Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Stephen Finch a prisoner at HMP Wayland on 23 May 2016

A report by the Prisons and Probation Ombudsman
Nigel Newcomen CBE

PO Box 70769
London, SE1P 4XY
Email: mail@ppo.gsi.gov.uk
Web: www.ppo.gov.uk
T | 020 7633 4100
F | 020 7633 4141

Our Vision

To carry out independent investigations to make custody and community supervision safer and fairer.

Our Values

We are:

Impartial: *we do not take sides*
Respectful: *we are considerate and courteous*
Inclusive: *we value diversity*
Dedicated: *we are determined and focused*
Fair: *we are honest and act with integrity*

The Prisons and Probation Ombudsman aims to make a significant contribution to safer, fairer custody and community supervision. One of the most important ways in which we work towards that aim is by carrying out **independent** investigations into deaths, due to any cause, of prisoners, young people in detention, residents of approved premises and detainees in immigration centres.

My office carries out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

Mr Stephen Finch was found hanged in his cell at HMP Wayland on 23 May 2016. He was 54 years old. I offer my condolences to Mr Finch's family and friends.

Mr Finch had been in prison for 16 months when he died, and prison staff had never identified him as at risk of suicide or self-harm. His actions on the night of 22 – 23 May were unexpected, although notes found in his cell after his death suggested that he might have been considering suicide for some time. There was little to indicate that Mr Finch was feeling particularly distressed or that he was at heightened and imminent risk of suicide. He gave no indication to anyone of his intentions or of the extent of his vulnerability. I therefore consider that it would have been difficult for staff at Wayland to have predicted his actions or prevented his death.

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

Nigel Newcomen CBE
Prisons and Probation Ombudsman **January 2017**

Contents

Summary 1
The Investigation Process 3
Background Information 4
Key Events 5
Findings 9

Summary

Events

1. In 20 January 2015, Mr Stephen Finch was remanded to HMP Chelmsford charged with arson against the Brahma Kumaris religious centre and the home of a follower of the religion. It was his first time in prison. At court, a nurse assessed Mr Finch's mental health and although he did not display any symptoms of a severe mental health problem, Mr Finch expressed some paranoid and delusional thoughts about the Brahma Kumaris. The nurse had some concerns about his risk of suicide and self-harm and completed a warning form.

2. At Chelmsford, Mr Finch said he had no thoughts of suicide or self-harm. He told healthcare staff that he had been diagnosed with myalgic encephalomyelitis/chronic fatigue syndrome (ME/CFS) and anxiety. His community records recorded that he did not have ME/CFS but had been diagnosed with chronic generalised anxiety disorder. The prison doctor continued his prescription for antidepressants, although it seems he was not taking them as prescribed when he died.

3. On 22 September, Mr Finch was transferred to HMP Wayland. At both Chelmsford and Wayland he reported a number of collapses and seizures and was assessed by healthcare staff who conducted tests and found no clinical cause for his symptoms. No one ever recorded any further concerns about his risk of suicide or self-harm.

4. Mr Finch was popular with other prisoners and appeared to have settled well at Wayland. No one reported any concerns about his risk of suicide or self-harm while he was there. On 21 May 2016, Mr Finch phoned his parents and seemed fine. Staff and prisoners who had contact with Mr Finch on 22 May had no concerns about him.

5. At about 4.55am on 23 May, the night patrol officer carried out a routine check of prisoners and found Mr Finch hanged in his cell. Staff went into Mr Finch's cell and despite signs that he was clearly dead, the night manager instructed them to attempt resuscitation. At 5.45am, the paramedics recorded that Mr Finch had died.

6. After Mr Finch died, staff found letters to his parents and partner, his last will and testament and a letter to staff. In the letters, Mr Finch said he was ending his life to escape the Brahma Kumaris. He thanked prison staff for their kindness and support and said that they were not responsible for his death.

Findings

7. Mr Finch had been in prison for 16 months when he was found hanged in his cell. He had never been assessed as at risk of suicide or self-harm in that time. In the days before he died, staff and prisoners thought he seemed his normal self. The notes found in Mr Finch's cell after his death suggested that he might have been contemplating suicide for some time, but we do not think that staff missed any signs that his risk had increased or that he needed additional support.

8. Mr Finch had a history of physical health problems and doctors assessed him frequently and conducted appropriate tests. Mr Finch had anxiety and was prescribed antidepressants, but was not taking them as prescribed. We are satisfied that the healthcare Mr Finch received at Wayland was appropriate.

9. When staff found Mr Finch hanged in his cell, they attempted to resuscitate him although he was clearly dead.

Recommendations

- The Governor and Head of Healthcare should ensure that prison and healthcare staff are given clear guidance and training, in line with established professional guidelines, about the circumstances in which resuscitation is inappropriate.

The Investigation Process

10. The investigator issued notices to staff and prisoners at HMP Wayland informing them of the investigation and asking anyone with relevant information to contact him. One prisoner asked to speak to him.

11. The investigator visited Wayland on 25 May. He obtained copies of relevant extracts from Mr Finch's prison and medical records and interviewed two prisoners.

12. NHS England commissioned a clinical reviewer to review Mr Finch's clinical care at the prison.

13. The investigator interviewed 11 members of staff and three prisoners at Wayland. The clinical reviewer joined the investigator for some of the interviews. At the initial report stage, the National Offender Management Service (NOMS) responded to the recommendations. That response has been annexed to this report.

14. We informed HM Coroner for Greater Norfolk of the investigation who gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.

15. One of the Ombudsman's family liaison officers contacted Mr Finch's partner to explain the investigation and to ask if she had any matters she wanted the investigation to consider. The family liaison officer and the investigator met Mr Finch's partner. She wanted to know more about Mr Finch's time in prison and the emergency response on the day he died. Mr Finch's partner received a copy of the initial report. She did not make any comments.

Background Information

HMP Wayland

16. HMP Wayland is a medium secure prison, near Thetford in Norfolk, holding over 1,000 men in thirteen residential units. Virgin Care provides healthcare services. There are no healthcare staff on duty at night at Wayland.

HM Inspectorate of Prisons

17. The most recent inspection of HMP Wayland was in August 2013. Inspectors reported that recorded levels of self-harm were low and the number of prisoners managed on Prison Service suicide and self-harm prevention procedures was slightly lower than at similar prisons. Good progress had been made on implementing the recommendations by the Prisons and Probation Ombudsman following investigations into two self-inflicted deaths. Inspectors reported that healthcare had improved since the last inspection and prisoners had access to a range of well-run clinics. Inspectors reported that many prisoners had a negative perception of staff-prisoner relationships. Most prisoners knew who their personal officer was and inspectors found good case entries on prisoner records.

Independent Monitoring Board

18. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report, for the year to May 2015, the IMB reported that Virgin Care delivered a sustainable, reliable service, although the IMB was concerned about the high numbers of temporary healthcare staff.

Previous deaths at HMP Wayland

19. Mr Finch's death is the fourth self-inflicted death at Wayland since 2014, and there has been another since Mr Finch died. In one of those investigations, we were concerned that staff attempted resuscitation when rigor mortis was present, which we also found in this investigation.

Assessment, Care in Custody and Teamwork

20. Assessment, Care in Custody and Teamwork (ACCT) is the care planning system the Prison Service uses for supporting and monitoring prisoners assessed as at risk of suicide and self-harm. The purpose of the ACCT process 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. Levels of supervision and interactions are set according to the perceived risk of harm. There should be regular multidisciplinary case reviews involving the prisoner. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011.

Key Events

21. In January 2015, Mr Stephen Finch was charged with two counts of arson against the Brahma Kumaris religious centre and the house of a follower of the religion.

22. On 20 January, Mr Finch appeared in court. A community mental health nurse assessed Mr Finch ahead of his court appearance. She recorded that Mr Finch said he had myalgic encephalomyelitis/chronic fatigue syndrome (ME/CFS) and had not worked for five years. (ME/CFS is a complex and debilitating chronic disease with a serious impact on one's quality of life.) Mr Finch told the community nurse that he had joined the Brahma Kumaris (a religious movement that teaches a form of meditation) 20 years earlier, but now believed that they were subversive and brainwashed members.

23. The community nurse recorded that Mr Finch was anxious about being remanded to prison and had recently had panic attacks. She noted that Mr Finch showed no signs of anxiety or depression and she found no evidence of serious mental health problems. Mr Finch said he occasionally had difficulty sleeping due to ruminating about the Brahma Kumaris. He told the community nurse that he had no current thoughts of suicide or self-harm but that about four years earlier, he had deliberately banged his head against a wall out of frustration. The community nurse completed a suicide and self-harm warning form (which escort and court custody staff use to alert others if they are concerned about suicide or self-harm).

24. That day, Mr Finch was remanded to HMP Chelmsford. This was his first time in prison. At his routine health screen in reception, Mr Finch told the nurse that he had been diagnosed with ME/CFS and anxiety. The nurse recorded that Mr Finch was not depressed, but held the apparently paranoid belief that the Brahma Kumaris had made him ill with ME/CFS, and referred him for a mental health assessment. Mr Finch said he had no thoughts of suicide or self-harm and the nurse did not begin suicide and self-harm prevention arrangements (known as ACCT), despite the community nurse's concern. Mr Finch told the nurse he had been prescribed sertraline, an antidepressant, in the community. After his health screen, Mr Finch saw a doctor who prescribed sertraline.

25. On 21 January, the mental health in-reach team discussed Mr Finch at a multidisciplinary meeting and decided he did not need support from the in-reach team and should remain under the care of primary healthcare services.

26. On 2 March, Mr Finch complained about the side effects of his antidepressants and a prison GP prescribed another antidepressant, fluoxetine, instead.

27. Between March and April, Mr Finch collapsed on two occasions and twice told healthcare staff he had had seizures. Healthcare staff assessed him on each occasion and a prison doctor concluded that Mr Finch's collapses were stress related. Mr Finch told the prison GP he had stopped taking fluoxetine and he was prescribed another antidepressant, mirtazapine. In May, prison doctors prescribed Mr Finch an anti-inflammatory for neck and shoulder pain and medication to treat dizziness.

28. On 20 July, Mr Finch was sentenced to five years in prison for racially/religiously aggravated criminal damage.

29. Between 22 August and 8 September, Mr Finch collapsed four times. He was examined by doctors, one of whom prescribed medication to help him sleep. One doctor noted that in 2014, a consultant had ruled out ME/CFS and had diagnosed Mr Finch with chronic generalised anxiety disorder, resulting in fatigue, leg weakness and pseudoseizures.

HMP Wayland

30. On 22 September, Mr Finch was transferred to HMP Wayland. A nurse assessed him in reception and recorded that he had no thoughts of suicide or self-harm. The nurse referred Mr Finch to the mental health team but did not record why. Mr Finch was assessed as able to keep his prescribed medication in his cell, meaning it was his responsibility to take it as prescribed.

31. On 23 September, a community psychiatric nurse (CPN) from the mental health team, assessed Mr Finch. Mr Finch told her he had no current thoughts of suicide or self-harm but that he continued to have some social problems because he had been brainwashed by the Brahma Kumaris. The CPN recorded that Mr Finch had no current symptoms of depression or anxiety, or of a serious mental illness, and could continue to receive support from the primary care team. The CPN referred Mr Finch to the wellbeing service for support. (The wellbeing service is provided to prisoners in Norfolk by the NHS and voluntary services. It aims to help prisoners with anxiety and low mood through self-care groups, guided self-help sessions and one-to-one sessions.)

32. On 24 September, a prison GP examined Mr Finch and recorded his history of falls associated with muscle weakness. She agreed to sign Mr Finch off work for two weeks while he settled down, and then reassess. In late October, Mr Finch started part-time work as a mentor in the education department.

33. On 13 October, Mr Finch had an appointment with the wellbeing service and on 23 and 30 October attended the stress control workshop. On 17 November, Mr Finch decided that he did not need any further support from the wellbeing service.

34. On 3 December, the prison GP prescribed Mr Finch melatonin, a natural sedative, to help him sleep. Although initially he said his sleep had improved, in late January, he complained of further problems and the prison GP prescribed a short course of zopiclone to treat insomnia.

35. In February 2016, Mr Finch said he had collapsed five times. After one of the collapses, healthcare staff carried out an echocardiogram (to detect abnormal heart rhythms) which was normal. After another collapse, doctors ordered a series of blood tests which showed no serious problems. The prison GP recorded that the collapses might be the result of a lack of sleep and noted that some of the blood tests should be repeated in four months.

36. In March and April, Mr Finch was examined three times by doctors. He continued to complain of dizziness, a lack of appetite, nausea and anxiety and he was prescribed build up drinks, vitamin D, zopiclone and naproxen for neck and

shoulder pain, as well as his existing prescription of mirtazapine. None of the doctors recorded any concerns about Mr Finch's risk of suicide.

37. During the late afternoon of Friday 20 May, Mr Finch asked Officer A for a printout of his prison bank account. Officer A told the investigator that Mr Finch regularly asked for a printout to check his expenditure. Mr Finch had a query about one of the payments, but the finance office had closed for the day so Officer A told Mr Finch to remind him after the weekend and they could look into it.

38. On 21 May, Mr Finch telephoned his parents. Mr Finch said nothing during the call to raise concerns. He said he was looking forward to their visit on 1 June.

Sunday 22 May 2016

39. On the afternoon of 22 May, Mr Finch spent time outside on the exercise yard with Mr B, a prisoner who lived on the same wing. Mr B told the investigator that Mr Finch was a popular prisoner who other prisoners sought out for advice. He said that, for a short period some weeks earlier, Mr Finch had asked other prisoners not to bother him. Mr B said that Mr Finch did not raise any concerns on 22 May, and they had walked together for some time. He said Mr Finch talked positively about his family and looked forward to their visits.

40. Mr C, another prisoner on the same wing, also talked to Mr Finch that afternoon. Neither Mr B nor Mr C had any concerns about Mr Finch that day and both thought he seemed his normal self.

41. At 4.51pm, Mr Finch rang his partner. She had a visitor at the time and was not able to talk and asked Mr Finch to ring back later. He said he would phone her during the week.

42. At around 5.30pm, Officer A locked prisoners on Mr Finch's wing into their cells. Mr Finch reminded Officer A about his query with his prison account, and said he would come and find the officer the next day. Between 8.30pm and 9.00pm, Mr D, the night patrol officer, checked all of the prisoners on Mr Finch's wing. He told the investigator that he could not recall seeing anything unusual when he checked Mr Finch.

Monday 23 May 2016

43. At about 4.55am on 23 May, Mr D started a routine check of all of the prisoners on Mr Finch's wing. When he reached Mr Finch's cell, he found that Mr Finch had blocked the observation panel in his cell door, so he looked through the inundation point for fire hoses in the door. He saw Mr Finch hanged with a sheet tied around his neck and to the window bars. Mr D ran to the wing office, alerted the night officers, Officer E, Officer F and Officer G who were in there and they all returned to Mr Finch's cell.

44. Mr D had a radio but did not radio a code blue medical emergency (indicating a prisoner is unconscious, not breathing or having difficulty breathing). He told the investigator that he thought it would be quicker to run to get assistance, as he knew the night staff were nearby.

45. According to the prison incident log, at 5.00am, Officer F radioed a code blue medical emergency and the officers went into the cell and cut the ligature from around Mr Finch's neck. Staff in the control room immediately called for an ambulance. There are no healthcare staff on duty at night at Wayland, but the officers checked Mr Finch for signs of life and considered that rigor mortis was present, indicating he had been dead for some time. They concluded that they should not try to resuscitate Mr Finch. When the night manager, Mr H, arrived at the cell, he told the officers to start resuscitation. Paramedics arrived at the cell at 5.20am, checked Mr Finch for signs of life and, at 5.45am, confirmed that Mr Finch had died.

46. After Mr Finch's death, staff found a last will and testament (dated 30 April 2016) and four letters in his cell. One letter was for his partner, two were for his parents, and one was for the officers working on his wing (dated 2 May 2016).

47. Mr Finch wrote to his parents that he could no longer cope with continued physical attacks by the Brahma Kumaris and had decided to take control by ending his life. Mr Finch wrote that prison staff had treated him with kindness and respect and were not responsible for his death.

48. In the letter to staff, Mr Finch apologised for what he had left them to deal with and thanked them for the kindness and respect they had shown to him. Mr Finch wrote that he wanted to make it clear that his treatment in prison had nothing to do with his decision to end his life.

Contact with Mr Finch's family.

49. At around 10.25am, the Deputy Governor visited Mr Finch's partner, his nominated next of kin, and told her about Mr Finch's death. In line with national instructions, the prison contributed to the costs of the funeral.

Support for prisoners and staff

50. On the morning of 23 May, the Head of Corporate Services debriefed the staff involved in the emergency response to allow them the opportunity to discuss any issues arising. She offered them her support and that of the staff care team.

51. The Governor issued notices to staff and prisoners informing them of Mr Finch's death. Officers and members of the chaplaincy team supported prisoners. Staff reviewed prisoners who had been assessed as at risk of suicide and self-harm in case they had been adversely affected by Mr Finch's death.

Post-mortem report

52. A post-mortem examination found the cause of Mr Finch's death was asphyxia by hanging. The toxicology examination found evidence of some of Mr Finch's prescribed medication (naproxen and zopiclone) in his body, but no evidence of mirtazapine (his prescribed antidepressant) or of any other illicit substances.

Findings

Identifying Mr Finch's risk of suicide and self-harm

53. When Mr Finch was remanded to prison in January 2015, he said that he had never attempted suicide before and reported only one incident of self-harm, about four years earlier. However, he had been diagnosed with anxiety and a mental health nurse at court considered he might be at risk of suicide and self-harm because of this and his apparently paranoid and delusional thoughts about the Brahma Kumaris. Mr Finch told staff at Chelmsford and Wayland that he had no thoughts of suicide or self-harm and at no point did staff consider that he needed to be supported by suicide and self-harm prevention arrangements. Mr Finch was prescribed antidepressants throughout his time in prison, although the toxicology results suggest he was not taking them as prescribed.

54. At Wayland, Mr Finch was popular with other prisoners and had apparently settled in well. He phoned his parents on 21 May and gave no indication that he was struggling to cope or contemplating suicide. His friends said that he had seemed in good spirits and his normal self on the 22 May.

55. In the letters found in his cell after his death, Mr Finch wrote that he had decided to kill himself to, as he saw it, escape the Brahma Kumaris. He said that staff at Wayland had shown him kindness and respect and were not responsible for his death. It seems from the dates on the last will and testament and one of the letters that Mr Finch may have been contemplating suicide for some time. We have found no evidence to indicate that staff should have identified that his risk of suicide had substantially risen in the days leading to his death and we do not think that they could reasonably have predicted his actions or prevented his death.

Clinical care

56. Mr Finch had a history of physical health symptoms including dizziness, insomnia, muscle weakness and collapses. He said he had been diagnosed with ME/CFS, although that diagnosis was rejected in 2014, and Mr Finch was then diagnosed with chronic generalised anxiety disorder. As noted earlier, he was prescribed antidepressants in the community, which continued in prison. As Mr Finch was assessed as able to keep his medication in his cell, it was his responsibility to take it as prescribed. There is no evidence that staff knew that Mr Finch was not taking his antidepressant medication.

57. At both Chelmsford and Wayland, Mr Finch complained of numerous collapses and was examined by prison doctors a number of times. The doctors conducted tests and investigated his symptoms and concluded that there was no obvious clinical reason for the collapses. They considered that Mr Finch's physical symptoms were probably stress or sleep related.

58. The clinical reviewer reviewed the clinical care Mr Finch received at Wayland. He was satisfied that Mr Finch's care was equivalent to what he could have expected to receive in the community.

Emergency response

59. Prison Service Instruction (PSI) 03/2013 (Medical Emergency Response Codes) requires governors to have a medical emergency response code protocol, which ensures an ambulance is called automatically in a life-threatening emergency. The protocol should give guidance on efficiently communicating the nature of a medical emergency, ensuring that staff take the correct equipment to the incident and that there are no delays in calling an ambulance. It explicitly states that all prison staff must be made aware of, and understand, the protocol and their responsibilities during medical emergencies.

60. Mr D did not radio a code blue medical emergency when he found Mr Finch hanged, but instead alerted the night officers who were in the wing office nearby. One of the night officers radioed a code blue when he arrived at the cell, very shortly afterwards. Mr D said that he knew he should have radioed a code blue, but thought that it would be quicker to run to the wing office and raise the alarm. We consider that there was only a very slight delay in calling the emergency code and that this did not affect the outcome for Mr Finch. We make no recommendation.

Resuscitation

61. The first prison officers to assess Mr Finch considered that rigor mortis was present, indicating that Mr Finch had been dead for some time. On that basis, they did not begin resuscitation. The night manager instructed them to begin resuscitation when he arrived a few minutes later. There are no healthcare staff on duty at night at Wayland.

62. European Resuscitation Council Guidelines 2010 state, "Resuscitation is inappropriate and should not be provided when there is clear evidence that it will be futile …" The guidelines define examples of futility as including the presence of rigor mortis. More recently, the British Medical Association (BMA), the Royal College of Nursing (RCN) and the Resuscitation Council (UK) issued guidance in October 2014 about making appropriate decisions in respect of resuscitation. The guidance says that every decision should be made on the basis of a careful assessment of each individual's situation. Decisions should never be dictated by 'blanket' policies. We understand that the natural inclination of prison and healthcare staff is to begin emergency first aid by giving life support. However, attempting resuscitation when someone is clearly dead is distressing for staff and undignified for the deceased. We make the following recommendation:

    The Governor and Head of Healthcare should ensure that prison and healthcare staff are given clear guidance and training, in line with established professional guidelines, about the circumstances in which resuscitation is inappropriate.

Prisons & Probation Ombudsman
Independent Investigations

PO Box 70769
London, SE1P 4XY

Email: mail@ppo.gsi.gov.uk
Web: www.ppo.gov.uk

T | 020 7633 4100
F | 020 7633 4141