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 at hospital, while in the custody of HMP & YOI Gloucester in October 2012

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 an investigation into the death of a man while a prisoner at HMP Gloucester. He was found hanging in his cell and died in hospital two days later in October 2012. He was 39 years old. I extend my condolences to his family and friends.

A clinical reviewer carried out a review of the medical care the man received at the prison. HMP Gloucester cooperated fully with the investigation.

The man arrived at HMP Gloucester on 27 August 2012. He had a long history of mental health problems and had frequently harmed himself. He was monitored as a risk of suicide and self-harm from the time he first arrived and for most of his time he was at the prison. On the evening of 12 October, he was found hanging in his cell. At first he was unresponsive, but prison and ambulance service staff managed to resuscitate him. He was taken to hospital, where he was placed on life support and remained unconscious. Sadly, his condition deteriorated in hospital and he died a few days later.

While there were a number of deficiencies in the operation of the Gloucester's suicide and self-harm procedures, I consider it would have been difficult to predict and prevent the man's actions that evening. Although a defibrillator was not used, prison and ambulance staff made commendably determined and prolonged efforts to resuscitate him when he was found hanging, enabling him to be transferred alive from prison to hospital. No recommendations are made for improvement as HMP Gloucester has now closed.

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
Prisons and Probation Ombudsman **October 2013**

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SUMMARY

1. The man was remanded into custody at HMP Gloucester on 27 August 2012. He died in hospital after he had been found hanging in his cell on the evening of 12 October. He was 39 years old and had a long history of mental health problems. He frequently threatened to harm himself and, during the previous week in prison, had cut his arms and tried to hang himself.

2. When he arrived at the prison, the man was immediately monitored under Assessment, Care in Custody and Teamwork (ACCT) procedures, the Prison Service system to help prevent suicide and self-harm. He was referred to a psychiatrist for a mental health assessment who recommended a management plan of support, monitoring and reviews by the mental health team at the prison. On 4 September, the psychiatrist saw him again and agreed to his request to stop prescribing an antipsychotic drug.

3. The next day, the man asked nurses if he could start his antipsychotic medication again but was told this would have to be discussed with the psychiatrist at the next multi-disciplinary team meeting on 11 September. The psychiatrist decided not to prescribe the medication again as he showed no signs of active psychosis. He became preoccupied about having his medication reinstated and, when it was not, his relationship with mental health professionals and other prison staff deteriorated.

4. The man continued to be monitored under ACCT procedures until 3 October, when it was decided that his risk of self-harm was low. On 8 October he deliberately cut his arm and ACCT monitoring began again. He gave several reasons for harming himself, including that his medication had been reduced and concern about his family relationships.

5. After a visit from a friend on12 October, who told him his ex-partner was now involved with someone else, the man was found hanging in his cell. Prison and ambulance service staff successfully administered cardiopulmonary resuscitation, and he was taken to hospital. Prison staff did not use a defibrillator as part of the resuscitation attempt, although there is no indication this affected the outcome.

6. It would have been difficult to predict the man's actions that night, but the investigation found that there were some deficiencies in the medical record keeping, the use of a defibrillator in an emergency and in the operation of ACCT procedures. As the prison closed in March 2013, we are unable to make recommendations about these matters.

INVESTIGATION PROCESS

7. Notices were issued to staff and prisoners, inviting anyone with relevant information to contact the investigator. Several prisoners responded and the investigator interviewed them.

8. The investigator first visited HMP Gloucester on 23 October 2013 and met the Head of Residence, who briefed him about the circumstances of the man's death. The investigator visited relevant parts of the prison and met the Safer Custody Manager, Family Liaison Officer and representatives from the Independent Monitoring Board (IMB) and the POA (prison officers' union.) He conducted interviews with staff and prisoners at Gloucester on 31 October, 12 December, and 23 January 2013

9. HMP Gloucester provided copies of the man's prison and medical records. The local Primary Care Trust commissioned a review of his medical care on 23 October, which was carried out by a clinical reviewer. There were also contributions from a Consultant Anaesthetist and an executive member of the United Kingdom Resuscitation Council and a Consultant Forensic Psychiatrist, who is the consultant lead in a prison mental health in-reach team. The review was received on 28 January 2013.

10. One of the Ombudsman's family liaison officers spoke to the man's mother on 1 November 2012, to tell her about the investigation and offer the opportunity to raise any matters that she would like to be considered during the investigation. His mother wanted to know more about what had happened during her son's time in prison and mentioned his history of self-harm and depression.

11. The post-mortem report found that the cause of the man's death was from the effects of hanging.

12. The family received a copy of the draft report as part of the consultation process and representations were made by a solicitor on their behalf. The family remain concerned and raised issues that have been addressed in separate correspondence.

HMP GLOUCESTER

13. HMP Gloucester was a local adult male prison and young offender remand centre which served the courts of Gloucestershire and Herefordshire. The prison closed in March 2013. At the time of the man's death, it held up to 321 prisoners. Health services at Gloucester were commissioned by Gloucestershire Care Services Primary Care Trust and provided by the 2gether NHS Foundation Trust.

14. Between the Ombudsman taking over responsibility for investigating deaths in prison custody in 2004 and Gloucester's closure, there were nine deaths, of which four were self-inflicted. One of the recommendations in the investigation of the death before the man's was about the use of defibrillators and we had similar concerns in this investigation.

HM Inspectorate of Prisons

15. HM Inspectorate of Prisons conducted an announced inspection of Gloucester in August 2010. Inspectors noted that:

> "There was a comprehensive and cohesive suicide prevention strategy. There were relatively low numbers of self-harm incidents and open assessment, care in custody and teamwork (ACCT) self-harm monitoring documents. Death in custody action plans were well developed and appropriately managed. ACCT documents were generally of good quality with evidence of positive staff-prisoner engagement. All prisoners on ACCT spoke of reasonable levels of care by most staff and there was some targeted support led by mental health staff and the drug strategy senior officer."

Independent Monitoring Board

16. Each prison has an Independent Monitoring Board (IMB) of volunteers from the local community to help ensure that prisoners are treated fairly and humanely. Gloucester IMB's most recent report reported that suicide and self-harm training had taken place. IMB members reviewed all ACCT self-harm documents and participated in some ACCT reviews. The IMB was positive about the support Insiders and Listeners provided to other prisoners. (Gloucester recruited experienced prisoners as Insiders and Listeners. Insiders supported new prisoners and Listeners were trained and supported by Samaritans, to offer confidential support to fellow prisoners who were emotionally distressed and might be at risk of suicide or self-harm.)

KEY EVENTS

17. The man was remanded into custody by magistrates on 27 August 2012, charged with two counts of threatening to kill. He was 39 years old and this was not his first time in custody. He was upset about being estranged from his partner and children, which had led to the charges against him.

18. The man had a long history of mental health problems and had spent time as an inpatient. He had last been discharged from a mental health facility on 14 August 2012, where he had been detained briefly for assessment. He frequently harmed himself by cutting, by tying ligatures around his neck and by overdoses of prescribed medication. A few weeks before he went into prison, his partner's cousin had died suddenly of natural causes. His mental state had deteriorated in the two months before he went into prison.

19. When he arrived at Gloucester on 27 August, a registered mental nurse (RMN) saw him. In view of his mental health history, the nurse referred him immediately to the prison secondary mental health service for review and assessment. He also requested his records from his community doctor.

20. The nurse was aware from the escort documents that the man had recently made superficial cuts to his left forearm and had tried to hang himself the previous week. The documents indicated that he had told his solicitor that he wanted to kill himself but he told the nurse that he had no current thoughts of harming himself. Nevertheless, the nurse decided he should be monitored under Assessment, Care in Custody and Teamwork (ACCT) procedures. The nurse noted that his recent actions had been impulsive and that his condition and safety needed to be fully assessed.

21. The man told the nurse that his community doctor was concerned that he might have bowel cancer and he had been referred to a local hospital for an endoscopy (a procedure where a flexible tube with a camera at one end is used to examine the body internally) on 31 August.

22. An immediate ACCT action plan, agreed by a Senior Officer (SO), specified that staff should engage the man in at least three conversations during the day and observe him at least five times during the night. The SO also noted that staff had explained that there was 24 hour access to the Samaritans and Listeners. There was no case manager assigned on the ACCT document. He was allocated a shared cell.

23. The next day, on 28 August, a prison doctor saw the man and prescribed medication for his mental health including diazepam. The doctor noted that he became agitated when talking about his need for high doses of diazepam and insisted that he would have fits without it. His community doctor confirmed the endoscopy appointment

24. Prison Service guidance requires an ACCT assessment interview to be held within 24 hours of an ACCT being opened but the man's assessment, carried out by an officer, did not take place until 29 August. The assessment was

followed by the first case review, chaired by a SO, with the man and two officers. At the review, he said he would hang himself as soon as he could. His risk was noted to be high. An ACCT caremap should be completed to set out specific actions for support and address individual needs. The SO listed four issues and corresponding actions, each of which was signed off as being completed at that meeting. At the review, it was agreed that he should be constantly supervised, but this level of observation was reduced to every 15 minutes at a multidisciplinary meeting later that afternoon. The next case review was recorded as scheduled for 6 September, but in fact daily reviews were held until 31 August.

25. Two RMNs attended the multidisciplinary ACCT care planning meeting on 29 August and arranged an urgent assessment for the following day with a consultant psychiatrist.

26. Two psychiatrists visited the man on 30 August to review his Risk Overview (RiO) records (a computerised clinical information system used by the local mental health service). They noted that he had been diagnosed with a borderline personality disorder and had a history of recurrent self-harm since his late teens. He also had a history of aggressive anti-social behaviour, including carrying weapons.

27. During the assessment, the man interacted well and, according to the psychiatrist, did not show any psychotic symptoms. Although he was noted to be pessimistic, he did not appear hopeless. He made a number of statements about the future but acknowledged that he had some ideas about harming himself. The assessment noted that he was of moderate to high risk of self-harm but a medium risk of suicide. The psychiatrist recommended that he should remain on ACCT monitoring and that his mental state should be reviewed regularly. It was noted that because of his heightened emotional state at the time, he was likely to react badly to unwelcome news.

28. A SO chaired an ACCT review that day, attended by a nurse and two officers. The man did not attend but no reason for this was recorded. The review reduced his observations to half-hourly during the day and hourly at night. His risk was noted to be raised rather than high. He moved to a safer cell that day. (A safer cell is designed to provide less opportunity for prisoners to harm themselves.) An ACCT review on 31 August, indicated he had settled and he told nurses that he no longer felt suicidal or at risk of harming himself. (At the next review on 3 September, he said he wanted to stop all his medication. His risk remained recorded as raised.)

29. On 1 September, the man deliberately flooded his cell and also demanded to go back to a single cell. Staff moved him temporarily to another cell.

30. On 4 September, the psychiatrist saw the man again and assessed him as a medium risk of self-harm or suicide. He wanted to stop some of his medication (risperidone, an antipsychotic and orphenadrine, a muscle relaxant). The doctor agreed to stop the risperidone immediately and the orphenadrine a week later. He advised healthcare staff to continue

monitoring and supporting him. He believed he would be granted bail at a court hearing on 7 September and said he would follow up his physical health problems with his community doctor on release as he did not want to attend a hospital appointment, scheduled for that day, handcuffed to prison officers. (On 8 September, he signed a disclaimer to that effect.) It is unclear whether this was a rescheduled endoscopy appointment.

31. On 5 September, the man asked for risperidone but was told that he could not have the medication again unless the psychiatrist prescribed it. The next day, the ACCT review reduced the frequency of observations and interactions to three conversations daily and five night checks. His risk was reduced to low and a further review was set for 13 September.

32. The man was not given bail at his hearing, which was held by video link on 7 September. The next day, he told an officer that he felt unstable and feared a psychotic episode because he had not had his medication. The officer checked with healthcare staff who said that he had received all his prescribed medication. He was told this and advised of other support available to him. He told the officer that he had no thoughts of self-harm or suicide. He repeated the request later and received the same response. He also repeated his request for a single cell and a few days later, he moved to cell B3-07, a single cell.

33. On 11 September, a mental health nurse told the man that his medication would not be changed. He was said to be angry about this but accepted it. However, two further entries in the ACCT record later that day, noted he remained unhappy about the reduction in his medication. A mental health review that afternoon decided that it would remain unchanged. Over the following days, he complained about his medication to several members of staff.

34. At an ACCT review meeting on 13 September, the man's mood was noted to be low. He had harmed himself the previous night. He told a SO that he did not think he would make it to his next court date. The senior officer increased his observations to hourly. He was reviewed soon after by two nurses.

35. The next day, the man remained anxious and requested medication for cancer from the wing staff and Inderal (for anxiety) from a nurse, who referred him to the prison doctor. On 15 September, a doctor decided not to prescribe Inderal as he saw nothing in his past medical history to justify it. That evening, he asked for use of the Samaritans telephone and spoke to a Listener the day afterwards.

36. The man remained annoyed that his antipsychotic medication had not been reinstated. He refused to see the psychiatrist because he said he might become aggressive towards him. He then refused to communicate with any medical or prison staff. He would not attend an ACCT review on 19 September, as a protest about not receiving the medication. However, he said that he felt no worse but definitely no better. The review meeting, held in

absence agreed that his risk level was raised and that he should continue to have hourly observations for a further week.

37. On 21 September, a mental health nurse and a SO went to see the man because he continued to ask for antipsychotic medication. The nurse explained to him that as he was not exhibiting symptoms of active psychotic illness, the psychiatrist saw no reason to prescribe the medication. A nurse wrote in his medical record that all healthcare staff should continue to reiterate that he would not receive the medication for this reason.

38. The man began daily safer custody support group therapy sessions with other prisoners on 24 September. During the first session, he told the group he felt that he would kill himself after his court case. The occupational therapist leading the group recorded that she did not consider that he had made a plan to kill himself. He also said that he was dying of cancer, (although he had not been diagnosed with cancer). She made an entry about his suicidal thoughts in the ACCT document and advised wing officers.

39. Two days later, on 26 September, at his ACCT case review the man said that he felt more settled and wanted to complete his sentence in prison rather than in a hospital. His medication had been reduced and he said he felt a lot better. A SO commented that he looked fresher, was much more talkative and could maintain eye contact. He said he wanted to work towards coming off ACCT monitoring. No reference was made to the thoughts of self-harm he had expressed just two days earlier. The review assessed his risk as low and reduced the frequency of observations to three conversations during the day and five observations at night

40. On 1 October, the man told a nurse that he planned to take his life after his second court appearance on 17 October, as he would then know the length of his sentence. She discussed the impact this would have on his children, with him to little effect. She reported the conversation to wing staff and made an entry on his ACCT document. His risk overview record also indicates that one of the occupational therapists tried to contact mental health staff to “add him and other Safer Custody members to their list to be seen”.

41. That day, his personal officer noted that the man “has been a bit up and down, to the point where he refused to interact with staff”. He encouraged him to improve his behaviour and, after their discussion, he engaged with him better.

42. After a group therapy session on 2 October, the occupational therapist took the man back to his cell. She noticed that he had added on a note he had previously stuck on his wall stating, “my kids keep me going” the words, “by 17th October I will be dead”. She knew he had written it either the previous night or that morning and recorded in the risk overview document that she had reported this to wing staff.

43. The next day, 3 October, the man attended an ACCT review, chaired by a SO, who had not been involved in any of the previous reviews. Two other

officers were also present but there was no healthcare representative. He was reported as “a lot happier in himself” and, “stated he has no thoughts of suicide or self-harm”. There was no reference to the intentions to take his life expressed during the two previous days or the note that the occupational therapist had reported seeing. His risk level was reduced to low and the ACCT was closed. A post-closure interview was scheduled for 10 October.

44. On 4 October, as a result of the occupational therapist’s report three days earlier, a nurse from the mental health team went to see him, who declined to interact with him that day. On 7 October, he told the nurse that he wanted no further input from the prison mental health team. He persistently refused any interaction with the prison mental health team, stating that they had let him down and had reduced his medication at too fast a rate.

45. The occupational therapist visited the man in his cell just before 3.00pm on 8 October, to discuss his refusal to engage with the mental health team. She discovered that he had self-harmed by cutting himself. He said that he had been hearing voices and that he had tried to remove a tattoo of his ex-partner’s name but he “had not gone deep enough”. He threatened to hang himself and became agitated. The nurse reported this to a SO, who convened an ACCT case review half an hour later, with an officer. No other staff attended. It is not clear from the documents whether he was present but it was noted that he had threatened the healthcare staff because they had reduced his medication. (His prescription chart showed that his diazepam dosage of 10mg am and 15 mg pm had been reduced that day by 5mg from the morning dose. There is no note in his medical record to say who approved this change.) The ACCT was reopened and his risk level was assessed as raised and he was to be observed hourly.

46. During the evening and night of 8 October, the man refused to interact or co-operate with staff. He told them he did not want to be subject to the ACCT procedures and frequent checks. He threatened staff, obscured his light and the observation panel in his cell door to make it difficult for them to see into his cell and he cut his right arm.

47. On 9 October, the man would not attend an ACCT review which was chaired by a SO with two other wing officers. No healthcare staff attended. He said that, “his head was spinning and if he came to the review, it might spin out of control”. The review noted that he still had issues about his medication and would not tell staff how he felt. His level of risk remained raised. Staff at a multidisciplinary meeting held later that morning concluded that he should receive continued support and monitoring but staff should be aware of the threats he had made.

48. The last ACCT review before the man’s death was held in the early afternoon of 10 October. It appears to have been chaired by a principal officer, but the signature is indecipherable. It was noted that he was still in crisis, believed that all authority was against him and he said he would not engage with healthcare staff. He complained of sleep disturbance due to the observations and these were changed to three conversations daily and five observations

during the night. There was no change to his level of risk, which was still regarded as raised. A further review was scheduled for 24 October.

49. Over the next two days, the man continued to complain about his medication. Although he did not generally interact with prison staff, he engaged normally with other prisoners. He submitted a formal complaint about his medication on 11 October. The complaints clerk acknowledged his complaint the next day, indicating that a formal response would be sent after it was investigated and then passed the form to the Head of Healthcare.

50. At lunchtime on 12 October, an Operational Support Grade (OSG) caterer was concerned about the man. She told the investigator that he had a "glazed, faraway look on his face". A prisoner had told her earlier that he was concerned about him, as he seemed down and not well. She asked him if he was all right and he replied that he was, but it was clear to her that he did not want to talk. She allowed him, exceptionally, to get some tobacco from a prisoner, who was working with her at the servery. Another OSG was so concerned about his demeanour that at about 12.30pm, she telephoned wing staff to tell them about him. She asked if he was on ACCT monitoring and the officer she spoke to confirmed this. At interview, she said that if he had not already been subject to ACCT procedures she would have asked for him to be placed on ACCT monitoring.

51. That afternoon, 12 October, an officer unlocked the man for a visit with a friend and thought he seemed his normal self. His friend later told the police that he had told him that his estranged partner was seeing someone else, which distressed him who was concerned about his children. Another prisoner, who had known the man since childhood, told the investigator that the man's partner had visited him during the afternoon, but it appears that it was actually a friend. The prisoner's view was that their contact might have "pushed [him] over the edge". He also said that he "might have had a better chance" if he had been in a double cell with another prisoner.

52. The man returned to B wing at around 4.15pm, and spoke to another prisoner, who thought he looked fine and acted normally. An officer thought he appeared subdued and he told him that his partner was "doing things on the out" but would not elaborate. The officer said he told him that he was in the prison all evening and that if he wanted to talk he should ask someone to contact him and he would come to see him later. He did not respond to this or to an offer of the use of a Samaritans telephone. The officer let him into his cell and left the door open until around 4.30pm. At 5.00pm, he asked another officer for some medication to "zonk him out" that night. The officer said that was a decision for the doctor. who was not in the prison until the next morning.

53. Around 6.00pm, a newly-trained Listener at Gloucester spoke to the man in his cell, who told him about the visit. He also discussed a solicitor's letter about him not getting appropriate medication. With his permission, the Listener contacted an officer, who telephoned the duty nurse. The nurse said that he had told healthcare staff that he no longer wanted the medication and

that it would be reviewed the next Tuesday by the mental health team. An officer relayed the information to him. The nurse noted that he would visit him after the Listener had left if necessary. An officer saw him in his cell again at 7.00pm and said he gestured to him that he was all right.

54. At around 7.40pm, an officer decided to check on the man following their earlier conversation. When he looked through the observation flap he saw him at the rear of the cell facing towards him. He was fully clothed and his head tilted slightly to the officer's right. He had a noose around his neck, made out of a ripped towel and tied to the window bars and his feet were off the floor. The officer immediately radioed the prison control room and sent a "Code Blue" emergency message. (Code Blue indicates a prisoner with breathing difficulties.) The control room officer immediately radioed the duty healthcare staff and the orderly officer, in charge of the prison that night, for assistance.

55. The officer then went into the cell and lifted the man's body to relieve the pressure on his neck. He estimated that other staff, the duty nurse and a SO, the orderly officer, arrived within a minute or so. The nurse helped support him, while the SO cut the towel from around his neck, with his anti-ligature knife. The officer and nurse then lowered him to the floor on his back. The nurse described his face as being dark in colour and he thought that he had probably died. He checked his airway, breathing and circulation but could not detect any respiration or pulse. He checked his fingernails for a capillary response, but found no circulation. He said that within a few seconds of arriving, he started cardiopulmonary resuscitation (CPR) chest compressions. At 7.45 pm the assistant orderly officer radioed to request an emergency ambulance.

56. The duty nurse told the investigator that when he started CPR he called for somebody to bring the defibrillator. He could not remember whether and if so, when it arrived but he did not use it because he thought he heard a radio message saying that the ambulance was at the prison gate. Another nurse told the investigator that he could not remember the prison defibrillator being in the cell, either during the emergency or after the man had left the prison when he and a paramedic removed their equipment. There is no other record or account of the defibrillator being brought to the cell.

57. The nurse and a healthcare assistant arrived with the emergency medical bag. They continued CPR. The duty nurse still performed chest compressions, the other nurse used a pump to get air into the man's lungs and the healthcare assistant passed equipment to them. The officer and SO left the cell to allow them more room. After a while, the nurses noticed that he was showing signs of breathing and an oximeter (to monitor the level of oxygen) which they had attached to one of his fingers indicated that blood oxygen was present.

58. A paramedic arrived at the cell just after 7.50pm and took over supervision of the man's care. The three healthcare staff continued CPR while the paramedic checked his condition and attached a portable electrocardiogram

(ECG) to him. This indicated that there was some electrical activity in his heart. The paramedic gave him an adrenalin injection and inserted an intravenous line to administer additional drugs. Two more paramedics arrived and shortly afterwards, they were joined by a helicopter team. As the cell was too small to accommodate everyone, the prison nurses left. Some time later, one of the paramedics indicated that he was breathing and had a pulse. After stabilising him, they prepared him for transfer to the ambulance. At around 8.20pm, the duty governor arrived at the prison and began to implement the prison's emergency contingency plan.

59. The duty nurse collected the man's medical record from the healthcare centre and gave it to the ambulance crew. The ambulance left the prison at 8.58pm, and took him to hospital with two officers escorting. He was not restrained.

60. At 9.10pm, the duty governor held a hot debrief for the staff involved (a meeting to discuss relevant issues and provide support after a serious incident). The staff were offered support from the prison care team.

61. The duty governor tried unsuccessfully to telephone the man's next of kin who was named in his ACCT document. He then tried to contact other family members identified in his prison records. He was unable to contact his mother but spoke to his sister, at about 10.15pm, who told him that the named next of kin he had tried to contact was the man's daughter, a child. His sister agreed to inform other family members and go to the hospital.

62. At hospital, the man was placed on a ventilator, sedated and moved to the Critical Care Unit. Just after midnight, approximately 20 visitors arrived at the hospital. Visitors were allowed to see him for a short period in pairs. The escort remained in place but this was reduced to a single officer from 12.30pm on 13 October.

63. The man's family and friends continued to visit him throughout that weekend but he remained unconscious. His condition deteriorated and a few days later hospital staff carried out tests to determine his brain activity. Two doctors declared him dead. His family were at his bedside.

64. The prison's family liaison officers met the man's family at the hospital at about 5.00pm that day and outlined their role. One officer maintained contact with the man's mother who was offered a contribution to the cost of the funeral. The funeral took place on 29 October, attended by an operational manager and a representative of the chaplaincy.

65. A post-mortem examination concluded that the man died from the effects of hanging.

ISSUES

Clinical and mental healthcare

66. When the man went into prison he had a significant psychiatric and self-harm history. His reception health screen assessment was thorough and the Registered Mental Nurse who conducted it arranged for a specialist mental health assessment. In view of his recent history of self-harm, the nurse started suicide and self-harm ACCT procedures. The prison doctor requested information from his community doctor, assessed his primary health care needs and prescribed appropriate medication.

67. A consultant psychiatrist assessed the man on 30 August, within three days of him entering prison. He recommended a management plan that offered support and monitoring by the mental health team (MHT) and that his mental state should be reviewed regularly. At a further consultation on 4 September, he asked the psychiatrist to stop his anti-psychotic and muscle relaxant medication. The doctor considered there was no reason to refuse the request and stopped both medications.

68. The next day, the man asked for his anti-psychotic medication to be re-started. Healthcare staff were unable to do so without discussing with the psychiatrist at the next multidisciplinary safer custody meeting on 11 September. The team subsequently endorsed the decision not to alter the current medication. After that, he was described as becoming fixated about the reinstatement of the antipsychotic medication. He constantly asked for it to be issued and his relationship with the mental health and other prison staff deteriorated because of this. He became uncooperative with healthcare and prison staff and ignored them when they tried to engage him in conversation.

69. In the short time the man was at Gloucester, the clinical reviewer is satisfied that his physical health needs were identified and managed appropriately. His mental health needs were much more complex and the prison took timely steps to identify them, including obtaining information from his community doctor and previous mental health records. The clinical reviewer asked a forensic psychiatrist to review his mental health care. He concluded:

> "He suffered from a complex and longstanding difficult to treat combination of emotionally unstable and anti-social personality disorder. Community services appear to have tried to support him both in the community and by accessing hospital. His remand to prison appears in retrospect to have been reasonable given the circumstances of the threats he had made and the difficulty he had had in making use of admission to hospital. The management by the mental health in-reach team and the psychiatrist appears to have been of a high standard and I do not think there are any significant deficiencies in the care that they offered to him".

70. The clinical reviewer considers that the care the man received at Gloucester was of a good standard and that healthcare staff addressed his physical and

mental healthcare needs promptly and appropriately.

Assessment, Care in Custody and Teamwork (ACCT) and assessment of risk.

71. ACCT is the Prison Service process for supporting and monitoring prisoners at risk of harming themselves. The purpose of ACCT is to try to determine the level of risk posed, the steps that might be taken to reduce this and the extent to which staff need to monitor and supervise the prisoner. Checks should be irregular to prevent the prisoner anticipating when they will occur. Part of the ACCT process involves drawing up a caremap to identify the prisoner's most urgent issues and how they will be met. Regular multi-disciplinary reviews should be held and the ACCT plan should not be closed until all the actions on the caremap have been completed.

72. The man had a long history of self-harm. Reception staff correctly assessed and identified his risk and put in place the ACCT procedures shortly after he arrived. Apart from a five day period in early October, he was subject to ACCT monitoring throughout his time at Gloucester.

73. However, there were a number of shortcomings in the management of the suicide and self-harm procedures which were not in line with Prison Service guidance. No case manager was assigned for overall management of the ACCT plan. His ACCT assessment interview was not conducted within 24 hours of the opening of the ACCT, as the guidance requires. Although some senior officers acted as case manager on several occasions which provided some continuity of care, some reviews were chaired by prison staff who had no previous involvement with the man. He moved to a single cell but there was no consideration at his ACCT reviews about whether this was appropriate and how this impacted on his risk. The ACCT review of 3 October was chaired by a senior officer who had not been involved in any previous reviews. The ACCT was closed, although there had been significant recent indicators of risk which were not discussed at the review. His last review on 10 October was chaired by a principal officer who had not previously been involved in his care. There was no healthcare input. Although there had been no reduction in his perceived level of risk and he was regarded as being in crisis, the frequency of observations were reduced at his own request. Despite being regarded as in crisis the next review was set for a fortnight later which we consider was too long.

74. The caremap is one of the most important elements of the ACCT process as those responsible for supporting the prisoner determine and list the actions necessary to address the prisoner's issues and reduce his risk of self-harm. The man's caremap listed four actions, of which three were completed and signed off on the day of the first case review on 19 August. The remaining action was to give access to Listeners and Samaritans when required. At each case review, the caremap was said to have been reviewed, but there was no evidence of any specific action or comments or that the caremap was ever updated. The issues and actions initially planned were inadequate and demonstrated a lack of staff understanding of the purpose of the caremap.

75. The mental health team played a significant role in the man's welfare. Therefore, it was important for them to attend ACCT reviews so that those involved in his care could give a fully rounded perspective. Although mental health staff had significant input into the ACCT process, they were only present at around half of the case reviews.

76. Some assessments of risk were inadequate. The man had told staff on 1 October that he intended to kill himself later that month and wrote it on a note on his wall either that day or the following day. Members of the mental health team recorded both incidents and reported them to officers. Despite this his ACCT was closed the next day. The case review where this was decided was chaired by a senior officer who had played no previous part in the management of his ACCT. However, the incident on 1 October was recorded in the ongoing record of significant events in the ACCT document; therefore those at the review should have been aware of it, discussed it and taken it into account when assessing his risk.

77. The man had threatened to hang himself many times and had attempted it in the past before his imprisonment. He had told prison staff of his intention to do so by 17 October. On the evening that he hanged himself it was recognised that there were some concerns and some measures were put in place to support him including him being seen by a Listener. An officer had said he was willing to talk to him about what he knew had been a difficult visit and commendably, went back to see him that evening because of his concern. Tragically, he was too late to prevent him hanging himself. To some extent his actions reflected the psychiatrist's assessment on 30 August, that he was likely to react badly to bad news. However, we are satisfied that staff interacted with him as well as he would allow them and it would have been very difficult to predict and prevent his specific actions that night. Nevertheless, many of the risk assessments and ACCT procedures were poor and did not suggest a well-thought through and coordinated approach to help protect him.

Emergency response on 12 October

78. The man was discovered hanging by an officer at 7.40pm, who promptly called for help using the relevant emergency code and tried to alleviate the pressure on his neck. Other prison and healthcare staff attended within a few minutes. An emergency ambulance was called quickly and there was no delay in ambulance staff getting into the prison.

79. Two nurses led the resuscitation attempt using recognised CPR techniques for about 20 minutes. However, it is unclear whether a defibrillator was brought to the cell. The duty nurse remembers that he called for somebody to collect the defibrillator when he started CPR. He believes it was delivered to the cell but he cannot remember when. He noted on a record of medical emergency form "sent for defib on way when paramedic arrived". The other nurse said he could not remember a defibrillator being in the cell at the time or afterwards when he collected medical equipment which would not suggest that one was brought. Confusingly, the nurses told the clinical reviewer that

there was no delay in the defibrillator being taken to the cell. The SO believes he saw the nurses using a defibrillator during the resuscitation attempt.

80. The clinical reviewer stated that during the period when resuscitation was entirely led by healthcare staff, no attempt was made to apply defibrillator pads in order to check whether the man was in a cardiac rhythm that might be treated by an electric shock. He considered that they might not have done so because they were preoccupied with the resuscitation techniques and expected paramedics to arrive shortly. The clinical record shows that the prison defibrillator was brought to the cell at about the same time as the first paramedic arrived. If this entry is correct, that here would have been a delay of about twenty minutes. Although we are unable to reconcile the differing accounts but it is apparent that the defibrillator was not brought quickly to the cell when the emergency was called.

81. When the first paramedic arrived, no cardiac rhythm was found but other cardiac electrical activity was detected. Cardiopulmonary resuscitation continued for a further ten minutes and additional ambulance staff arrived and took over completely from prison staff. They continued to resuscitate the man for a further hour and established a cardiac rhythm before taking him to hospital.

82. A consultant anaesthetist, and an executive member of the United Kingdom Resuscitation Council, said:

> "The quality of the cardiac massage and artificial ventilation of the man must have been of a high quality for paramedics to arrive twenty minutes after he was found hanging and still detect signs of life that were worth their continuing efforts to save him. Best practice would have been to apply defibrillator paddles to check for a shockable heart rhythm almost immediately upon their arrival. However, death by hanging is almost invariably associated with a progressive slowing of the heartbeat and then the heart just stopping. This form of heart malfunction is not treatable by electric shock treatment. The opposite situation where the heart is beating massively too quickly (ventricular fibrillation) is a heart rhythm abnormality that is most improvable through electric shock treatment. Therefore it is very, very unlikely that application of the defibrillator paddles to his chest almost as soon as they were available would led to an increased chance of his recovery from hanging."

83. We commend the skill and the efforts of the two prison nurses in resuscitating the man, allowing him to be taken to hospital alive.

84. The consultant anaesthetist's opinion is that use of a defibrillator would have made no difference to the man's outcome. However, such an omission in other circumstances could make the difference between survival and death and there is a need to ensure that defibrillators are taken quickly to such emergencies in prisons.