

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr James Maughan a prisoner at HMP Bullingdon on 11 July 2016

**A report by the Prisons and Probation Ombudsman
Nigel Newcomen CBE**

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*



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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 James Maughan died on 11 July 2016 after being found hanged in his cell at HMP Bullingdon. He was 33 years old. I offer my condolences to Mr Maughan's family and friends.

I am concerned that staff at Bullingdon missed opportunities to act on Mr Maughan's evident risk factors and did not use suicide and self-harm prevention procedures appropriately. Even when one staff member was concerned about Mr Maughan's risk the night before he died, he did not have sufficient training or experience to start suicide prevention procedures. I also share the clinical reviewer's concern that in considering the overall management of Mr Maughan's mental health in prison, his care was not equivalent to that which he could have expected to receive in the community.

I am particularly disappointed that both these areas of concern have arisen in previous investigations and that they have to be repeated in Mr Maughan's case.

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

Nigel Newcomen CBE
Prisons and Probation Ombudsman

April 2017

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Summary

Events

1. On 7 October 2015, Mr James Maughan arrived at HMP Bullingdon. He had a history of mental health problems, substance misuse, suicide attempts, self-harm and symptoms consistent with a personality disorder. On 13 October, staff decided that Mr Maughan did not meet the criteria for being seen by the mental health in-reach team, without conducting a face to face assessment.
2. Shortly after arriving at the prison, Mr Maughan told a community mental health worker that he wanted to end his life by hanging himself with a rope. The mental health worker told prison staff about this, but there is no evidence that anyone spoke to Mr Maughan or considered starting Prison Service suicide and self-harm prevention measures, known as ACCT.
3. Mr Maughan cut his arm on two occasions in December when he was told that he would be transferred to HMP Portland. Staff started ACCT procedures, which remained in place until January. He was eventually transferred to Portland. Mr Maughan was placed under ACCT measures there in February, when he told staff that he was thinking of killing himself because he was so far from home. He was then transferred to Onley, where staff ended monitoring on 18 March when they assessed he was no longer at risk of suicide or self-harm.
4. When Mr Maughan was returned to Bullingdon in April, a GP prescribed an antidepressant, but Mr Maughan did not take his medication or go to his medication review appointments. There is no evidence that healthcare staff followed this up.
5. At around 8.45pm on 10 July, when a new member of staff responded to Mr Maughan's cell bell, he threatened to cut himself with a plastic spoon and a broken metal TV aerial if he did not get cigarettes. The member of staff radioed an emergency code. Officers and a nurse responded, but Mr Maughan was upset and would not let the nurse examine him. No one started suicide and self-harm prevention procedures or checked him after 11.00pm that evening.
6. Mr Maughan was found hanging in his cell the next morning. Staff and paramedics tried to resuscitate Mr Maughan but, at 6.38am, paramedics recorded that he had died.

Findings

7. The investigation found that staff failed to consider all of Mr Maughan's known risk factors and did not start suicide and self-harm prevention procedures at Bullingdon, shortly after his arrival, when Mr Maughan told a community mental health worker that he wanted to hang himself, or when he said he had cut himself and intended to hurt himself again the night before he died. One staff member did consider Mr Maughan's risk of suicide and self-harm the night before he died, but did not have sufficient training or experience to start ACCT procedures.
8. The clinical reviewer concluded that in considering the overall management of Mr Maughan's mental health, his care was below the standard provided in the

community. Staff decided that he did not meet the criteria to be seen by the mental health team, without assessing him in a face to face appointment. Mr Maughan did not receive appropriate follow up from the mental health team after a community mental health worker alerted them that he was at risk of suicide. Healthcare staff did not follow up with Mr Maughan when he did not take his medication, missed his medication review appointments, and did not attend a medication review with a GP on his return to Bullingdon, despite a change to his medication.

Recommendations

- The Governor should ensure that:
 - staff are aware of, consider and record all the known risk factors for suicide or self-harm. They should open an ACCT whenever a prisoner has recently self-harmed, expressed suicidal intent or has other significant risk factors. When, exceptionally, they decide not to begin ACCT procedures for prisoners with significant risk factors, they should clearly record the reasons;
 - all staff receive ACCT training and are adequately trained to ensure that they are able to take appropriate action on discovery of an unresponsive prisoner or an apparent death.

- The Head of Healthcare should ensure that:
 - mental health services meet the needs of prisoners at Bullingdon, with a referral system that results in timely, face to face assessments using all relevant information for appropriate continuity of care and follow-up, and that prisoners have access to services equivalent to those in the community;
 - transferred prisoners attend a prompt medication review with a GP so that there are no unnecessary breaks in treatment and to assess the prisoner's mental state when their medication has changed;
 - there is appropriate follow-up by healthcare staff when a prisoner misses their medication.

The Investigation Process

9. The investigator issued notices to staff and prisoners at HMP Bullingdon informing them of the investigation and asking anyone with relevant information to contact her.
10. The investigator visited HMP Bullingdon on 14 July. She obtained copies of relevant extracts from Mr Maughan's prison and medical records and interviewed two prisoners.
11. NHS England commissioned a clinical reviewer to review Mr Maughan's clinical care at the prison.
12. The investigator and clinical reviewer interviewed six members of staff and two prisoners at HMP Bullingdon on 2 August. The investigator interviewed one member of staff on 13 September, two members of staff and one prisoner by video link on 11 and 18 October, and one member of staff by phone on 19 October.
13. We informed HM Coroner for Oxfordshire of the investigation who sent the results of the post-mortem examination. We have given the coroner a copy of this report.
14. One of the Ombudsman's family liaison officers contacted Mr Maughan's family through their lawyer, to explain the investigation and to ask if they had any matters they wanted the investigation to consider. Mr Maughan's family wanted to know whether he received adequate mental health treatment and support, if he was being bullied, whether he was checked by staff on the night of 10 July, how he got scratches on his arm, whether he was calling out during the night of 10 July and morning of 11 July and, if so, why prison staff did not hear him. Mr Maughan's family's lawyer received a copy of the initial report. Mr Maughan's family pointed out some factual inaccuracies. This report has been amended accordingly.

Background Information

HMP Bullingdon

15. HMP Bullingdon is a training and local prison, serving the courts of Oxfordshire and Berkshire. It holds up to 1,114 men. Care UK has been the healthcare provider since 1 April 2016. Cotswold Medicare Ltd provides general practitioner services. South Staffordshire and Shropshire NHS Foundation Trust provide care for those with severe and enduring mental illness and secondary mental health services. Before 1 April 2016, healthcare services were provided by Virgin Care and Oxford Trust NHS Foundation Trust provided secondary mental health services.

HM Inspectorate of Prisons

16. The most recent inspection of HMP Bullingdon was in June 2015. Inspectors found that the quality of personal officer work was inconsistent, and few prisoners knew who their personal officer was. There were few personal officer entries in prisoners' case notes. Inspectors noted that levels of self-harm were much lower than comparable prisons and that the support and mentoring unit was a good initiative to help prisoners identified as being likely to find life on a standard wing difficult.
17. Inspectors reported that the two primary mental health nurses provided good support to prisoners with mild-to-moderate anxiety and depression. However, the mental health service was not sufficiently multidisciplinary and did not support prisoners with wider mental health needs. Psychological interventions were limited, with only computer-based cognitive behavioural therapy. Counselling was available only through the chaplaincy. The Inspectorate reported that the mental health team saw all new referrals within 72 hours, but there was no cover for staff absence, which reduced the provision of services.

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 published annual report for the year to 31 July 2015, the IMB reported that the prison continued to have trouble recruiting staff, particularly nurses. A shortage of officers meant that they were often diverted from core functions, such as the offender management unit.

Previous deaths at HMP Bullingdon

19. This was the fifth self-inflicted death at HMP Bullingdon since 2015. We have previously identified the importance of using all available information and considering risk factors when determining a prisoner's risk of suicide and self-harm. We have also identified that mental health services commissioned for Bullingdon should reflect the population's need, including prisoners with personality disorders, and that prisoners have access to services equivalent to those available in the community. Finally, we have recommended that prisoners referred to the mental health team have timely, appropriate, face-to-face assessments. We repeat these concerns in this report.

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 multi-disciplinary case reviews involving the prisoner. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011.

Key Events

21. On 7 October 2015, Mr James Maughan arrived at HMP Bullingdon after police charged him with several offences including theft, making a false statement and burglary. It was not his first time in prison.
22. Mr Maughan's Person Escort Record (PER, a document which accompanied him from court to prison) noted that he had recently self-harmed and threatened to kill himself. Mr Maughan told the nurse that he had schizophrenia with visual and auditory hallucinations for which he took medication and had received treatment from a psychiatrist in the community. The nurse explained how to access mental health services in Bullingdon and referred Mr Maughan to a GP, but did not start suicide prevention measures or refer him for a mental health assessment.
23. The next day, a prison GP assessed Mr Maughan and noted that he had a history of psychotic illness. He continued his prescription of amisulpride (an antipsychotic), citalopram (an antidepressant) and trazodone (another antidepressant) and referred Mr Maughan to the mental health team.
24. On 9 October, a mental health nurse recorded that she had reviewed Mr Maughan's notes from community mental health services which noted that his symptoms did not appear to suggest a psychotic illness, but an antisocial personality disorder. She recorded his previous treatment plan was to continue with citalopram and trazodone. On 13 October, the mental health team agreed that Mr Maughan did not meet the criteria to be supported by the mental health team because he did not have a severe and enduring mental illness, and was not a risk to himself or others. The mental health in-reach team were not resourced to support prisoners with personality disorders.
25. On 22 October, Mr Maughan's community mental health worker visited. Mr Maughan told him that he was thinking about hanging himself, hearing voices and not getting his medication. After attempting to speak to prisoner officers about his concerns, the worker was told to contact the mental health team. The next day, he contacted a nurse about his concerns and she noted that she spoke to an officer on Mr Maughan's wing. There is no evidence that anyone spoke to Mr Maughan about the worker's concerns or that any further action was taken. About a month later, the worker spoke to a mental health nurse, but was told that Mr Maughan was not on the mental health caseload and that he should speak to healthcare staff or officers with any further concerns.
26. On 23 November, Mr Maughan was sentenced to two years and eight months imprisonment.
27. On 14 December, Mr Maughan refused to get on the escort van to transfer to HMP Portland. Mr Maughan said that he did not want to transfer because the prison was far away from his family and, when he got onto the escort van, he cut his arm. Mr Maughan was taken back to the wing and he remained at Bullingdon where he was monitored by staff under the ACCT process.

HMP Portland

28. On 29 December, Mr Maughan was transferred to HMP Portland. A nurse recorded that Mr Maughan cut himself as soon as he got on the escort van and was given first aid and his cuts were dressed. When he arrived at Portland, staff noted that he was subject to ACCT measures and referred him for a mental health assessment. A GP continued his prescription for trazodone and amisulpride.
29. On 11 January, staff ended ACCT procedures. Mr Maughan's caremap actions were complete, and he said that he did not have thoughts of suicide or self-harm, was taking his antidepressant medication, and had an appointment with the mental health team.
30. On 1 February, a doctor reviewed Mr Maughan's medication because he had not been taking his amisulpride or trazodone. The doctor prescribed a lower dose of trazodone and noted that Mr Maughan needed an urgent mental health assessment. On 15 February, a nurse noted that Mr Maughan did not attend his mental health assessment because he was unable to be escorted by officers.
31. On 25 February, staff started ACCT procedures after Mr Maughan said he was feeling suicidal, was unable to cope, and was stressed about being so far away from his family. Staff assessed Mr Maughan's risk as low, and noted two actions on his caremap, which were for Mr Maughan to apply for a transfer to be closer to his family, and to be assessed by the mental health team. Staff continued to regularly observe Mr Maughan while he was at Portland but he transferred before he was assessed by the mental health team.

HMP Onley

32. On 16 March, Mr Maughan was transferred to Bullingdon and then to HMP Onley the next day. On 18 March, staff at Onley decided to end ACCT procedures because Mr Maughan was happy to have been transferred closer to his family and had an appointment to be assessed by the mental health team.
33. On 30 March, a security intelligence report noted that Mr Maughan's probation officer had contacted the prison to say she had received a phone call from Mr Maughan's partner. Mr Maughan's partner said that he was distressed, tearful, and anxious about his mental health and his court case. Staff noted that they would ask wing staff to check Mr Maughan. The next day, Mr Maughan's offender supervisor noted that Mr Maughan said that he was not receiving his medication, was waiting to see the mental health team and had no TV in his cell.
34. On 31 March, a GP prescribed fluoxetine (an antidepressant) for Mr Maughan but noted that he needed to be reviewed by a psychiatrist before he would prescribe amisulpride. Mr Maughan was transferred to Bullingdon before he was assessed by the mental health team or a psychiatrist at Onley.

HMP Bullingdon

35. On 4 April, Mr Maughan was transferred back to Bullingdon. His PER noted that Mr Maughan 'claimed to be under threat' at Onley. The nurse in reception noted

that Mr Maughan was taking medication for mental health problems and had no thoughts of suicide or self harm. Two days later, a prison GP (who did not see Mr Maughan) noted that he had been taking fluoxetine and renewed his prescription for 20mg.

36. On 22 April, an offender supervisor received a call from Mr Maughan's probation officer. The probation officer said that Mr Maughan told his family that he could not go to education because he was under threat in the prison, and that he was not taking medication. The offender supervisor sent an email to the mental health in-reach team. There is no evidence that the mental health team made an appointment for Mr Maughan.
37. On 26 April, Mr Maughan's personal officer noted that Mr Maughan preferred to work as a cleaner on his wing, because he was worried that other prisoners might threaten him elsewhere in the prison. Mr Maughan did not say he was actually being threatened by other prisoners and reassured the officer that he had no problem with the prisoners on his wing at that time.
38. Throughout April and May, Mr Maughan continued to work as a wing cleaner and asked staff several times about his eligibility for home detention curfew (a scheme that allows prisoners to live outside of prison to help them prepare for life after their release).
39. On 10 June, Mr Maughan visited a prisoner's cell. The prisoner said that Mr Maughan accused him of taking his property and then started a fight. He said this was unusual behaviour for Mr Maughan because they were friends and he thought Mr Maughan's actions might have been the result of his mental health condition. The personal officer heard a noise coming from Mr Maughan's cell and noticed other prisoners had gathered outside. He went into the cell and saw the prisoner swinging a chair at Mr Maughan, who was throwing punches. He pulled the prisoner out of the cell and noted a red mark around his face. Mr Maughan had blood and red marks on his face and neck. A nurse recorded that he had a superficial cut on his forehead and red marks around his neck. Mr Maughan did not want any treatment and was taken to the segregation unit.
40. On 11 June, an officer noted that the Governor, healthcare staff, and a member of the chaplaincy had visited Mr Maughan in the segregation unit. A nurse assessed that Mr Maughan was fit to remain in the segregation unit. The same day, prison staff punished Mr Maughan for fighting by limiting the money he could spend for seven days. Mr Maughan remained in the segregation unit until 13 June, when he was moved to a cell on another wing.
41. The prisoner said that he saw Mr Maughan again after he was segregated, but he could not remember when. He said that Mr Maughan talked to him, and that he did not make any sense. Mr Maughan spoke about the police and said there was a camera in someone's glasses. He said that he saw Mr Maughan the next day, and had a normal conversation with him.

Events of 10 July 2016

42. On 10 July, Mr Maughan's partner visited him and during the visit he became paranoid and afterwards spoke about the police and being recorded. Around

lunchtime, in line with the local violence reduction policy, Mr Maughan was moved to another wing because he told staff that he felt threatened. A security intelligence report noted that Mr Maughan and his cellmate had 'fallen out'.

43. Mr Maughan was moved to the same wing as his brother-in-law. Mr Maughan told him that there were wires in his cell and the police were watching him. His brother-in-law described Mr Maughan as disturbed and paranoid. He said that Mr Maughan got his dinner and went into his cell between 6.10pm and 6.30pm.
44. At around 8.45pm, Mr Maughan pressed his cell bell. An operational support grade (OSG) went to his cell and Mr Maughan said he would cut himself if he did not get cigarettes. He was a new member of staff on his first night shift, so he phoned a prison manager, who told him that Mr Maughan could not have any cigarettes. A short time later, Mr Maughan pressed his cell bell again and the OSG told Mr Maughan that he could not have any cigarettes. Ten minutes later, Mr Maughan pressed his cell bell a third time. He showed the OSG a plastic spoon with a sharpened end and a broken metal aerial and said he was about to make cuts to his arm with the aerial lead. He could see scratches on Mr Maughan's arm but said that he was not bleeding. He said that he thought Mr Maughan was about to cut himself, so he radioed a code red (which indicates an emergency when there is a loss of blood) at approximately 9.20pm.
45. A few minutes later, staff arrived at Mr Maughan's cell and opened the door. Mr Maughan said he wanted cigarettes and to move to the segregation unit. An officer asked him to show him where he had cut himself and Mr Maughan showed him some scratches on his arm. A nurse said that Mr Maughan spoke in a hostile voice and asked to be taken to the segregation unit because 'nothing is being done for me here'. She said that Mr Maughan would not show her any cuts on his arm, and said that there was no need for him to be seen by the nurse because he intended to cut himself more.
46. The manager arrived at Mr Maughan's cell with an officer. He said that he noticed a mark on Mr Maughan's right arm, but did not think it was recent. The manager, the officer and the nurse said that they did not think Mr Maughan was bleeding, and the manager said that he could not see sharp objects or blood. The manager and officer said that Mr Maughan did not threaten to harm himself. The manager described Mr Maughan as aggressive and said he demanded to be taken to the segregation unit or he would smash up his cell. He said he was concerned about staff safety, so he told Mr Maughan they were leaving and locked his cell door.
47. After staff left Mr Maughan's cell, they went back to the wing office. The manager asked two officers to stay on the wing for half an hour to support the OSG. He said that he asked the officers to check Mr Maughan again before they left the wing. The OSG had not been trained in the ACCT process. He said that he asked the officers if Mr Maughan should be managed under the ACCT process, but he said he was told this was not required. No one remembered the OSG asking about the ACCT process.
48. One officer said that he checked on Mr Maughan about 25 minutes later, and asked him if he was alright, but Mr Maughan told him to leave him alone. Both officers left the wing. At approximately 11.00pm, the OSG said that he tried to

talk to Mr Maughan, but he just sat on his bed and looked at him. He said that he did not check Mr Maughan again that night. He was the only officer on the wing that night and said that he did not hear anything further during the night.

49. A prisoner said that he heard shouting and banging during the night, but did not know that it was Mr Maughan, so did not pay much attention to it. He said that he took a sleeping tablet, but the shouting and banging woke him up through the night. Another prisoner on the wing said that he also heard Mr Maughan shouting that evening. He said that Mr Maughan said he was going to cut himself or kill himself if he did not get tobacco, and that he heard an officer come and speak to him around 10.00pm.

Events of 11 July 2016

50. At about 5.30am, the OSG started his morning roll check. When he got to Mr Maughan's cell, he saw him sitting on the floor at the end of the bed closest to the door. He said that the light was on in the cell and he could not tell what was happening, but he knew by Mr Maughan's face that something was not right, so he phoned the manager, who went straight to the wing.
51. The manager looked through the observation panel when he arrived at Mr Maughan's cell with the other night officers. He noted that he was in a seated position at the end of the bed, facing the sink and toilet area of the cell. He saw that Mr Maughan had a ligature around his neck made from a sheet. He went into the cell and noted that the ligature was attached to the bed frame and Mr Maughan was pale and not breathing. He asked an officer to cut the ligature and told another officer to call a code blue (which indicates circumstances such as when a prisoner is unconscious or not breathing). At 5.39am, the officer radioed a code blue and the control room called an ambulance. The manager placed Mr Maughan on the floor and tried to resuscitate him until healthcare staff arrived at about 5.45am and took over.
52. At 6:13am, an ambulance arrived and paramedics were in Mr Maughan's cell three minutes later. They continued attempts to resuscitate Mr Maughan but they were not successful and at 6.38am, recorded that he had died.

Contact with Mr Maughan's family

53. At around 8.50am, a prison family liaison officer and the duty governor went to Mr Maughan's partner's home and told her that he had had died. They offered condolences and support. The prison contributed to the costs of Mr Maughan's funeral, in line with national guidance.

Support for prisoners and staff

54. After Mr Maughan's death, the duty 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. The prison posted notices informing other prisoners of Mr Maughan's death, and offering support.

Post-mortem report

55. The post-mortem report stated that Mr Maughan's cause of death was hanging.

Findings

Assessment of risk suicide and self-harm

56. Prison Service Instruction (PSI) 64/2011, covering safer custody, lists a number of risk factors and potential triggers for suicide and self-harm. Any member of staff who receives information, including that from external agencies, or observes behaviour which may indicate a risk of suicide or self-harm must open an ACCT.
57. Mr Maughan had a number of risk factors for suicide including a history of self-harm and suicide attempts, depression and symptoms consistent with a personality disorder. We consider that staff should have started ACCT procedures when the community mental health worker told them that Mr Maughan was having suicidal thoughts and planned to hang himself with a rope, and when Mr Maughan threatened to cut himself the night before he died. We have criticised staff at Bullingdon before for failing to identify prisoners at risk of suicide or self-harm, in line with national instructions.
58. Staff who responded to the code red the night before Mr Maughan died said that they did not think that he was at risk of suicide or self-harm, despite him scratching his arm and continued threats to self-harm. The OSG had not been trained in the ACCT process and said that, after he called the code red, he asked the night manager and an officer if they should start ACCT procedures, but was told it was not necessary.
59. The ACCT document lists factors to consider when determining whether a prisoner's level of risk of suicide or self-harm is low, raised or high. Actual self-harm and threats to self-harm should have indicated that Mr Maughan was at least at raised risk of suicide or self-harm that evening. It is concerning that senior and experienced staff did not consider starting an ACCT, despite Mr Maughan's presentation that evening.
60. The OSG was a new staff member who was working his first set of nights the week that Mr Maughan died. He told investigators that he had been given no training as part of his induction. He said that when Mr Maughan threatened to cut himself the night before he died, he did not start ACCT procedures himself because he had not received the training to do so. Neither did he go into Mr Maughan's cell or call an emergency code when he found him hanging the next morning. He told the investigator that he had no training in how to respond to an emergency situation.
61. We are concerned that the OSG did not have the experience or sufficient training to start ACCT procedures when a prisoner threatened to self-harm, or to respond appropriately in an emergency situation. We are also concerned that no one started suicide and self-harm prevention measures that night. We make the following recommendation:

The Governor should ensure that:

- **staff are aware of, consider and record all the known risk factors for suicide or self-harm. They should open an ACCT whenever a prisoner has recently self-harmed, expressed suicidal intent or has**

other significant risk factors. When, exceptionally, they decide not to begin ACCT procedures for prisoners with significant risk factors, they should clearly record the reasons;

- **all staff receive ACCT training and are adequately trained to ensure that they are able to take appropriate action on discovery of an unresponsive prisoner or an apparent death.**

Mental health

62. The clinical reviewer concluded in his report that no one in the prison's primary care or mental health team adequately assessed or followed up Mr Maughan's mental health needs, including his risk of suicide and self-harm.
63. Bullingdon does not have a complex needs service for prisoners diagnosed with a personality disorder. Prisoners with personality disorders are not accepted on the caseload of either the primary mental health team or the mental health in-reach team, because they do not meet the eligibility criteria. We are concerned that, while Mr Maughan would have been eligible for care in the community, despite his complex needs, he did not meet the criteria to receive care from mental health services in prison. The decision not to accept Mr Maughan on the mental health team caseload was not adequately informed, as it was made without assessing Mr Maughan in person.
64. We have criticised the inadequate provision of mental health services at Bullingdon in a previous investigation. The Deputy Head of Healthcare told the investigator that her team is working with the mental health in-reach team to review the criteria for accepting a referral for mental health services.
65. When Mr Maughan returned to Bullingdon in April 2016, he did not have any face to face appointments with a GP except when a GP saw him in the segregation unit. A number of repeat prescriptions were issued to Mr Maughan, and a medication review would have provided the GP with the opportunity to review his mental state and his medication, particularly given his medication had changed since he was last at Bullingdon. Although Mr Maughan did not attend several medication review appointments and he reportedly forgot to take his medication on several occasions, healthcare staff did not follow this up. We make the following recommendation:

The Head of Healthcare should ensure that:

- **mental health services meet the needs of prisoners at Bullingdon, with a referral system that results in timely, face to face assessments using all relevant information for appropriate continuity of care and follow-up, and that prisoners have access to services equivalent to those in the community;**
- **transferred prisoners attend a prompt medication review with a GP so that there are no unnecessary breaks in treatment and to assess the prisoner's mental state when their medication has changed;**
- **there is appropriate follow-up by healthcare staff when a prisoner misses their medication.**

Alleged threats from other prisoners

66. Mr Maughan's family were concerned that he was threatened by other prisoners while he was at Bullingdon. We spoke to officers and prisoners about whether Mr Maughan told staff he felt threatened on 10 July. Staff arranged for him to transfer wings that day, in line with the prison's violence reduction policy.

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