Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Jonathan Palmer a prisoner at HMP Wandsworth on 19 November 2015

A report by the Prisons and Probation Ombudsman
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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 Palmer was found hanged in his cell at HMP Wandsworth on 19 November 2015. He was 30 years old. I offer my condolences to Mr Palmer's family and friends.

Mr Palmer's mental health was assessed a number of times in the five months he was at Wandsworth. Although his behaviour was increasingly strange and he reported evidently delusional thoughts, mental health specialists concluded that he did not have a psychotic illness. We do not know whether Mr Palmer's erratic behaviour was caused by drug use and I am concerned that Wandsworth does not have a dual diagnosis policy to support prisoners with both mental health and substance misuse problems.

Mr Palmer's family had serious concerns about his mental health and his risk to himself. His wife called the prison over a hundred times, and it is unacceptable that there is little evidence that these concerns were noted or action taken as a result.

The investigation found that there were a number of missed opportunities to support Mr Palmer using Prison Service suicide and self-harm prevention procedures as his behaviour became more erratic. However, I recognise it would have been difficult for staff to predict his actions on 19 November.

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 **August 2016**

Contents

Summary

Events

1. On 3 June 2015, Mr Jonathan Palmer and his two brothers were remanded to Wandsworth, charged with murder. Mr Palmer said he had never attempted suicide or self-harmed. He said he was dependent on pain relief medication and buprenorphine, a heroin replacement medication. A doctor prescribed buprenorphine and he began a diazepam detoxification programme. He shared a cell with one of his brothers in the drug treatment wing.

2. Mr Palmer had a history of anxiety and depression for which a prison GP prescribed medication. However, his family and prison staff became concerned about his bizarre behaviour and paranoid thoughts. Mental health professionals, assessed Mr Palmer seven times. These assessments, including two by a psychiatrist, concluded that Mr Palmer did not have a psychotic illness and considered his symptoms might have been the effects of 'spice' a new psychoactive substance (NPS) which Mr Palmer said he had been using. Although post-mortem tests indicated that Mr Palmer had not used NPS or other illicit drugs in the three months before his death, it appears that he had used them earlier.

3. Mr Palmer spent several periods in the prison's segregation unit because of his conduct. He smashed his cell twice, allegedly punched an officer and tried to assault another prisoner. On 12 August, the night manager began Prison Service suicide and self-harm prevention procedures, known as ACCT, as he was concerned about Mr Palmer's low mood. The next day, a case review concluded that he was not at risk and ended the monitoring.

4. Mr Palmer continued to behave erratically, including lighting fires in his cell, but mental health staff still considered he did not have a psychotic illness. His brothers and his wife remained very concerned about Mr Palmer's mental health. Mr Palmer's wife spoke to staff in the prison's safer custody department several times about her concerns, most recently on 15 November, but no one logged these calls or took any action.

5. At 1.56pm on 19 November, an officer unlocked Mr Palmer's cell for him to attend a visit with his wife and found him hanged by a torn sheet attached to the bed frame. Staff and paramedics were unable to resuscitate Mr Palmer and paramedics recorded that he had died.

Findings

6. There were a number of occasions when we believe staff should have considered monitoring Mr Palmer as at risk of suicide and self-harm, which would have allowed a better and holistic assessment of his risk. He was managed under ACCT procedures only once, for less than 24 hours in August 2015, and we identified some omissions in that process. We are concerned that Mr Palmer's family's concerns about him were not properly recorded and there is no evidence of action as a result. Mr Palmer behaved increasingly erratically shortly before his death, which should have triggered further assessments of his risk, but

we recognise that it would have been difficult for staff to have predicted his actions on 19 November.

7. Despite Mr Palmer's bizarre and erratic behaviour, mental health specialists concluded that he did not have a psychotic illness. No one obtained his community medical records to check for any previous mental health concerns. We consider that Mr Palmer's reported use of NPS use might have clouded some of the mental health assessments and we are concerned that the prison does not have a dual diagnosis policy to help manage prisoners with both mental health and substance misuse problems.

8. The clinical review concluded that Mr Palmer received appropriate treatment for substance misuse with a diazepam detoxification programme and buprenorphine treatment. However, healthcare staff should have done more to support and monitor Mr Palmer when he decided to stop taking all of his prescribed medications in October.

Recommendations

- The Governor should ensure that staff manage prisoners at risk of suicide or self-harm in line with national guidance, including:
    - Considering and recording all the known risk factors of a newly arrived prisoner when determining their risk of suicide and self-harm;
    - Case reviews recording and taking into account all the known risk factors and triggers when considering the risk of suicide and self-harm, including use of NPS;
    - Considering whether setting a fire amounts to an act of self-harm, requiring ACCT monitoring;
    - That ACCT checks are carried out as directed, at unpredictable intervals and documented in the on-going record;
    - Holding post-closure reviews as directed.

- The Governor should ensure that any concerns from a family member or friend about a prisoner's welfare and safety are appropriately recorded and followed up, and any actions documented. Staff should open an ACCT when they receive information from family members which indicates a risk of suicide or self-harm

- The Head of Healthcare should ensure that staff request and record relevant community health records for newly arrived prisoners.

- The Head of Healthcare should ensure that there is a clear dual diagnosis policy and that all referrals have a structured mental health assessment, irrespective of ongoing substance misuse issues.

- The Head of Healthcare should ensure that the reasons for a prisoner not taking prescribed medication are clearly documented. When mood altering medication is not collected, the mental health team should be informed and follow this up with the prisoner.

- The Governor should ensure that staff consistently follow a clear pathway for managing prisoners suspected of using NPS and other illegal substances.

The Investigation Process

9. The investigator issued notices to staff and prisoners at HMP Wandsworth informing them of the investigation and asking anyone with relevant information to contact her. No one responded.

10. The investigator visited Wandsworth on 26 November 2015. She obtained copies of relevant extracts from Mr Palmer's prison and medical records.

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

12. The investigator and another investigator and family liaison officer interviewed 19 members of staff and two prisoners at Wandsworth on 15 and 21 December 2015, and 5 January and 4 April 2016. The clinical reviewer attended interviews with healthcare staff. The investigator and the family liaison officer interviewed Mr Palmer's two brothers at HMP Belmarsh on 7 December 2015.

13. We informed HM Coroner for Inner West London of the investigation who gave us a copy of Mr Palmer's toxicology report. The coroner has a copy of this report.

14. The family liaison officer contacted Mr Palmer's wife to explain the investigation and to ask if she had any matters she wanted the investigation to consider. She asked that we consider whether Mr Palmer received appropriate mental health treatment at Wandsworth. She said that she had phoned the prison many times to raise concerns about Mr Palmer's mental health and his risk to himself, but nothing had been done in response. She gave us detailed telephone records to show when she had called the prison.

15. Mr Palmer's brothers, who were also his co-defendants, were both concerned that staff had attributed Mr Palmer's behaviour to his use of new psychoactive substances (NPS) rather than assessing and treating his deteriorating mental health. One of Mr Palmer's brothers gave the investigator a list of prisoners who he thought could provide evidence. Not all of the prisoners were still in prison and could be traced and only two agreed to be interviewed. One of the prisoners we interviewed has since died.

16. Mr Palmer's family received a copy of the initial report. The solicitor representing them wrote to us raising a number of questions that do not impact on the factual accuracy of this report. We have provided clarification by way of separate correspondence to the solicitor.

Background Information

HM Prison Wandsworth

17. HMP Wandsworth is a local prison in southwest London that holds over 1,250 men and primarily serves the courts in south London. St George's University Hospitals NHS Foundation Trust provides healthcare services at the prison.

HM Inspectorate of Prisons

18. The most recent inspection of HMP Wandsworth was in February and March 2015. Inspectors reported the quality of ACCT documents was variable and many of those examined were poor. Case reviews were often late, with minimal attendance. The daily complex case review meeting, where all new prisoners subject to ACCT processes were discussed alongside complex longer-term cases, was a useful initiative but residential staff did not attend regularly. Mental health services were good.

19. The substance misuse strategy was well coordinated, with a detailed supply reduction strategy. The mandatory drug testing rate was similar to other local prisons but inspectors noted there had been a number of finds of spice' (highly potent synthetic cannabinoids that are potentially more harmful than cannabis but do not show up in mandatory drug tests). Substance misuse treatment started promptly, but not all new arrivals received appropriate monitoring and observation. There was a lack of supervision of controlled drug administration in the first night centre. Mental health services were generally good but the dual diagnosis service (for those with co-existing mental health and substance misuse problems) was no longer running and there was insufficient integration between clinical, psychosocial and mental health services.

Independent Monitoring Board

20. 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 staff shortages had impacted on service delivery. The number of permanent healthcare staff was at the lowest ever level and the IMB reported that this had delayed assessments.

21. Some prisoners suffering from the effects of taking new psychoactive substances (NPS) had been admitted to the prison's mental health inpatient unit and one had been admitted to a secure psychiatric unit after taking such a substance. The IMB noted that the dual diagnosis nurse post no longer existed. There was a protocol for prisoners suspected of taking NPS to be monitored in a dedicated cell on D Wing and an increased number of prisoners suffering from the effects of taking NPS were held in the mental health unit and the segregation unit. The IMB noted that procedural inefficiencies led to too many disciplinary hearings being deferred.

Previous deaths at HMP Wandsworth

22. There were four other deaths at Wandsworth in 2015, two of which were self-inflicted. In those investigations, we were concerned that staff did not adequately identify and assess the prisoner's risk of suicide. We were also critical of the management of ACCT procedures and the emergency response arrangements. These matters arose again in this investigation. .

Assessment, Care in Custody and Teamwork

23. Assessment, Care in Custody and Teamwork (ACCT) is the Prison Service care-planning system to support prisoners at risk of suicide or self-harm. The purpose of ACCT is to try to determine the level of risk, how to reduce risk and how best to monitor and supervise the prisoner.

24. After an initial assessment of the prisoner's main concerns, levels of supervision and interactions are set according to the perceived risk of harm. Checks should be irregular to prevent he prisoner anticipating when they will occur. There should be regular multidisciplinary review meetings involving the prisoner. As part of the process, a caremap (plan of care, support and intervention) is put in place. The ACCT plan should not be closed until all the actions on the caremap have been completed.

25. All decisions made as part of the ACCT process and any relevant observations about the prisoner should be written in the ACCT booklet, which accompanies the prisoner as they move around the prison. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011.

New Psychoactive Substances (NPS)

26. NPS are an increasing problem across the prison and immigration detention estates. They are difficult to detect, as they are not identified in current drug screening tests. Many NPS contain synthetic cannabinoids, which can produce experiences similar to cannabis. NPS are usually made up of dried, shredded plant material with chemical additives and are smoked. They can affect the body in a number of ways including increasing heart rate, raising blood pressure, reducing blood supply to the heart and vomiting. Psychological effects can include psychosis and hallucinations, depression and suicidal thoughts, antisocial or paranoid behaviour and emotional and erratic behaviour.

27. As well as emerging evidence of dangers to both physical and mental health, there are other links to suicide or self-harm. Trading in these substances, while in custodial settings, can lead to debt, violence and intimidation.

28. In July 2015, we published a Learning Lesson Bulletin about the deaths associated with use of NPS. We identified dangers to physical and mental health, as well as risks of bullying and debt and possible links to suicide and self-harm. The bulletin identified the need for better awareness among staff of the dangers of NPS; the need for more effective drug supply reduction strategies; better monitoring by drug treatment services; and effective violence reduction strategies because of the links between NPS and debt and bullying.

Key Events

29. On 1 June 2015, Mr Jonathan Palmer and his two brothers were arrested and charged with aggravated burglary and murder. Mr Palmer reported a number of physical and mental health problems, and had with him his prescribed medication of diazepam, tramadol, and pregabalin (all to relieve the pain from a spinal abscess) and citalopram (an antidepressant). He said that he had never harmed himself but felt very anxious and upset. Mr Palmer said he was not dependent on any substances but later told a police doctor that he had a history of seizures when he stopped taking his prescribed medication. The doctor prescribed him diazepam and dihydrocodeine (another pain relief medication).

30. On 3 June, Mr Palmer and one of his brothers were remanded to HMP Wandsworth. Mr Palmer's escort record from the police and the courts noted no concerns about Mr Palmer's mental health. Mr Palmer and his brother arrived at Wandsworth together. Mr Palmer had been in prison before, but not Wandsworth.

31. At an initial health screen, Mr Palmer was tearful but told Nurse A that he had no thoughts of suicide or self-harm and had never attempted suicide. An hour later, he said he was addicted to opiates and the nurse referred him to the prison's drug treatment service.

32. Ten minutes later, Mr Palmer gave a urine sample which tested positive for cocaine, benzodiazepines, cannabinoids and buprenorphine (a synthetic opiate, which is usually prescribed to treat heroin addiction). Mr Palmer's brother told the investigator that he had given the urine sample for his brother, as Mr Palmer did not use drugs but they wanted to be together in the drug treatment wing. Mr Palmer's wife told us that Mr Palmer used his brother's prescribed buprenorphine in the community, and was addicted to it.

33. Nurse B, a substance misuse nurse, reviewed Mr Palmer and checked with his community pharmacy that he was prescribed diazepam 10mg, pregabalin 300mg, tramadol 100mg and citalopram 30mg. No one requested his community GP records. Mr Palmer said he also used buprenorphine illicitly. The nurse examined Mr Palmer using a standardised drug withdrawal assessment. He had no significant symptoms of drug withdrawal, but because of his positive urine sample, he was allocated to the drug treatment wing and referred to the substance misuse service. No one in reception considered that Mr Palmer was at risk of suicide or self-harm.

34. Later that evening, Mr Palmer told Dr A that he had been prescribed 16mg of buprenorphine daily in the community. The doctor prescribed an initial dose of 2mg, until this could be checked. He also prescribed citalopram, co-dydramol (a pain relief medication) and a reducing dose of diazepam as a 12-week detoxification programme. A healthcare assistant, A, checked Mr Palmer five times that night but did not take his blood pressure or pulse, or record whether Mr Palmer had any withdrawal symptoms.

35. On 4 June, Nurse C saw Mr Palmer for a routine second day assessment and noted that he appeared stable, with mild withdrawal symptoms. Mr Palmer said he was depressed and had been prescribed citalopram. The nurse thought he

seemed very stressed and he told her that he had killed someone by accident. The nurse phoned Mr Palmer's pharmacy again, who confirmed that he had been prescribed citalopram, pregabalin, and diazepam, but also said he was prescribed nitrazepam (for anxiety). No one asked for written confirmation of Mr Palmer's prescribed medications or requested his community GP records. The nurse noted Mr Palmer's physical conditions and that he walked with the aid of a crutch.

36. Dr B saw Mr Palmer and noted that he was anxious and depressed, especially about his alleged offence. He was tearful but said he had no thoughts of suicide. The doctor referred him to the mental health team. He prescribed Mr Palmer pregabalin and increased his dose of buprenorphine.

37. Later that afternoon, Nurse D, a mental health nurse, assessed Mr Palmer and incorrectly recorded that he was due to appear in court the next morning for sentencing. They discussed the charges against him and that he felt angry and frustrated. He said he had a cell with his brother and wanted to continue sharing with him, as they supported each other. Mr Palmer said he had no thoughts of suicide or self-harm. There is no record that the nurse standard clinical tools to assess Mr Palmer's mental health. She recorded that she did not think he needed any mental health treatment but had asked him to contact the team again if he needed help.

38. Healthcare assistants checked Mr Palmer that evening and three times during the night. They did not take any physical observations or assess Mr Palmer for withdrawal symptoms.

39. On 5 June, Mr Palmer told a substance misuse nurse, that his prescribed dose of buprenorphine was not enough and asked for it to be increased. She assessed his withdrawal symptoms, but noted that Dr B had already arranged for the dose to rise to 6mg that day. The next day, Mr Palmer again said his dose was insufficient. A healthcare support worker noted he was tearful, very low in mood, and showed mild withdrawal signs. There was no record of whether Mr Palmer had any thoughts of suicide or self-harm.

40. On 6 June, Mr Palmer's other brother was remanded to Wandsworth and allocated to the drug treatment wing. Mr Palmer's brothers each shared a cell with Mr Palmer at different times to support him.)

41. On 7 June, healthcare assistant, B, assessed Mr Palmer for signs of withdrawal and checked his pulse rate and blood pressure. Mr Palmer said he felt anxious, low and tearful because of the charges he was facing, but had no thoughts of suicide or self-harm. He again said that his current dose of buprenorphine was not enough and healthcare assistant B told him to discuss it with the doctor at a scheduled appointment the next day.

42. On 8 June, Dr B reviewed Mr Palmer, who said he had insomnia and felt cold but was sweating. The doctor increased Mr Palmer's dose of buprenorphine to 8mg daily.

43. That day, Mr Palmer told a drug worker from the Rehabilitation of Addicted Prisoners Trust (RAPt), that he had used cannabis and cocaine in the community

and misused the pain medication he had been prescribed, because of his spinal abscess. The drug worker noted that Mr Palmer needed support and referred him to the chaplaincy team, a RAPt family support worker and to the mental health team again, because Mr Palmer said that he had been waiting for a mental health referral in the community. The drug worker noted that they could not begin work on Mr Palmer's substance misuse problems until he was more stable. He planned to see Mr Palmer again on 9 October.

44. On 11 June, Mr Palmer told a RAPT family support worker, that he did not have enough money and he had not been feeling emotionally stable enough to speak to his wife since he had arrived at Wandsworth. The RAPT agreed to call his wife on his behalf. She noted that Mr Palmer seemed very low in mood but he said he had no thoughts of suicide or self-harm..

45. On 12 June, the RAPT worker phoned Mr Palmer's wife and discussed arrangements for Mr Palmer's wife and children to visit him. On 15 June, Mr Palmer's wife phoned the RAPT worker after visiting Mr Palmer and said that Mr Palmer had been very emotional and was upset that he still did not have any money to phone her and speak to their children. The RAPT worker said she would check Mr Palmer later in the week and let her know how he was. (Mr Palmer's wife subsequently telephoned the RAPT another eight times before his death, with concerns about her husband's mental health. The last time was on 28 August, and the RAPT worker advised her to speak to safer custody staff, as she was unable to answer her questions.)

46. On 16 June, Dr C, a psychiatrist, reviewed Mr Palmer's case and recorded that the primary care mental health team had discussed Mr Palmer because he had been charged with murder. She noted that Nurse D had not identified any mental health problems when she had assessed him and had considered that he seemed to be coping well in prison. The doctor noted that Mr Palmer had said that he had no thoughts of suicide or self-harm and that the primary mental health team did not plan to offer Mr Palmer any further treatment at that time.

47. On 16 July, Mr Palmer's wife phoned the RAPT worker, as she was concerned that he had not called her that day. The RAPT worker went to see Mr Palmer and told him his wife was worried. She thought he seemed drowsy and confused. He said that his mother had recently been diagnosed with cancer and that his brother was taking care of him. He told her that he would call his wife and the RAPT worker phoned her to let her know.

48. Later that evening, an officer found Mr Palmer crouched on the floor of his cell unresponsive and in a very drowsy state. Nurse E managed to rouse and examine him. She checked he was breathing and recorded his pulse and blood pressure, which were within normal ranges. She suspected that he might have taken illicit drugs, including new psychoactive substances (NPS), and arranged for healthcare staff to check him intermittently during the night. She also arranged for Mr Palmer and his brother to have a drug test the next morning and to see a doctor. Healthcare assistant, A, checked Mr Palmer at 00.13am and 1.29am and noted that he appeared to be asleep and breathing normally. The next morning, Mr Palmer tested positive for benzodiazepines and buprenorphine, which he was prescribed. The test used could not detect NPS.

49. Wandsworth has an NPS protocol, which was first issued in December 2014, and outlines the actions staff should take when they suspect a prisoner has used NPS. It says that healthcare staff should move the prisoner to the prison's mental health inpatient facility or to a constant supervision cell in the drug treatment wing, if the prisoner appeared agitated. A doctor should assess the prisoner to consider prescribing medication to treat withdrawal symptoms and to decide whether it is safe for the prisoner to continue with his prescribed medication. For the first two hours, prisoners should be checked every 30 minutes but monitoring should continue for two to four days. Mr Palmer remained on the wing, but was checked only twice during the night. He did not see a doctor or have his medication reviewed, as outlined in the protocol in place at that time.

50. On 20 July, an officer submitted a security report, noting a strong smell of cannabis in the wing showers. Four prisoners, including Mr Palmer and one of his brothers, were using them at the time. There is no record of any further action. That day, Mr Palmer's wife rang the RAPT worker and said she was concerned about his mental state. She said that she had told him his mother had only weeks left to live and she was worried he would not be able to cope. The RAPT worker discussed the call with drug worker, A, who said he would visit Mr Palmer on the wing. He did not record whether he had done this.

51. The next day, 21 July, Mr Palmer's wife visited him and officers monitoring CCTV saw Mr Palmer take an item from a bag of nappies and swallow it. Supervising Officer (SO) A ended the visit and Mr Palmer was searched and moved to the segregation unit, in line with the local policy.

52. When staff questioned him, Mr Palmer said he had only swallowed a sweet. He seemed alert and orientated, but was tearful and insistent that he had not taken any drugs. Although he said he had thoughts of harming himself, no one began ACCT procedures. Nurse F considered that Mr Palmer could be safely segregated but that staff should check him hourly and alert healthcare staff if he became drowsy or unresponsive.

53. Because Mr Palmer was suspected of taking an illicit substance, he was not given his prescribed diazepam and Nurse F noted that his current buprenorphine prescription should be reviewed. (The dose was not changed). A urine drug test detected benzodiazepines and buprenorphine. Mr Palmer was charged with a disciplinary offence. The matter was referred to the police, but nothing further had happened before Mr Palmer died. The next day, Mr Palmer returned to the cell he shared with his brother.

54. On 8 August, an officer submitted a security report noting that Mr Palmer had refused to leave his cell to collect his medication and had said that there were laser beams coming up from the floor into his teeth. The officer did not talk to Mr Palmer about this, but spoke to his brothers, who said that Mr Palmer had recently taken spice, which had affected his mental health. The officer did not refer this to healthcare staff and the security department took no action. There was no record of this in Mr Palmer's prison record or the wing observation book. Mr Palmer's brothers told the investigator that they had never told staff that Mr

Palmer had used spice. They said that Mr Palmer had never used spice at Wandsworth.

55. The next day, 9 August, officers moved Mr Palmer to another cell after he had had a fight with his brother, broke cell furniture and flooded their cell. Staff noted that Mr Palmer was covering his head with his hands and rocking in the cell. Nurse B examined him and noted that, although he had calmed a little, he was still agitated and upset. Staff moved him to the segregation unit and charged him with fighting. (The charge was not proceeded with as a manager decided that, because of his strange behaviour, Mr Palmer was not fit to plead.)

56. Nurse G examined Mr Palmer in the segregation unit and recorded that he seemed settled and coherent. The nurse noted that Mr Palmer's brothers had told officers that Mr Palmer was struggling to cope in prison and with the charges against him, and that he had smoked spice three days earlier. The nurse considered that Mr Palmer could be safely segregated. Mr Palmer was not monitored in line with the NPS protocol and no further action was taken to investigate whether he had used spice.

57. On 10 August, Dr D, a psychiatrist, and a mental health nurse, Nurse H, saw Mr Palmer in the segregation unit. Mr Palmer appeared very agitated and said he had used spice. He clutched his head and said there was a microchip in it. He had red marks on his scalp, but said he had not harmed himself. He then became too distressed to continue with the assessment. The doctor and the nurse discussed Mr Palmer with segregation unit officers, who thought that his symptoms were similar to other prisoners who had smoked spice. The doctor and the nurse agreed that Mr Palmer's psychotic symptoms were consistent with spice use. They thought that he posed a risk to himself because he was so distressed and because of the marks on his head but did not begin ACCT procedures or refer him for any further mental health support.

58. Dr D and Nurse H told the investigator that they were unable to complete a detailed examination as Mr Palmer was too distressed, but it was clear that he had paranoid psychotic symptoms. They thought that he should be moved to a constant supervision cell in line with the NPS protocol and discussed their concerns with a prison manager. The prison manager told them that, under the protocol, Mr Palmer should move to the mental health unit. The Head of Healthcare disagreed and said Mr Palmer should be constantly supervised in the segregation unit or on a standard wing. Mr Palmer remained in the segregation unit, where he was constantly supervised. No one recorded any further concerns about Mr Palmer that night.

59. On 11 August, Nurse G examined Mr Palmer and noted that he appeared calm and alert and was polite and respectful. He had no recollection of what had happened and said he was sorry he had damaged prison property. Later that day, Dr D prescribed promethazine 25mg (to be dispensed as required) for acute agitation because of taking spice.

60. On the morning of 12 August, Mr Palmer returned to a single cell on D Wing. Shortly afterwards, smashed the sink in his cell and hurt himself.

61. Mr Palmer told officers he had smoked spice on 8 August, and they said he needed a period of detoxification before healthcare staff would be able to assess him. A member of staff submitted another security report noting that Mr Palmer's brothers had admitted smoking spice and that Mr Palmer had also smoked it, which explained his behaviour. The information was passed to the searching and dog section team and to senior managers. (As noted earlier, Mr Palmer's brothers denied that they had said that Mr Palmer had smoked spice. They also said they had not admitted to officers that they had used it.)

62. At 8.30pm, Officer A, discovered that Mr Palmer had been left in the cell with the broken sink and blood on the floor. She radioed for a member of healthcare staff and the night manager to attend. Nurse E examined Mr Palmer and noted he did not need any treatment, but she offered him a dose of promethazine. She referred him to the mental health team. Wing staff cleaned the cell.

63. As Mr Palmer was behaving strangely and seemed very low in mood, the night manager decided to begin ACCT procedures. Officer A completed the first page of the ACCT plan and noted that Mr Palmer's behaviour was erratic and he seemed down. The officer recorded that she had spoken to one of Mr Palmer's brothers who was concerned about him and said he had recently punched Mr Lewin, which was out of character. The night manager instructed staff to check Mr Palmer twice an hour.

64. The night manager completed the ACCT immediate action plan. He noted that Mr Palmer should remain in the cell, which should be made safe and clean and that staff should check him twice an hour. He referred Mr Palmer to the mental health team. Officer A checked Mr Palmer at regular, half-hourly intervals during the night (except between 4.00am and 5.06am, when no checks were recorded).

65. At 10.30am on 13 August, an administrator from the safer custody team, assessed Mr Palmer as part of ACCT procedures. Mr Palmer said he did not know why he was on an ACCT and that he was on a "come down" from smoking spice. She noticed that Mr Palmer had cut his hand, but he said this had happened when he had smashed his sink and it was not an act of self-harm. He again attributed his actions to the effects of spice. Mr Palmer said he had no thoughts or history of self-harm, although he said he found it hard to think straight.

66. At 11.00am, SO B chaired the first ACCT case review with the administrator from safer custody, Officer B and Nurse H. Mr Palmer told them that he had not been thinking straight when he had smashed his cell and attributed it to smoking spice a few days earlier. The nurse noted that Mr Palmer showed no psychotic symptoms and he said he had no thoughts of suicide and self-harm. The SO noted that the case review had decided that ACCT procedures were not appropriate to monitor a prisoner suspected of using spice, unless they also considered he was at risk of suicide and self-harm. They decided to end the ACCT monitoring, as they assessed Mr Palmer as a low risk of suicide or self-harm. The nurse considered that Mr Palmer did not need any further mental health intervention.

67. Between 14 and 18 August, staff completed a locally devised ACCT post-closure summary sheet. No concerns were noted until 17 August, when SO C wrote that Mr Palmer had behaved very strangely when he had collected his medication

and the nurse had thought he might have taken spice. No further action was taken to investigate this. There were no further entries after 18 August. A post-closure review, scheduled for 20 August did not take place.

68. On 25 August, Mr Palmer completed the diazepam detoxification programme. On 29 August, Nurse I assessed Mr Palmer in his cell after wing staff were concerned about him. Mr Palmer was lying on his bed screaming and holding his head in his hands. He said that his television was talking to him, the government was out to get him, and the only way he could get out of the prison was in a coffin. The nurse calmed Mr Palmer and checked his vital signs, which were normal. Mr Palmer gave a urine sample, which was positive for buprenorphine and diazepam (which he was prescribed). The nurse was concerned about Mr Palmer's mental health and referred him to the mental health team for a routine review.

69. Later that day, Mr Palmer complained of chest pain. Nurse J assessed him for symptoms of drug withdrawal and recorded that his blood pressure was raised. Mr Palmer seemed agitated and the nurse calmed him and gave him paracetamol. He checked Mr Palmer during the night, and had no further concerns about him.

70. On 1 September, an officer asked someone from the mental health team to assess Mr Palmer because he was behaving bizarrely. The mental health team discussed the referral and agreed that someone needed to assess Mr Palmer to rule out drug-induced psychosis. Nurse K assessed Mr Palmer later that day. He noted that Mr Palmer was distracted, restless and unable to maintain a reasonable conversation and concluded that he was having a manic episode. Mr Palmer said he had recently taken spice, although said he could not remember when. The nurse told Mr Palmer that he needed a period of detoxification, but that a mental health nurse would assess him again the next week, if he continued to have psychotic symptoms.

71. Nurse K noted that Mr Palmer had not given any indication that he intended to harm himself, but that he should be managed under ACCT procedures. However, the nurse did not open an ACCT and he did not discuss this with wing staff.

72. On 7 September, Nurse K assessed Mr Palmer again and noted he was unkempt and restless, and his cell was untidy. Initially, Mr Palmer said he did not have any mental health issues, but acknowledged that he was depressed, had trouble sleeping and was not eating properly. He said he had no thoughts of suicide or self-harm, or of harming anyone else. He said he was not hallucinating, but said that his water had been poisoned. He said that he was not sure whether he had been charged with murder. The nurse recorded that Mr Palmer was distressed and distracted throughout the conversation. He agreed to have a psychiatric review. Later on 7 September, Dr E, a psychiatrist, prescribed Mr Palmer a five day course of promethazine (25mg), but did not see him.

73. The next day, 8 September, Dr F, a psychiatrist, and Nurse K reviewed Mr Palmer. They noted his history of depression and drug dependence. Mr Palmer said his only concern was that his current 8mg dose of buprenorphine was not enough. Dr F noted that Mr Palmer appeared well kept, coherent and there was no evidence of a thought disorder. He recorded that Mr Palmer denied any

symptoms of psychosis and discharged him from the mental health team caseload. He told Mr Palmer how to get in touch again, if he needed help.

74. Also on 8 September, staff at a multidisciplinary complex case review meeting (which considers prisoners under ACCT supervision, or subject to incident reports), discussed Mr Palmer and noted that healthcare staff suspected him of swapping his medication with other prisoners. They noted that his wife had telephoned the safer custody department, as she was concerned about his wellbeing and his deteriorating mental health. The staff noted that Mr Palmer had an appointment with Dr F that day.

75. On 16 September, Nurse L examined Mr Palmer in his cell because he was anxious, had complained that his heart was racing and he had palpitations. His blood pressure was slightly high, but his pulse was normal. Mr Palmer said he had not taken any illicit substances. The nurse tried to calm him, and arranged for another nurse to check him again later.

76. Two hours later, wing staff called Nurse B to Mr Palmer's cell, because he said his heart was racing again. The nurse noted that Mr Palmer said he had not taken any illicit substances, that he appeared alert and displayed no psychotic symptoms. The nurse reassured Mr Palmer, but took no further action.

77. A little later that afternoon, Mr Palmer went to the wing medication hatch to collect his buprenorphine. When he got there he refused the tablet and said he did not want to take it anymore. (The prescription was then stopped.) Nurse C told wing officers what had happened and recorded this in the wing observation book, noting that he appeared stable and she did not think he was a risk to himself. Mr Palmer continued to take citalopram and pregabalin, and his medical records show that he was prescribed buprenorphine again from 28 September. There is no record that anyone monitored Mr Palmer for withdrawal symptoms when he stopped taking buprenorphine. No one recorded any concerns about him during that time.

78. On 28 September, Mr Palmer refused to return to his cell on D Wing and became aggressive. Officers physically restrained Mr Palmer, moved him to the segregation unit and charged him with disobeying a lawful order. The case was referred to an independent adjudicator, but was not heard before Mr Palmer died. A nurse assessed that Mr Palmer could safely be segregated. Over the next two days, healthcare staff saw Mr Palmer in the segregation unit and had no concerns about his health or his risk to himself.

79. On 30 September, Mr Palmer's wife rang a member of the chaplaincy team. She was concerned about her husband and had been told that he had been assaulted by an officer and was now in the segregation unit. The member of the chaplaincy team recorded in Mr Palmer's prison record that she said she could not give his wife any information, but Mr Palmer could formally complain about his treatment if he wanted to. Mr Palmer left the segregation unit and moved to E Wing that day.

80. On 1 October, Mr Palmer told Dr G, a locum GP, that he was due to appear in court on 25 November and was anxious about the sentence he would get if he

was convicted. Mr Palmer said that he thought he was being prescribed fake medication, which is why he had stopped taking buprenorphine for a while.

81. Mr Palmer told Dr G that he heard voices and that he had stuffed toilet paper into his ears to try to shut the voices out. He said that the voices gave him commands and called him names. He said he thought he was being given fake medication. Mr Palmer said that he had not been totally honest with Dr F, and asked to see him again. Dr G removed the toilet paper from Mr Palmer's ears using forceps and told him not to do it again. Dr F noted that it was easy to engage with Mr Palmer, that he made good eye contact, spoke normally, but displayed thought disorder. The doctor planned to see Mr Palmer six weeks later but did not refer him to Dr F again, or to the mental health team for further assessment.

82. The next day, 2 October, Mr Palmer flooded and smashed his cell and was moved to the segregation unit again. A nurse assessed him as suitable to remain there and treated cuts on his thumb and leg. At a disciplinary hearing on 5 October, Mr Palmer was required to pay £120 to cover the damage to his cell.

83. On 4 October, while still in the segregation unit, Mr Palmer again refused to take buprenorphine. Dr G stopped the buprenorphine prescription later that day. The next day, 5 October, Mr Palmer went back to a single cell in the drug treatment wing (D Wing).

84. On 7 October, Mr Palmer tried to stop Officer C from closing his cell door after receiving his medication and punched him in the face. He was charged with assault and moved to the to the segregation unit again. (The disciplinary hearing had not concluded before Mr Palmer died.)

85. On 9 October, Mr Palmer moved to a single cell on E Wing . His brothers remained on D Wing, the drug treatment wing. Staff noted that he could not go back to the D Wing, because he had allegedly assaulted an officer there. While being escorted to E Wing, Mr Palmer tried to assault another prisoner and had to be restrained. Officers took him back to the segregation unit and charged him with another disciplinary offence. (The disciplinary hearing was later adjourned for Mr Palmer to seek legal advice and had not been completed before his death.) A nurse examined Mr Palmer and assessed him as fit for segregation.

86. On 10 October, Mr Palmer refused to take citalopram and pregabalin because he did not think he needed it. He continued to refuse all of his prescribed medication so the prescriptions were stopped. There is no record that he was prescribed any medication again before his death. There is also no record that anyone discussed his decision not to take medication with him, or explained the possible side effects or withdrawal symptoms he might experience. No one monitored him for possible withdrawal symptoms.

87. At 6.23pm on 10 October, Mr Palmer phoned his wife and said he thought he was "losing it a bit". He said he was trying to settle on E Wing and was going to ask for a job, but had trouble with some of the officers on the wing. Mr Palmer said he needed to stop taking his medication, but was hearing voices. His wife said he needed antipsychotic medication. Mr Palmer told her he was not in debt

to anyone. On 23 October, Mr Palmer phoned his wife again. He told her that there were steroids in his food and water, and that he had magnets in his head.

88. One the evening of 26 October, Nurse M examined Mr Palmer, as he had reported having heart palpitations. He seemed very anxious, was tearful, spoke about voices in his head and asked for help. The nurse gave him some breathing exercises to help manage his anxiety and reduce the palpitations. She also referred him urgently to the mental health team.

89. On 28 October, Nurse N, a mental health nurse, assessed Mr Palmer who said he had magnets in his head and special powers. He asked to be prescribed pregabalin again and said he had stopped his medication too quickly. The nurse advised him to ask for an appointment with the substance misuse team. The nurse recorded that she thought Mr Palmer was trying to manipulate staff, and Dr F and Nurse K had concluded that he did not have any mental health problems. Nurse N noted that Mr Palmer had no psychotic symptoms, did not seem low in mood, said he was eating and sleeping well and had no thoughts of suicide or self-harm. She noted that Mr Palmer did not need a follow up mental health appointment.

90. On 3 November, Nurse N and Dr H, a psychiatrist, discussed Mr Palmer and agreed that he did not show any signs of mental health problems, but seemed to be seeking stimulant medication. (There was no further explanation of why they thought that.)

91. On 13 November, Mr Palmer phoned his wife and said he felt under pressure and his heart was pounding. He told her again, that he thought the prison had put steroids in his food and water and that he had magnets in his head. He said he was not taking any illicit drugs.

92. On 13 November, Mr Palmer was sharing a cell with another prisoner. The night patrol officer responded to Mr Palmer's cell bell and saw him throwing paper onto a fire in the cell. Mr Palmer was charged with a disciplinary offence for setting the fire and was moved to a different cell on E Wing, on his own. The next day, he set two more fires and was charged with further disciplinary offences. (Again, the adjudication process was not completed before Mr Palmer died.)

93. Nurse N examined Mr Palmer and found he had not suffered any physical injuries. She made a routine referral to the mental health team, as she was concerned about his behaviour. There is no record that anyone considered whether his actions amounted to a suicide attempt or was an act of self-harm, requiring ACCT procedures.

94. On 16 November, a healthcare administrator noted in Mr Palmer's medical record that the mental health team had discussed and assessed him several times. The administrator noted that he had an appointment with a prison GP on 25 November and so did not need a further mental health assessment.

95. At 11.54am that day, Mr Palmer phoned his wife and said he was feeling better, but was missing his children. Mr Palmer's wife told us that she had been worried about Mr Palmer and had phoned the prison's safer custody department a number of times between June and November, while he was at Wandsworth.

Her last call to a member of staff in the safer custody team had been on 15 November. One of the safer custody administrators remembered that Mr Palmer's wife had phoned several times, but no one had logged any of her calls or taken any action in response.

19 November 2015

96. On 19 November, SO A took Mr Palmer for a visit with his solicitor. However, his solicitor had arrived late and had not been allowed into the prison. Mr Palmer was escorted back to E Wing.

97. At 9.53am, Mr Palmer phoned his wife and said he felt scared and guilty. He said he was worried about the trial. Mr Palmer was tearful and expressed some delusional thoughts, including that he was being poisoned and that he was hearing voices. His wife told him he was not well but he said that he was all right and just wanted to see her. His wife was due to visit him that afternoon and Mr Palmer said he would see her in a couple of hours.

98. Officer D locked Mr Palmer in his cell at 9.59am. At 11.53am, two officers (Officer E and Officer F) took Mr Palmer's lunch to his cell. .

99. Officer G was working on E Wing over lunchtime. He did not speak to Mr Palmer and Mr Palmer did not ring his cell or otherwise come to his attention.

100. At about 1.50pm, SO A arrived on E Wing to collect prisoners for social visits. CCTV footage shows she reached Mr Palmer's cell at about 1.56pm. She knocked on his door but he did not reply, and she could not see him through the observation panel in the door. The SO unlocked the door, went into the cell and found Mr Palmer hanged by a piece of sheet tied attached to the bed frame.

101. SO A immediately radioed for healthcare staff to attend. The member of staff who was working in the control room, asked her to repeat her message and this time, the SO said it was a code blue emergency (indicating circumstances such as when a prisoner is unconscious or not breathing). The member of staff in the control room phoned for an ambulance straightaway.

102. Officer G responded and reached Mr Palmer's cell at 1.57pm. He supported Mr Palmer's body, while SO A untied the ligature. They lowered Mr Palmer to the floor just as Nurse L arrived.

103. Nurse L checked Mr Palmer and found no signs of life. Four other nurses also arrived and helped the nurse with cardiopulmonary resuscitation. They attached a defibrillator, which found no shockable heart rhythm so the staff continued resuscitation.

104. At 2.15pm, paramedics arrived at Mr Palmer's cell and took over emergency treatment. Mr Palmer did not respond and, at 2.58pm, the paramedics recorded that he had died.

Contact with Mr Palmer's family

105. SO D, a prison family liaison officer, went to see Mr Palmer's wife, who had arrived at the prison for her visit. He told her that Mr Palmer had been found

unconscious and that healthcare staff were with him. Mr Palmer's wife was very upset, but said she had to go home to look after her children. The SO promised to telephone her as soon as he had further news. As they left the visits area, they saw Mr Palmer's brother and Mr Palmer's wife told him what had happened.

106. After Mr Palmer's wife had left the prison, SO D learnt that Mr Palmer had died. He went to see Mr Palmer's brothers with a manager and a chaplain and broke the news of his death. Staff arranged for them to phone their grandmother for support.

107. At about 5.00pm, SO D arrived at Mr Palmer's wife's house but she was not at home. In the meantime, Mr Palmer's wife had phoned the prison because she had heard that Mr Palmer had died. The SO went to speak to her at her sister's house and gave her more information about what had happened. When he got back to the prison, the SO spoke to Mr Palmer's brothers again.

108. The prison contributed to the cost of Mr Palmer's funeral, in line with national policy.

Support for prisoners and staff

109. The governor debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.

110. The prison posted notices informing other prisoners of Mr Palmer's death, and offering support. Staff reviewed all prisoners assessed as at risk of suicide and self-harm prevention procedures in case they had been adversely affected by Mr Palmer's death.

111. Mr Palmer's brothers were transferred to Belmarsh prison shortly after his death. They said they did not want to move because they felt they needed to stay at the prison where he died, but the prison considered a move would be in their best interests.

Post-mortem report

112. As part of the post-mortem toxicology analysis, a toxicologist examined a sample of Mr Palmer's hair, which showed that he had used citalopram and promethazine (which he had been prescribed) and mirtazapine (an antidepressant which he had not been prescribed) in the three months before his death. The pathologist concluded that Mr Palmer had not taken NPS or other illegal drugs in the three months before he died.

Findings

Assessment and management of risk of suicide and self-harm

113. Prison Service Instruction (PSI) 64/2011, covering safer custody, lists a number of risk factors and potential triggers for suicide and self-harm. These include substance misuse, physical and mental health problems and the seriousness of the charges the prisoner faces. Mr Palmer had been charged with murder and faced a mandatory life sentence if convicted. He misused drugs and had physical health problems, as well as suffering from depression and anxiety.

114. We consider that there were a number of occasions during Mr Palmer's time at Wandsworth, when he should have been monitored, or at least considered for ACCT monitoring, but this was not done:

- In his first few days in prison, Mr Palmer said that he felt stressed and anxious about the murder charge a number of times. He was sometimes low and tearful and said he was suffering withdrawal symptoms.
- On 21 July, Mr Palmer said that he had thoughts of self-harm.
- On 10 August, a psychiatrist and mental health nurse assessed Mr Palmer and considered that he posed a risk to himself.
- On 1 September, Nurse K noted that Mr Palmer was having a 'manic episode' and should be managed under ACCT procedures but this did not happen.
- On 13 and 14 November, Mr Palmer lit three fires in his cell. No one considered whether these were suicide attempts or acts of self-harm.

115. Between 12 August and 13 August Mr Palmer was monitored under ACCT procedures for less than 24 hours. A case review decided to end ACCT monitoring as they considered that Mr Palmer's concerning behaviour at the time was the result of using NPS, and monitoring under ACCT procedures was not necessary. We consider that the decision to end ACCT monitoring was made too early without a full consideration of his risk factors, his episodes of worrying behaviour and without taking into account the psychiatrist's assessment of 10 August, which noted that he posed a risk to himself.

116. In July 2015, we issued a Learning Lessons Bulletin about the use of NPS, including the dangers to both physical and mental health and the possible links to suicide and self-harm. While we accept that ACCT procedures are not necessary simply because a prisoner has used NPS, there was no evidence that staff considered whether his apparent use of NPS had increased his risk of suicide.

117. While he was subject to ACCT monitoring, staff checked Mr Palmer at regular and predictable intervals, contrary to instructions in PSI 64/2011. There was no check at all between 4.00am and 5.00am on 11 August. Staff did not hold a post-closure review to check whether his risk remained low.

118. Mr Palmer's family and prison staff were concerned about his mental health and behaviour, which became increasingly erratic and dangerous, including lighting

fires in his cell just a few days before he died. While we recognise that it would have been very difficult for staff to have predicted or prevented his actions on 19 November, we are concerned that staff did not fully consider all his risk factors, which could have been considered more holistically using ACCT procedures. We make the following recommendation:

The Governor should ensure that staff manage prisoners at risk of suicide or self-harm in line with national guidance, including:

- **Considering and recording all the known risk factors of a newly arrived prisoner when determining their risk of suicide and self-harm;**
- **Case reviews recording and taking into account all the known risk factors and triggers when considering the risk of suicide and self-harm, including use of NPS;**
- **Considering whether setting a fire amounts to an act of self-harm, requiring ACCT monitoring;**
- **That ACCT checks are carried out as directed, at unpredictable intervals and documented in the on-going record;**
- **Holding post-closure reviews as directed.**

Mr Palmer's family's concerns

119. Mr Palmer's wife gave us her telephone records, which showed that she made well over 100 telephone calls to the prison while her husband was there, most of which were because she was worried about his mental health and his risk to himself. The member of the RAPt team, routinely recorded details of her contact with Mr Palmer's wife.

120. Mr Palmer's wife told us that she had spoken many times to members of the safer custody team about her concerns and had left messages on their answer machine. No one from the safer custody team recorded any details of her calls, or the action they had taken in response, although they said that they kept a log of contacts from concerned families. Mr Palmer's wife did not consider that prison staff took her concerns about her husband's welfare sufficiently seriously. The last time she had phoned the safer custody team was on 15 November, just four days before Mr Palmer died. Again there is no record of any response.

121. Mr Palmer's brothers also said that they repeatedly told staff that they were concerned about his mental state and that he should be monitored under ACCT procedures.

122. Prison Service Instruction 64/2011 says, "All staff who receive information, including from concerned family members,…must communicate their concerns immediately to the Residential, Daily or Night Operational Manager, and/or consider opening an ACCT Plan and make a record in an appropriate source e.g. observation book, NOMIS, Security Information Report, ACCT Plan." Elsewhere the PSI has a mandatory requirement that if staff receive information from a concerned family member that indicates an increase in a prisoner's risk, they should begin ACCT procedures. We are concerned that the calls from Mr Palmer's wife and the views of his brothers, the people who knew him well and

would be best able to recognise a change in his mood, were poorly handled. We make the following recommendation:

The Governor should ensure that any concerns from a family member or friend about a prisoner's welfare and safety are appropriately recorded and followed up, and any actions documented. Staff should open an ACCT when they receive information from family members which indicates a risk of suicide or self-harm

Mental health

123. The clinical reviewer noted that Mr Palmer had longstanding and chronic anxiety and depression. He had been prescribed antidepressants for some time in the community. In March 2015, his community doctor was concerned that he might be developing a paranoid illness and referred him urgently to a psychiatrist. It is not clear whether he saw a psychiatrist as a result.

124. PSO 3050, about continuity of healthcare, says that staff should make efforts to retrieve any information required from the prisoner's GP or other relevant service he has recently been in contact with. No one from the prison requested Mr Palmer's community medical records so healthcare staff were unaware of his medical history. We make the following recommendation:

The Head of Healthcare should ensure that staff request and record relevant community health records for newly arrived prisoners.

125. Mr Palmer behaved erratically and bizarrely at Wandsworth. A mental health nurse assessed him five times and a psychiatrist twice. Only Dr D, who tried to assess Mr Palmer on 10 August, considered he had symptoms of psychosis. When Dr F assessed Mr Palmer in September, he concluded that he did not have a psychotic illness and could be discharged from the mental health team's caseload. A mental health nurse assessed Mr Palmer again at the end of October and again concluded that he was not suffering from a psychotic illness. It is therefore difficult to know what caused Mr Palmer's strange and paranoid behaviour.

126. Some of Mr Palmer's earlier contacts with mental health specialists were in the context of his suspected use of NPS and drug dependency. Mr Palmer told mental health specialists that he had smoked spice. Some of the mental health assessments appear to have been clouded by this issue and did not fully consider whether Mr Palmer was also suffering from a mental illness. Prisoners with mental health, possibly masked by drug problems should not be excluded from mental health services or receive any less support for mental health problems. Wandsworth does not have a specific dual diagnosis policy, although since Mr Palmer's death they have taken steps to improve treatment options for prisoners with a dual diagnosis. We make the following recommendation:

The Head of Healthcare should ensure that there is a clear dual diagnosis policy and that all referrals have a structured mental health assessment, irrespective of ongoing substance misuse issues.

Medication

127. When he arrived at Wandsworth, Mr Palmer said that he used buprenorphine in the community. Although Mr Palmer's brother said he provided the urine which was tested in the reception area, Mr Palmer's wife later told us that Mr Palmer was dependent on buprenorphine and took his brother's prescribed buprenorphine. It was therefore appropriate for doctors to prescribe buprenorphine to alleviate withdrawal symptoms, even if not based on a genuine urine sample. Mr Palmer was also dependent on a number of pain relief medications. The clinical reviewer concluded that Mr Palmer was appropriately prescribed a 12-week diazepam detoxification programme, which he successfully completed.

128. On 16 September, Mr Palmer refused his buprenorphine and did not take it for 12 days. On 10 October, he stopped taking his all of his medications and was not prescribed them again before his death. Mr Palmer's medical record contains little reference to his stopping his medication. The presumption is that Mr Palmer had the mental capacity to make such decisions about his treatment but no one discussed his decisions with him, queried the reasons or questioned his capacity. No one monitored him, although he had previously reported a history of seizures when he stopped taking his prescribed medication.

129. In the PPO's publication about prisoners' mental health (published in January 2016) we noted that healthcare leads need to ensure that there is a robust system for flagging prisoners' non-compliance with medication and that there is clear guidance for healthcare staff about dealing with non-compliance. We noted that prison and healthcare staff have a responsibility to talk to prisoners who do not take their medication, discuss the reasons with them and encourage them to comply with taking it. We make the following that recommendation:

The Head of Healthcare should ensure that the reasons for a prisoner not taking prescribed medication are clearly documented. When mood altering medication is not collected, the mental health team should be informed and follow this up with the prisoner.

New psychoactive substances

130. Mr Palmer told staff a number of times that he had smoked 'spice', a New Psychoactive Substance (NPS). Staff recorded that Mr Palmer's brothers had also told them he had smoked spice, although they told us they had never said this.

131. At the time of Mr Palmer's death, Wandsworth had a spice protocol, written in December 2014 (since slightly revised in December 2015). The protocol set out the actions staff should take when they suspected a prisoner of being under the influence of spice. In Mr Palmer's case, staff did not always follow the guidance set out in the protocol and did not consistently submit security reports when they suspected him of using illicit drugs. Managers appeared to disagree about where and how to monitor prisoners suspected of being under the influence of NPS.

132. Although the post-mortem toxicology examination concluded that Mr Palmer had not used spice or other NPS in the three months before his death (i.e. after 19

August), it is possible that Mr Palmer's self-reported use of NPS triggered his apparent psychotic symptoms and behaviour. We make the following recommendation.

The Governor should ensure that staff consistently follow a clear pathway for managing prisoners suspected of using NPS and other illegal substances.

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