13. The investigator contacted the Senior Desk Editor at the Sunday Sun to obtain a copy of letters that the man wrote to a journalist working at the newspaper. In these letters, he wrote about his state of mind while he was in prison.

14. One of the Ombudsman's family liaison officers (FLOs) spoke to the man's cousin, who was the preferred point of contact for the man's next of kin, his mother. The FLO explained the purpose of the investigation and provided the man's relatives with an opportunity to raise any issues for the investigation to consider. The man's cousin said that his cousin's mother's primary concern was that prison staff were aware that her son was depressed and taking medication. The issue of his mental health and the support that he received while in prison is addressed in this report. The relatives received the draft version of this report but did not make any further comments.

15. We are sorry that pressure of work in the PPO's office has led to some delay in producing this report.

HMP NORTHUMBERLAND

16. The merger of two separate prisons, HMP Acklington and HMP Castington was announced in 2010, and work began to integrate all of the functions in April 2011. On 31 October 2011, the merged prisons became known as HMP Northumberland. HMP Northumberland accommodates up to 1348 adult male prisoners. The man lived in the part of the prison which was formerly HMP Castington. Medical services at the prison are provided by a private company.

17. Because HMP Northumberland is recently formed, there are not yet any relevant published reports from HM Inspectorate of Prisons or the local Independent Monitoring Board covering the new role of the prison.

Previous deaths at HMP Northumberland (Castington site)

18. The Ombudsman's office has been responsible for investigating deaths in custody since April 2004. Before the man's death, we have investigated one death at Castington. This was in 2005, when Castington was responsible for young offenders rather than adult prisoners, and there are no similarities with the circumstances of his death.

KEY EVENTS

19. The man was sentenced on 2 August 2010 to eight years' imprisonment after being convicted of handling stolen goods. His trial received extensive media coverage as the goods involved included a copy of Shakespeare's First Folio which had been stolen from an exhibition at Durham University library. He was regarded as something of a fantasist and his flamboyant appearance at court hearings, such as turning up in a horse-drawn carriage led by a piper or in a silver limousine, also attracted press attention.

20. After sentencing, the man was taken to HMP Durham. On 9 September, he was transferred to what was then HMP Acklington and, on 29 September, to what was then HMP Castington.

21. When the man arrived at Castington, a nurse saw him for a routine health screen and noted in the electronic clinical record that he suffered from depression and was prescribed fluoxetine, an anti-depressant medication. He told the nurse that he had suffered an emotional breakdown 17 years earlier and had been in regular contact with a community psychiatric nurse before his imprisonment. He declined a referral to the prison's mental health team because he felt well on his medication. The nurse also noted that he had problems with alcohol dependence and high blood pressure.

22. The next day, the man saw a doctor about his medication. In addition to fluoxetine, he was prescribed lisinopril and amlodipine (which are medications used to treat high blood pressure). He continued to receive the medications while at Castington.

23. For the remainder of 2010 and the first half of 2011, the man seemed to settle well. He completed courses relating to thinking skills and alcohol awareness, and his course tutors told the investigator that he contributed well to group work. Entries in his records were always positive and mentioned that he got on well with members of staff and other prisoners, was pleasant and polite, and participated in the prison regime.

24. On 1 November 2010, the man received enhanced status. This is the highest of three levels in the Incentives and Earned Privileges (IEP) scheme designed to encourage good behaviour in prisons. (The three levels are basic, standard and enhanced.) He moved to Houseblock 5, a unit for prisoners with the enhanced status, where there are additional privileges such as more time out cells during the day.

25. The man regularly attended chapel activities. One of the chaplains described him as pleasant, polite and intelligent. A fellow prisoner told the investigator that he was easy to talk to and very knowledgeable about subjects such as history and religion.

26. During 2010 and 2011, the man saw healthcare professionals in the prison for physical health problems, but did not report any emotional or additional

mental health problems. He continued to be prescribed fluoxetine for depression.

27. In November 2010, the man was refused leave to appeal against his conviction and sentence, but appealed against this decision. The appeal process continued throughout 2011.

28. On 1 May 2011, the man told a nurse that he had been taking 20mg of fluoxetine per day rather than his prescribed 60mg. He saw a doctor three days later and said he had been managing well at this dosage. His prescription was therefore reduced to 20mg per day.

29. On 13 July, the man's cell was searched as part of a standard landing search. He was found to have around 30 litres of fermenting liquid in his cell. As a result, his enhanced status was removed and he was moved to Houseblock 4, a standard residential unit. At a disciplinary hearing, he was given 35 additional days in custody for this breach of Prison Rules.

30. The man saw a doctor on 9 August. He complained of back pain, said he felt low in mood and was concerned about his mother being in poor health. He said he had not been sleeping well and his mind was wandering, though his appetite was okay. The doctor noted that he made good eye contact and that his speech was normal in rate and rhythm. There was no evidence of hallucinations or thought disorder. He had no thoughts of self-harm or suicide. The doctor discussed options with him and prescribed citalopram, a different anti-depressant medication, instead of fluoxetine.

31. On 22 August, the man saw a doctor. He told the doctor that he experienced palpitations after taking citalopram. The doctor advised him to stop taking the medication and, instead, prescribed 20mg of fluoxetine daily.

32. There were no reported issues between August and October 2011. Officers continued to report that the man was settled on the wing and that he was pleasant and polite in his interactions with others.

33. On 17 November, the man saw a doctor for a review of his medication. He said his mood felt stable, his appetite and sleep were okay, but his concentration was poor. She suggested that he should try taking fluoxetine on alternate days rather than every day. She saw him again on 9 December. He told her that he wanted to take his fluoxetine daily and that he had felt worse when taking it on alternate days. An increase to 40mg daily was discussed, but the dosage was kept at 20mg daily.

34. When the man's cell was searched on 4 January 2012, a large quantity of prescription medication dating back to August 2011 was discovered. As a result, his medication was taken from him and he was issued medication as required rather than to keep in his possession. A nurse wrote in the clinical record that this made him extremely angry. The nurse noted that he was verbally abusive to him and another member of staff on 6 and 7 January. He

received IEP warnings for this and risked being reduced to the basic regime should further warnings be issued.

35. On 11 January, a doctor met the man and the pharmacist. The doctor wrote in the clinical record that he did not think he was overusing medication, and decided that he should have his medications in possession. There was nothing in the clinical record to suggest that that the doctor considered whether he might be failing to take his medication as required or storing it up. However, he also noted that the man had been prescribed fluoxetine when "his requirement and need for taking this have reduced". No further justification was given about why he no longer needed to be prescribed fluoxetine, but the medication was stopped.

36. Several members of staff told the investigator that they noticed changes in the man's mood in early 2012. SO A said that the man seemed to take "a step back" and that he sometimes saw him walking around the exercise yard alone. An officer noticed that he was unshaven and more reluctant to leave his cell. SO B said:

> "He would say … "I'm absolutely ruined, this is the end of me, I've lost my enhanced, I'm going to have to start all over again" … he was [also] having some lengthy discussions with his legal team about his appeal."

37. The chaplains also noticed a change in the man's mood, describing him as much more depressed and low. A chaplain said that he seemed to be punishing himself, talking about the mistakes that he had made and how he would not be able to put them right.

38. On 30 January, the man was found guilty for the inappropriate storage of medication in his cell. He was given 14 days loss of association (time out of cell with other prisoners). His IEP status was reviewed and he was reduced to the basic regime.

39. On 2 February, the man saw a nurse. He said he had experienced what she described as "unusual thought processes" since the middle of January. He said that when he looked in the mirror, he did not see himself looking back. He also said he was not eating, drinking or sleeping normally, though there was nothing new causing him additional stress. He said he did not have any thoughts of self-harm or suicide. She referred him to a mental health nurse.

40. The next day, a member of the education department wrote that the man had seemed low in mood and had complained of feeling depressed. She spoke to a member of staff on the wing about her concerns. Another member from the education department wrote in his record the same day that she had talked to him about how he was feeling and he had told her that he "wished he would not wake up the next day". Despite this, an ACCT was not opened.

41. On 5 February, SO A wrote in the prisoner record that the man had been given a cordless telephone to call the Samaritans. The SO wrote that he was

stressed about his appeal and although he had no thoughts of self-harm, he was low in mood following the recent disciplinary hearing.

42. The next day the man saw a doctor and discussed his low mood. The doctor thought his mood had deteriorated since he stopped taking fluoxetine. He prescribed 20mg of fluoxetine daily.

43. On the same day, the man saw a nurse for a mental health assessment. The nurse wrote in his clinical record:

> "The man describes a change in his mood since 11 January at which time he describes beginning to feel hopeless and despondent for reasons which he is unable to explain. Using a lot of metaphor he described the changes in his mood and thinking, becoming pessimistic and lethargic where he once felt the complete opposite. Despite this he has no intention to self-harm as this would distress his elderly mother too much."

44. The nurse also wrote that he had spoken to the man about his mental health, how he coped with prison, and the links between those factors and his offences. He agreed to see him again in one week.

45. The man spoke to SO B on 6 February and said he was finding it difficult to improve his low mood after the disciplinary hearing. He was concerned about how he could return to enhanced status. The SO assured him that one adjudication was not the end of the world and he should try to put it behind him and gain positive reports. Three people who worked in the prison gym all made similar entries in his record over the next three days.

46. On 10 February, an Assessment, Care in Custody and Teamwork (ACCT) document was opened. The ACCT process is designed to provide additional support and monitoring to prisoners thought to be at increased risk of self-harm and suicide. A Concern and Keep Safe form, the first stage of the ACCT process, was completed by a member of the education department, who wrote:

> "The man has been very low over the last few weeks. He has not discussed any particular threats to his life with me until late yesterday afternoon when he mentioned having 'suicidal thoughts'. Prior to this, he has mentioned he has been feeling low and regretting the actions which brought him to prison."

47. This form was completed at 8.30am. At 9.30am, SO B completed an Immediate Action Plan. The purpose of the plan is to keep the person at risk safe for an initial period of up to 24 hours, before they undergo a detailed interview with a trained ACCT assessor. The SO wrote that the man was on his normal wing, should have regular conversations with unit staff, and could call the Samaritans from his cell using a cordless telephone if required.

48. The assessment interview took place at 2.30pm. An officer who works in the safer custody department (responsible for the management of ACCTs in the

prison) told the investigator that she went to the unit to find that the assessment interview paperwork had been completed by SO B, who was not a trained ACCT assessor. Knowing that a trained assessor should complete the interview, the officer took over, spoke to the man and made her own notes on the assessment paperwork. She noted that "He communicates well, he has been talking about pacing up and down in his cell, thinking about how he ruined his own life. He mentioned 'self-loathing', 'shame' and 'guilt'." She also wrote: "States he thinks about taking his own life but said it is not a thing he would actually do. He described them as 'fleeting' thoughts'".

49. The officer identified that the man was worried about the appeal of his conviction, but, in terms of positive and supportive factors, had a close bond with his mother. SO B wrote on the form that he was to be monitored regularly by unit staff and that he should speak to him or other unit staff if his mood worsened.

50. SO B, when recalling the interview, told the investigator:

> "This was probably one of the worst states I've seen him in. He was extremely low; he was talking about how his whole world had ended. He couldn't see any way forward for himself; his whole life was at an end. Most prisoners when they come into prison, they can break a sentence at a certain point. He had no perception of that so he couldn't see any light at the end of the tunnel; he could just see a black hole."

51. The first review of the man's ACCT, which should have taken place no later than 24 hours after the initial concern being raised, was conducted on 11 February at 9.00am, just outside the 24 hour period. SO B and an officer attended. The SO wrote on the review form that he should "help himself and staff to lift him from this deepening black mood". He was identified as a raised risk to himself (one of three levels, low, raised or high can be identified) and a referral was made to the mental health team. A further review was scheduled for 17 February.

52. A Caremap, part of the ACCT paperwork that lists issues and goals, as well as action required to overcome and achieve them, was completed on 11 February. SO B wrote on the form that an issue was the man's "deeper black mood" and that the goal was for his mood to lift. He wrote that he would receive support from unit staff and would also need to help himself. The second issue was "low mood and unusual behaviour". The goal was for his mood to lift and behaviour to change. The required action was referral to a mental health nurse (though he was already seeing a nurse by this point) and the SO noted that this had been completed the previous day. The officer identified a third issue, him being unable to talk to his peers. She identified the goal as him talking to the Samaritans, with the required action being telephone contact and a visit being arranged.

53. SO B explained to the investigator that the man's mood had "deepened and deepened" throughout the day to a point where members of staff were increasingly concerned about him. In response, the SO asked a mental

health nurse to see him. The nurse noted in the clinical record that he was pacing around the wing office and asked her for valium, which she said would not be appropriate. He continued to pace around but eventually sat down when asked to do so. He told her that he was struggling to "get his head around" his sentence and being in prison.

54. After the nurse had seen the man, another ACCT review was held at 3.30pm. SO B, the man and the mental health nurse were present. The SO wrote on the review form that he had "continued to fall deeper into his dark mood" which he had "allowed to envelope him". He continued to present a raised risk, and the next review was scheduled for 17 February.

55. One of the prison's chaplains wrote on 13 February that the man had attended the chapel, seemed "less frantic", and seemed to be processing his thoughts more clearly. He mentioned "self-loathing and feelings of guilt for things he has done in the past".

56. A nurse saw the man on 13 February. He wrote in his clinical record that he reported a number of anxiety-related symptoms, such as racing thoughts, perspiration, palpitations, intrusive thoughts, agitation and sleep disturbance. These followed visits from his solicitor about his appeal. He said he had been ruminating about time being added to his sentence as the outcome of his appeal. The nurse wrote that he was requesting medication to help with his difficulties, but he explained that a different approach might be better to test whether the anxiety would subside. He provided him with stress and anxiety self-help literature and said he would review him in a few days.

57. The nurse wrote in the man's clinical record on 14 February that he had spoken to a consultant psychiatrist about him and was advised that he could increase the fluoxetine prescription to 60mg daily if required. He also noted that his symptoms might be better controlled with therapeutic intervention such as cognitive behavioural therapy.

58. On 16 February, an officer wrote that the man had experienced "probably his worst week in prison". He described him as behaving in a very anxious and frantic manner. He noted that he had seen the mental health nurse and used the Samaritans phone which had helped him get through the night.

59. The man saw a nurse on the same day, who wrote in the clinical record that he was still having difficulty coming to terms with his situation. He talked to him about different therapeutic approaches, and wrote that he appeared to be interested in considering this approach.

60. On the morning of 17 February, the man saw the mental health nurse and said he was "at his wit's end" and wanted medication to help calm him down. She reported that he was settled during the consultation and advised him to wait to see the mental health nurse regarding any change in medication.

61. The same afternoon, the man attended an ACCT review with SO B and an officer. The SO wrote on the form that the man was "happy with the care he

is receiving". They agreed to continue with the current care plan and a further review was scheduled for 23 February. The level of risk was not indicated, but the SO said during interview that it remained unchanged from the previous review. He wrote on the Caremap that there had been no change in his mood. The officer recalled that he said he still felt low but that he thought he was making progress. They also talked about his relationship with his mother. The officer also said that he had not had any thoughts of self-harm, but also acknowledged that this was not recorded on the ACCT review form.

62. A nurse next saw the man on 20 February. He wrote in the clinical record that he continued to struggle with prison and the reality of his situation, which he repeatedly referred to in "catastrophic terms". He went on to say:

> "During the course of our session he proceeded to kneel and lie on the floor which he said was an attempt at relieving stress. He asked whether mental health inpatient setting care might be a more appropriate setting for him to which I replied that I disagreed. I have suggested that this might be a problem which he needs to 'ride out' in the short term. I will continue to see him periodically to monitor health and we may then engage in more productive psychological work when his ability to concentrate is less impaired. I have urged him to continue reading the self-help information I provided in the meantime."

63. The next review of the man's ACCT took place on 23 February. It was conducted by SO C, with an officer and the man. The officer was consulted by telephone by the SO before the review. She explained during interview that she did not have any concerns but explained to the SO that she had arranged for some representatives from the Samaritans to visit the man the next day.

64. The review form on 23 February was completed in more detail than had previously been the case. SO C wrote that he had spoken to the man at length about the support that he was receiving from unit staff and from the mental health nurse. He also wrote that a nurse had referred him to see a psychologist. The SO noted that the man felt he was suffering a mental breakdown and was struggling to cope with the length of his sentence. The ACCT remained open, though his risk level was reduced to low. No further information was given about why the level of risk was reduced. A further review was scheduled for 29 February.

65. The day after the ACCT review, the man saw some volunteers from the Samaritans as planned.

66. On 25 February, SO A noted in the man's record that he might have been given some sleeping tablets by another prisoner in the Alcoholics Anonymous meeting that he attended regularly. He spoke to him, who said he had been offered some tablets but knew it was wrong and not in his best interests to accept them, and so he did not. He was very concerned that the incident might affect the general view of him and his recovery, but the SO assured him that as long as he was being truthful, it showed that he was moving in the

right direction. There is nothing to suggest that this information was passed on to the prison's security department.

67. The same day, an officer noted in the man's record that he still appeared very low in mood. He had spoken to the Samaritans by telephone for lengthy periods most nights, to the extent that they had called the prison to say he was taking a lot of their time. (It was this that had prompted an officer to arrange a visit from the Samaritans so that he could discuss some of his issues in person.) He told the officer that the visit had not really been of benefit as they had discussed the same issues as previously.

68. The man saw a nurse on 28 February. They discussed the ways in which he had previously used techniques of avoidance, such as adopting new personas and maintaining an extravagant lifestyle, and how his current situation made it impossible to use such protective behaviours. The nurse noted in the clinical record that they both agreed that the current levels of distress were significantly disproportionate to his circumstances.

69. The man's ACCT was reviewed on 29 February. SO B recalled that the man approached him and asked him to close the document because he felt that, while he had benefited from the support, the process had served its purpose and was no longer necessary. The SO agreed with this assessment and told the investigator that he had seen a "vast improvement" in his demeanour. As a result, the ACCT was closed. No other members of staff were present at the review and no mention was made on the review form about whether objectives listed on the Caremap had been completed. A post-closure review, intended to examine the closing of the document and check whether any further support is needed, was scheduled for 5 March. There is nothing in the ACCT document to indicate that this review took place as planned.

70. A nurse saw the man a further three times after the closure of his ACCT. On 5 March, he "continued to describe overwhelming feelings of despair and guilt" and they discussed ideas for getting him to a point where he might be able to engage in more meaningful psychological work. The nurse suggested guided relaxation and offered to find a CD of exercises. Three days later, the nurse delivered some self-help material to him and said that he would discuss the relaxation CD with the security department. On 12 March, he again saw him but noted that the session did not proceed as planned because he had been preoccupied about a legal visit the previous week. The nurse noted that they used the session to consider the pros and cons of his situation and how it might impact upon therapeutic work.

71. Another prisoner also saw the man a number of times in early March. He kept a diary of their interactions. He told the investigator that, during an Alcoholics Anonymous meeting on 3 March, the man told the group that he wanted to end his life, and also took some sleeping tablets from another prisoner. The prisoner said he reported this to an officer and that the man was searched as a result, but no tablets were found. There does not appear to be any record of this in the documents provided to the investigator. Between 6 and 11 March, the prisoner made several notes that the man had said he wanted to

end his life or made similar statements and reported his concerns to members of staff on each occasion. Again, there is nothing to reflect these conversations in the man's records.

72. On 8 March, an officer wrote in the man's case notes that he had spoken to him during the association period. He said he still felt very low, though the officer thought some improvement had been made.

73. SO A saw the man on either 10 or 11 March when he was out of his cell collecting a meal. He told the investigator that he had heaped his plate with food and, when he mentioned this, he replied that his appetite was good and he was eating well. The SO said he looked "fairly chirpy".

13 March

74. The man saw a chaplain twice on 13 March, in the morning and again in the afternoon. The chaplain recalled that he talked about his imprisonment and asked about how people with long sentences coped. He also talked about monks and wondered how they came to terms with solitary confinement. The chaplain said that he often talked about similar subjects and that, as usual, attempting to divert the conversation to something different was not successful. He did not think he presented differently than when he had seen him before and did not have any reason to be concerned that he might harm himself.

75. The prisoner saw the man shortly before 4.00pm. He said he looked very low in mood. The prisoner told the investigator that the man said he was going to kill himself that night. He did not say how he planned to do it, but said he did not care about living and wanted to die. He said he would not give him any more information. He said he reported this to an officer on the same corridor. There is no record of this anywhere in the man's prison file. The prisoner did not know the name of the officer and, during interview, said he had not seen him in the prison since the man's death. He was not able to describe him other than to say he was old.

76. An officer wrote in the man's record at 7.29pm. He noted that he was showing some positive progress but that he would deny it and was still seeing everything in a negative way. He said: "Staff are encouraging him on and he appreciates this, but in his own head cannot see things getting better".

77. Officer A began work at 7.30am and received a handover from the member of staff working overnight, who raised no concerns about the man. The officer then completed a roll check of prisoners on the unit. This involves looking in cells through the observation panel in the door to check that prisoners are accounted for and that nothing is obviously wrong. The officer did not notice that anything was wrong in the man's cell, though the cell was in darkness at the time.

78. At around 7.50am, Officer A, SO A and Officer B began unlocking cells so that prisoners could collect their breakfast. Prison officers are usually expected to

get a response from prisoners before opening a cell but Officer A explained that, rather than disturbing prisoners immediately as the cell doors were opened, officers would routinely unlock all the cells on a landing before returning to cells where the prisoners had not yet emerged. Officer B unlocked the man's cell and returned to it a couple of minutes later. He told the investigator that he was often one of the last prisoners on the landing to leave his cell for breakfast, but that by the time he returned to the cell after unlocking it, he had usually switched his cell light on. When the officer went back the cell was still in darkness.

79. Officer B said he pushed the cell door open and tapped the man's foot, which was outside the bed covers. He said there was no response and he sensed that something was wrong. He pushed the door wide open so that light from the landing lit the cell and then went in. He said he was about shake him to wake him when he noticed blood on his chest. Although he was not fully aware of the situation, he knew that something was wrong and left the cell to ask other officers to assist him.

80. Officer A recalled that he was on the same landing, two or three cells away, when Officer B approached him. Officer A said the officer looked very pale and shocked. He told Officer A that something was wrong and that he should go into the cell, then continued to walk past him. Officer A noticed shoe prints in blood on the landing. He went to the cell and switched on the light. He explained to the investigator that the man was lying on his back, with his mouth and eyes wide open. The officer said that there was blood around his neck area with two indentations either side of his throat, and that there was a pool of blood on the floor. (It is clear from the evidence of those who saw the cell that there was a significant amount of blood on the floor of the cell.) The officer said that he thought of looking for a pulse but did not see any signs of movement.

81. Officer B, meanwhile, had alerted the SO that something was wrong. The SO told the investigator that Officer B appeared to be very shocked. He went to the cell and described the scene in a similar way to Officer A. He said he thought the man had died, but his initial reaction was to contact healthcare staff. As he went back to the wing office, Nurse A arrived on the unit in the course of her normal duties.

82. The nurse told the investigator that when she arrived on the unit, intending to assist a colleague with dispensing medication, the SO asked her to attend the man's cell. When she arrived on the landing an officer told her that he appeared to be dead. She said her initial impression was that he had lost a lot of blood and had died. She explained that she checked for a radial pulse and did not find one. She noted that his pupils were fixed and dilated. She said she thought there was no point trying to pursue resuscitation because of the amount of blood he had lost.

83. Although she did not attempt resuscitation, the nurse asked Officer A to bring her colleague who was already working on the same unit. Nurse B went to the cell, taking emergency medical equipment. She told the investigator that

there was a “colossal amount of blood” and that the man showed no signs of life. Nurse A then used a stethoscope to listen for heart and breathing sounds for a minute, checked radial pulses, and again checked his pupils. She found no signs of life.

84. An officer and the duty governor attended the man’s cell, but were both told by the nurses that resuscitation would be futile. A doctor arrived at the prison to start work shortly after 8.30am. He was immediately informed of what had happened and went to the cell. He performed the same checks as Nurse A and found no signs of life.

85. A short letter was found in the cell, dated 11 March. It read:

> “Hi Mam. Que sera sera. What will be will be. Love, your son. xxx <u>Now</u> I’m OK. No more pain ever.”

86. Prisoners on the unit were informed in person that the man had died. Other prisoners were informed by a written notice. A ‘hot debrief’ was held on the same day and chaired by the duty governor. A number of staff members went home rather than continuing their shifts because of the distressing nature of what they had witnessed. All prisoners on an open ACCT were reviewed on the same day to check if any further support was required.

87. The prison’s family liaison officer and one of the operational managers visited the man’s family that morning to inform them of his death.

Events after the incident

88. A memorial service for the man was held in the prison’s chapel on 20 March and was attended by prisoners and members of staff. The funeral took place on 22 March and was conducted by one of the prison chaplains. Members of staff from the prison attended the service. In line with national guidance, the prison offered a contribution towards the cost of the funeral.

89. A post-mortem examination was undertaken on 15 March. The pathologist noted that there were four incisions to the man’s neck, one of which had severed the jugular vein. Nine razor blades were found on his bed adjacent to his body. The cause of his death was haemorrhage due to incised wounds to the neck.

ISSUES

Mental health support

90. When the man arrived at Castington, he had a prescription for fluoxetine, an anti-depressant medication. He saw a doctor and explained that he felt that his depression was well controlled. He declined a referral to the mental health team at that point.

91. Some changes to the man's medication were made during his time at Castington. In May 2011, he said he had been taking 20mg of fluoxetine rather than his prescribed 60mg. His prescription was reduced accordingly. On 9 August, he complained of interrupted sleep and poor concentration. A doctor prescribed citalopram rather than fluoxetine, though this caused him to experience palpitations and so he was again prescribed fluoxetine.

92. Another doctor suggested to the man on 17 November that he should take fluoxetine on alternate days rather than every day. On 9 December, however, he reported that he had felt worse with this arrangement and he returned to a daily dosage. The clinical reviewer, in his clinical review, noted that the National Institute for Health and Clinical Excellence (NICE) guidelines make no reference to prescribing antidepressants on alternate days.

93. On 9 December, a doctor considered increasing the man's fluoxetine prescription to 40mg daily. However, on 11 January 2012, another doctor saw him and decided to discontinue his prescription. Several members of staff noticed a difference in his mood, demeanour and appearance in early 2012. On 6 February, he saw another doctor, who noted that his mood had deteriorated since he had stopped taking fluoxetine, and prescribed 20mg daily.

94. It appears that there was little if any continuity and agreement about the anti-depressant medication that the man was prescribed. He saw a number of different doctors who took varying approaches. A doctor prescribed anti-depressants on alternate days despite there being no clinical guidance about this method. Only one month after a doctor considered doubling his daily dosage of fluoxetine, another doctor discontinued it completely. The corresponding note in the clinical record did not contain much detail about why the medication was no longer considered necessary. His mood then deteriorated, and the original dose was prescribed again a month later. There was no consistent approach to the prescribing of his medication. We make the following recommendation:

    The Head of Healthcare should ensure a consistent approach to prescribing anti-depressant medication that is in the patient's best interests, and in line with clinical guidance.

95. After a deterioration in the man's mood during January 2012, he was assessed by a nurse on 6 February. He agreed to offer support and psychological intervention and had further appointments with him on 14, 16,

20 and 28 February, and 5, 8 and 12 March. During these appointments he spoke about his imprisonment in very negative terms and had "overwhelming feelings of despair". The nurse talked about the possible benefits of cognitive behavioural therapy, though the overall theme of the appointments seemed to be that he was too anxious and preoccupied for any meaningful work to take place. The nurse attempted to overcome this using relaxation aids and providing information about stress management.

96. In the clinical review, the clinical reviewer was critical of the fact that there was no review of the man's care by a psychiatrist. Although a psychiatrist's opinion was sought on 14 February, this was not a detailed review. He did not see a psychiatrist during his time at Castington. The clinical reviewer noted that, during February 2012, he was seeing a mental health nurse, was subject to suicide and self-harm monitoring procedures and had been observed pacing in a unit office. The clinical reviewer wrote: "These signs are evidence of marked interference in functioning and would therefore fit the criteria for the NICE defined category of 'severe depression'". He made the following recommendations, which we endorse:

The Head of Healthcare should ensure that all mental health staff are trained in and follow the key recommendations of the NICE depression clinical guidance.

The Head of Healthcare should ensure that, in cases of established depression, anti-depressant medication should be provided alongside talking therapy interventions, with regular review of the patient's condition.

Assessment, Care in Custody and Teamwork (ACCT)

97. The ACCT process was started on 10 February after concerns were raised about the man's low mood and remained open until 29 February. Because of the limited information on some of the review forms, it was not always clear what, if any, additional support was offered and provided. There appeared to be little coordination with other support being provided. For example, by the time the ACCT was opened he had already had an appointment with a nurse, whom he saw a further four times during the course of his ACCT. The nurse does not appear to have been invited to ACCT reviews or asked about his views about his risk of suicide and self-harm. A nurse attended the review on 11 February, but, contrary to Prison Service guidance, no other review involved any members of staff other than prison officers.

98. When the man was on an ACCT, ACCTs were governed by the provisions of Prison Service Order (PSO) 2700. This set out the requirements for case reviews, and states that "specialist staff … involved in the care of the prisoner … must be invited to attend the next case review". If they cannot attend, they should be invited to contribute by telephone or in writing. PSO 2700 has now been replaced by Prison Service Instruction (PSI) 64/2011. In the section on ACCTs, there is a mandatory requirement for case reviews to be multi-disciplinary wherever possible. He had regular contact with healthcare staff

and chaplains but, apart from a nurse on one occasion, they were not represented at the ACCT reviews. Multi-disciplinary representation in his case would have provided a much more rounded and informed perspective on his level of risk and care. We make the following recommendation:

The Governor should ensure that ACCT reviews are multi-disciplinary and include all relevant people involved in a prisoner's care.

99. The ACCT documents were not always well completed and there were some errors in the process. The assessment interview, which took place on 10 February, was started by SO B, who was not a qualified ACCT assessor. An officer realised this and took over. The required frequency of observations and conversations recorded on the front page of the document were very vague, stating only that "regular conversations with unit and education staff" should take place and that "regular entries day and night" should be made in the document. While "hourly observations" were stipulated and carried out, there was no indication given of whether this applied to daytime and overnight periods. Records of reviews completed on 11 and 17 February were insufficiently detailed, and no level of risk was recorded on the latter. There was no explanation why the level of risk was reduced to low at the review of 23 February. It is important that ACCT documentation is completed accurately and comprehensively to help keep prisoners safe. We make the following recommendation:

The Governor should ensure that ACCT procedures follow the guidance in Prison Service instructions and that all ACCT documents are completed accurately and comprehensively so that there is a clear understanding of the level of risk and observations required.

100. A decision to close the ACCT was taken on 29 February after the man himself asked for this to be done. We are concerned that the decision was taken by SO B alone without any consultation with others involved in his care. The SO told the investigator that he had seen a "vast improvement" in the man's demeanour. This was not consistent with notes that were made in his records. Four days earlier, concerns had been raised that he had been given sleeping tablets by another prisoner. An officer had noted that he remained very low in mood. The day before the ACCT was closed a nurse had written in the clinical record that his levels of distress were significantly disproportionate to his circumstances.

101. The SO decided to close the ACCT after a direct request from the man. He conducted a review, but did so by himself. This is poor practice. There is a requirement that ACCT reviews must be attended by at least the case manager, a residential officer from the area where the prisoner lives and a member of non-discipline staff. It therefore follows that ACCTs should not be closed by a review meeting held in isolation by an SO. Caremap objectives should also be considered as part of ACCT reviews. There was no evidence that this was the case here and ACCTs should not be closed until all the Caremap objectives have been achieved.

102. The closing of the ACCT did not prevent the man from continuing to see the nurse, or from receiving support from members of staff on the unit or in the chapel. However, SO B's decision to close the ACCT meant that there was no further formal monitoring or reviews of him. We make the following recommendation:

The Governor should ensure that ACCTs are closed only by multi-disciplinary panels, and that all Caremap actions are completed before an ACCT is closed.

103. A post-closure review was arranged for 5 March, but there was no evidence that this took place. Post-closure reviews are an integral part of the ACCT process and are essential in ensuring that prisoners at risk of suicide or self-harm are kept safe. In the man's case we consider that a post-closure review on 5 March is likely to have led to the ACCT being re-opened. On that day he described to a nurse that he had "overwhelming feelings of despair". We make the following recommendation:

The Governor should ensure that post-closure reviews are held within seven days of the closure of ACCTs.

Information from another prisoner

104. A prisoner told the investigator that in a conversation on the afternoon of 13 March, the man told him that he intended to end his life that night. He said that the man did not go into any further details. He said he reported his concerns to an officer as soon as the conversation ended, but was worried that nothing was done in response.

105. There was nothing in the man's prison file to suggest that such a concern was recorded or acted upon. The prisoner was unable to recall the name of the officer and described him only as old. At the time of interview, he said that he had not seen the officer in the prison recently. While there is no reason to disbelieve his version of events, and he did have an apparently contemporaneous record of his interaction with the man, it is difficult to substantiate the claim and to establish who, if anyone, should have recorded and acted upon the information.

Emergency response

106. When members of staff entered the man's cell on the morning of the incident, there seemed to be an immediate presumption from both discipline and medical staff that he had died. Those involved and interviewed by the investigator consistently spoke of very large quantities of blood on his body, the bedclothes and the floor of the cell.

107. Nurse A checked for signs of life and decided not to commence cardio-pulmonary resuscitation (CPR). She and another nurse said that performing chest compressions would simply force any remaining blood from his body.

They were clear that attempting to resuscitate him would be futile. The doctor who verified the death endorsed this decision.

108. In his clinical review, the clinical reviewer noted that Nurse A checked for a radial rather than central pulse and that the justification given for not attempting CPR seemed to be the large amount of blood rather than the absence of any sign of life. Referring to the Primary Care Trust's verification of death policy, he pointed out that the factors suggesting that resuscitation is futile are listed as hypostasis (discoloration of the skin where blood has pooled inside the body), rigor mortis or decomposition. He went on to say that: "Signs of marked blood loss per se should prompt a clinician to attempt resuscitation unless there are one or more of the signs above". However, he acknowledged that resuscitation in such circumstances would involve administering fluid replacement, and that this would not normally be expected of nurses. He mentioned that such intervention is "only undertaken in some prisons by medics".

109. Based on the scene described by the members of staff involved, and the fact that Nurse A checked for signs of life and found none, we are satisfied that the decision not to perform CPR was appropriate.

CONCLUSION

110. Throughout much of the man's time in custody, few problems were identified. However, in early 2012, his mood, demeanour and appearance deteriorated. He appeared to begin to despair about coping with the length of his sentence and outcome of his appeal. He had been treated for depression but a number of different doctors took an inconsistent approach to the management of his medication. Because of concern about his state of mind, suicide and self-harm procedures were begun but these were not well managed. Reviews were not multi-disciplinary and his ACCT was closed by a single Senior Officer who did not consult others involved in his care. After the ACCT was closed he continued to receive support from chaplains, his mental health nurse and officers on his unit. He remained low in mood though some unit staff thought there was a slight improvement. ACCT monitoring was not considered again after 29 February, despite his evident low mood. One prisoner said he had passed on concerns that he intended to kill himself on the night in question, but we have been unable to substantiate this. When he was found there were no signs of life and resuscitation was not attempted.

111. It seems that the man was a prisoner whose mood and overall outlook on life deteriorated over a relatively short period time. He became fixated with his sentence and appeal and the remainder of his time in custody seemed insurmountable. Although he received some support, we are critical of what did not seem to be a very integrated or consistent approach to the management of his risk.

RECOMMENDATIONS

1. The Head of Healthcare should ensure a consistent approach to prescribing anti-depressant medication that is in the patient's best interests, and in line with clinical guidance.

   The recommendation was accepted. The GP service will standardise prescribing practice and the issue will be highlighted to the clinical director.

2. The Head of Healthcare should ensure that all mental health staff are trained in and follow the key recommendations of the NICE depression clinical guidance.

   The recommendation was accepted. All mental health staff will be trained in NICE guidance. Copies of NICE guidance are available to all members of staff.

3. The Head of Healthcare should ensure that, in cases of established depression, anti-depressant medication should be provided alongside talking therapy interventions, with regular review of the patient's condition.

   The recommendation was accepted. The mental health team will ensure that when a prisoner is offered psychological/talking therapies, other alternative treatments are explained. Where an anti-depressant medication is prescribed and while the mental health team is involved, the mental health practitioner will ensure regular reviews with the GP and the patient.

4. The Governor should ensure that ACCT reviews are multi-disciplinary and include all relevant people involved in a prisoner's care.

   The recommendation was accepted. A staff information notice will be issued regarding a multi-disciplinary approach to all ACCT case reviews and ensuring that all documents are completed accurately and comprehensively, and with a completed Caremap. The notice will also emphasise that, following the closure of ACCT documents, the first post-closure review must take place within seven days.

5. The Governor should ensure that ACCT procedures follow the guidance in Prison Service instructions and that all ACCT documents are completed accurately and comprehensively so that there is a clear understanding of the level of risk and observations required.

   The recommendation was accepted. See response to recommendation 4.

6. The Governor should ensure that ACCTs are closed only by multi-disciplinary panels, and that all Caremap actions are completed before an ACCT is closed

   The recommendation was accepted. See response to recommendation 4.

7. The Governor should ensure that post-closure reviews are held within seven days of the closure of ACCTs.

   The recommendation was accepted. See response to recommendation 4.