Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Calam Atour, a prisoner at HMP Erlestoke, on 13 May 2015

A report by the Prisons and Probation Ombudsman Nigel Newcomen CBE

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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*

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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 Calam Atour was found hanged in his cell at HMP Erlestoke, on 13 May 2015. He was 41 years old. I offer my condolences to Mr Atour's family and friends.

The investigation of Mr Atour's death has exposed a number of deficiencies which staff at Erlestoke need to address. I am concerned that, due to poor medicine prescribing and monitoring practices, Mr Atour did not receive a satisfactory standard of healthcare at Erlestoke. Moreover, despite his suicidal thoughts, no one referred him for a mental health review.

I am also concerned that there were weaknesses in the operation of suicide and self-harm prevention procedures. However, while Mr Atour had shown suicidal intent earlier on the day he died, he subsequently agreed to attend a medication review the next day, which reassured staff. To an extent, his subsequent actions were sudden and unexpected and I recognise that it would have been difficult for staff to identify his imminent risk. However, they should have considered increasing his level of observations until his risk was fully reviewed.

Finally, the investigation has identified the need for improved safety checks of prisoners when unlocking cells and better emergency response.

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 **January 2017**

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Summary

Events

1. On 2 January 2015, Mr Calam Atour was conditionally released from HMP Exeter where he had been serving a five and a half year sentence for burglary and theft. On 30 January, he was recalled to prison and sent to HMP Bristol. He had a history of mental health problems, including depression and drug misuse. On 16 April, Mr Atour moved to HMP Erlestoke.

2. On 22 April, Mr Atour reported that someone had stolen his pregabalin (a medication prescribed for neuropathic pain) from his cell. Pregabalin is often traded and misused in prisons and a nurse told Mr Atour that a doctor would have to complete a medication review and it was unlikely that it would be re-prescribed. In the meantime, a doctor prescribed a reducing dose of pregabalin, which he collected daily.

3. On 27 April, Mr Atour told a nurse that he was in pain and feeling suicidal. The nurse began Prison Service suicide and self-harm prevention procedures, (known as ACCT).

4. At 8.20am on 13 May, Mr Atour told his offender supervisor that he would not be around the next day. The officer interpreted this as a suicidal intention, but considered that Mr Atour was more positive by the end of their meeting and had agreed to go to a planned medication review the next day. The officer reported the conversation to a manager, who considered no immediate action was needed as Mr Atour had a planned ACCT case review that afternoon. Just over three hours later, before the case review, an officer found Mr Atour hanged in his cell. Resuscitation attempts were unsuccessful and at 12.25pm, paramedics recorded that Mr Atour had died.

Findings

5. The investigation found that staff at Erlestoke did not manage Mr Atour's risk of suicide and self-harm effectively. There was no healthcare input at Mr Atour's three ACCT case reviews and no consistency of case management. Although problems with medication were identified as his main concern, there was little evidence of active efforts to resolve this as a priority. When Mr Atour indicated a suicidal intention to an officer on the morning of the day he died, the officer appropriately discussed this with a manager. We consider that they made a reasonable decision that he did not need an immediate ACCT case review as one was already scheduled that day, but they did not appear to consider increasing his level of observations until the review was held.

6. Mr Atour had been allowed to keep supplies of medication in his cell, in spite of a history of poor compliance and concealing medication. This decision partly led to his medication being stopped, which became a major issue for Mr Atour. It does not appear that his anxieties about his medication were ever satisfactorily resolved. The clinical reviewer was concerned that Mr Atour was prescribed a non-standard medication for depression without a clear clinical justification or

monitoring. Record keeping was poor and it was not possible to know exactly when he received his prescriptions. He never had a mental health review despite his suicidal thoughts.

7. The officer who alerted prisoners that it was time for lunch did not check Mr Atour's welfare when he unlocked the courtesy lock on his cell. Although it would not have affected the outcome, there was a delay of several minutes in calling an ambulance as, contrary to national instructions, the prison's local protocol requires staff to confirm whether or not an unresponsive prisoner is breathing before the control room calls an ambulance.

Recommendations

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

    - A multi-disciplinary approach for all case reviews, with continuity of case management.
    - Healthcare staff attending at least all first case reviews.
    - Setting caremap actions, which are specific and meaningful, aimed at reducing prisoners' risks and actively followed up.
    - Reviewing levels of observations whenever an event occurs which indicates an increase in risk.
    - All staff, including healthcare staff, recording relevant information about risk, observations and interactions with prisoners in ACCT documents, which accompany the prisoner.

- The Governor and Head of Healthcare should ensure that the prisoners identified as being at risk of suicide and self-harm are referred urgently for a mental health assessment.

- The Head of Healthcare should ensure that medication risk assessments take full account of a prisoner's history of drug misuse and compliance with medication.

- The Head of Healthcare should ensure a consistent approach to prescribing antidepressant and antipsychotic medication that is in the patient's best interests, in line with clinical guidance and properly recorded. Clear reasons for prescribing decisions should be entered on the SystmOne medical record and prisoners on antidepressant and antipsychotic medication should be reviewed regularly and monitored for known side effects.

- The Governor should ensure that, when a cell door is unlocked, staff satisfy themselves of the wellbeing of the prisoner and that there are no immediate issues that need attention.

- The Governor should ensure that control room staff call an ambulance as soon as an emergency medical code is called and that the local emergency protocol properly reflects the requirements of PSI 3/2013.

The Investigation Process

8. The investigator issued notices to staff and prisoners at HMP Erlestoke informing them of the investigation and inviting anyone with relevant information to contact him. Three prisoners responded.

9. The investigator visited Erlestoke on 19 May. He obtained copies of relevant extracts from Mr Atour's prison and medical records.

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

11. The investigator interviewed 18 members of staff and five prisoners. The clinical reviewer joined the investigator for five of the interviews with staff.

12. We informed HM Coroner for Wiltshire and Swindon of the investigation who gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.

13. One of the Ombudsman's family liaison officers contacted Mr Atour's family to explain the investigation and to ask if they had any matters they wanted the investigation to consider. Mr Atour's family contacted us through their solicitor. His family said that Mr Atour had no history of depression or self-harm and they thought his death was suspicious.

14. Mr Atour's family received a copy of the initial report. The solicitor representing the family 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

HMP Erlestoke

15. HMP Erlestoke is a medium security prison near Devizes in Wiltshire, which holds around 500 men. Great Western Hospitals NHS Foundation Trust provides health services at the prison. Nurses are on duty from 8.00am to 5.00pm Monday to Friday. There is an out-of-hours service at night and weekends. GPs from a local practice run a clinic each weekday morning.

HM Inspectorate of Prisons

16. The last inspection of Erlestoke in October 2013 found that there were few incidents of self-harm and ACCT documents were completed to a good standard. Prisoners reported good care and support from staff. Inspectors found that over 98 per cent of prescribed medicines were held by prisoners in their cells and there were problems with prisoners trading their medicines.

Independent Monitoring Board

17. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help ensure that prisoners are treated fairly and decently. The IMB annual report for 2014-2015 reported serious concerns about prisoners trading medication and using new psychoactive substances (such as spice, a synthetic cannabis substitute).

Previous deaths at HMP Erlestoke

18. Mr Atour was the second prisoner to die at Erlestoke since February 2010. The last death in May 2014 was from the toxic effects of heroin. In that investigation we made a recommendation, which Erlestoke accepted, that staff should check the wellbeing of prisoners when unlocking their cells. We repeat that recommendation.

Assessment, Care in Custody and Teamwork

19. ACCT is the Prison Service process for supporting and procedures prisoners at risk of harming themselves. The purpose of the ACCT is to try to determine the level of risk posed, the steps that might be taken to reduce this and the extent to which staff need to monitor and supervise the prisoner. Checks should be at irregular intervals to prevent the prisoner anticipating when they will occur. Part of the ACCT process involves assessing immediate needs and drawing up a caremap to identify the prisoner's most urgent issues and how they will be met. Regular multidisciplinary reviews should be held. The ACCT plan should not be closed until all the actions of the caremap have been completed. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011.

Key Events

20. Mr Calam Atour was convicted of burglary and theft in 2011, and later sentenced to five and half years' imprisonment. He had been in prison many times. He had a history of drug misuse and mental health problems, including depression. He had been assessed as at risk of suicide and self-harm several times during his sentence and was supported by ACCT procedures. On 2 January 2015, Mr Atour was conditionally released from HMP Exeter.

21. On 30 January, Mr Atour was recalled to prison, after being arrested and charged with theft. He was sent to HMP Bristol and arrived with a self-harm warning form, completed by the escort services, to alert the prison to his risk. At an initial health assessment, Mr Atour told a nurse that he had mental health problems for which he was taking mirtazapine (an antidepressant). He said that he had no thoughts of suicide or self-harm, although he had used a ligature to harm himself in prison 15 to 20 years earlier. The nurse did not record that he had been previously managed under ACCT procedures.

22. Shortly afterwards, a prison GP reviewed Mr Atour and noted that he felt unwell. She prescribed mirtazapine, pregabalin for facial nerve damage and a reducing dose of buprenorphine (subutex) for opioid dependency, which Mr Atour said he had been receiving in the community. (The prison confirmed his community prescription.)

23. On 6 March, a nurse noted that Mr Atour had tried to pretend that he had taken his subutex when he was given it. (Prisoners sometimes do this to sell the medication to others. Mr Atour had previously misused medication in this way.) In response, a prison GP wrote a new prescription for a rapid subutex detoxification. On 17 March, a nurse noted that Mr Atour had again tried to conceal his subutex. He completed the detoxification programme on 19 March.

24. On 7 April, a prison GP noted that Mr Atour did not believe that the mirtazapine was working. He asked to be prescribed seroquel (a brand of quetiapine, an antipsychotic medication) which he had previously obtained illicitly in prison and said that it had helped his depression. The GP noted that the mirtazapine should be reduced, then stopped and replaced with quetiapine.

25. On 16 April, Mr Atour was transferred to HMP Erlestoke. When he arrived, a nurse assessed that he was suitable to keep his medication in his cell and he signed a compact, agreeing to keep it safe.

26. Mr Atour went to Marlborough Wing, Erlestoke's reception unit. On 17 April, at an initial health screen, a nurse noted that he had been assaulted in Bristol (on 15 February) and had a serious head injury. The nurse recorded that he was chatty and alert and his depression appeared well controlled by medication. He said he had no thoughts of suicide or self-harm.

27. Officer A worked on Marlborough Wing and said that Mr Atour was uncooperative. He would not listen to instructions and was very slow to respond when asked to go back to his cell at lock-up times. He did not engage with officers and, while he interacted more with prisoners, he was very much a loner.

28. Officer A said that on the afternoon of 19 April, Mr Atour was found in another prisoner's cell, apparently under the influence of drugs. He thought this was probably spice, a synthetic cannabinoid, known as a new psychoactive substance. The officer said that Mr Atour did not respond when he asked him if he was okay. The officers laid him on the bed and an officer stayed in the cell and monitored him. After 20 minutes, Mr Atour was able to stand up and walk back to his own cell. The officer asked him what he had taken, but he just giggled and said he had not taken anything.

29. Officer A reported the incident to the orderly officer (the manager in charge of the operation of the prison), who arranged for Mr Atour to be checked every 30 minutes up to 9.00pm and every hour from 9.00pm until the morning. The officer submitted a security report about the incident.

30. On the morning of 20 April, a prison GP prescribed Mr Atour 28 days of quetiapine and 28 days of amitriptyline. Officer A spoke to Mr Atour about the incident the day before. Mr Atour again denied that he had taken any drugs. The officer asked a worker from the substance misuse team to see Mr Atour.

31. On 21 April, the substance misuse worker spoke to Mr Atour, who denied that he had used drugs two days before. He said that he expected to be released shortly and did not want any help. The worker told him that if he changed his mind he could refer himself to the service. The worker said that he knew Mr Atour from the past, although he had not been his main support worker then.

32. At 10.00am on 22 April, Mr Atour told a nurse in the healthcare centre that someone had stolen his pregabalin tablets from his cell the previous evening. She said that he was responsible for keeping his medication secure and it was unlikely that he would be given any more. She told him that he would need to apply in writing for a doctor to review his medication and decide whether to prescribe the pregabalin again.

33. A prison GP prescribed a reducing dose of pregabalin for daily issue, until the medication review. Mr Atour had been receiving 600 milligrams (mg) of pregabalin daily. The GP prescribed 400 mg of pregabalin for two days and 200 mg for the next two days. He noted "… unable to keep medication safe despite importance of this being discussed at induction, no further [medication] except reducing dose of [pregabalin], will need to put in [an application if he] wishes to discuss this further".

34. Later that day, Mr Atour went to the healthcare unit to collect his afternoon dose of pregabalin. A nurse noted that when he realised that his other medication had been stopped, he became "verbally" aggressive and officers had to take him away.

35. On 24 April, an officer telephoned a nurse to say that Mr Atour was asking about his medication. She told the officer why most of Mr Atour's medication had been stopped and that he would need to make an application if he wanted a review. Mr Atour had his last dose of pregabalin on 25 April.

36. On the morning of 27 April, Mr Atour went to the healthcare unit and told a nurse that he had passed out in his cell that morning. He said that he had intense head pain and felt suicidal. He said that if he attempted suicide, he would “do it properly”. He told her that he had submitted an application that morning, to see a doctor about his medication. She discussed the medication issue with a prison GP, who advised her that once they received the application, a routine appointment should be made. In view of Mr Atour’s comments, the nurse began ACCT suicide and self-harm prevention procedures.

37. An officer assessed Mr Atour an hour later as part of the ACCT procedures. Mr Atour said that he was felt very low in mood, which usually happened when he did not get his usual medication. However, he told the officer that he did not intend to carry out his earlier threat of suicide.

38. A custodial manager and the officer held an ACCT review with Mr Atour. There was no member of healthcare staff present, although this is a mandatory requirement for first ACCT case reviews. The custodial manager told the investigator that a nurse had briefed her before the review but there is no note of that in the ACCT record. When the investigator checked with the nurse, she said that she had not given her a briefing.

39. The custodial manager noted in the record of the ACCT case review that Mr Atour felt quite low and was very concerned that his medication had been stopped. He said he had been told that a doctor would review his medication within seven days and he would not attempt suicide or harm himself in the meantime. She noted that they would have to wait to see what happened at the medication review and entered the need for a review as the only action in the ACCT careplan (which should have actions designed to reduce risk). The case review assessed Mr Atour’s risk of suicide and self-harm as low and that staff should have three meaningful conversations with him during the day, with hourly checks during the night. The next case review was scheduled for 4 May.

40. At 2.00pm on 27 April, Mr Atour moved from the induction unit to Alfred Wing, a standard prison wing. Later that afternoon, Mr Atour asked to see the substance misuse worker from the substance misuse team. He told the worker that all his medication had been taken from him so he had started using illicit drugs to cope. The worker said he was concerned that the onus seemed to be on Mr Atour to resolve the situation. He spoke to and emailed a nurse to suggest that they have a three-way meeting. The nurse emailed to say that Mr Atour had only just submitted an application for a doctor’s review so he would not be seen until early the next week. The worker then telephoned a wing officer and asked them to make a GP appointment for Mr Atour and was told they would do so. He arranged to see Mr Atour again after the medication review.

41. On the morning of Wednesday 29 April, Mr Atour went to the healthcare centre and told a nurse that he wanted his medication back. The nurse told him that he would need to see a doctor first. Mr Atour swore at her and said that he was going to go to the segregation unit. On his way out, Mr Atour pressed the emergency alarm and swore again. (Later that morning, a prison GP noted that an appointment had been made for the following Monday.)

42. Mr Atour spent several hours in the segregation unit, but there is little in his records about his brief time there. A custodial manager told the investigator that officers would have responded to the emergency alarm. As Mr Atour had asked to go to the segregation unit they would have taken him there as the best way to try to calm the situation, before trying to persuade him to return to his own unit.

43. Mr Atour went back to Alfred Wing that afternoon. In the evening, he told an officer that he was okay, but he was not happy that he would have to wait until 5 May to see a doctor about his medication.

44. On 1 May, Mr Atour told a nurse that he had ongoing head pain. The nurse spoke to the duty doctor who agreed to a five-day supply of paracetamol and ibuprofen. The nurse advised him to keep the medication secure and noted that he had a doctor's appointment the next week.

45. While he was waiting to see the nurse, Mr Atour was alleged to have been abusive towards an officer who had escorted him to the healthcare centre. The officer said that Mr Atour remained agitated throughout so he had charged him with a disciplinary offence. (This was considered at a disciplinary hearing the next day. The hearing was adjourned to allow time for a mental health report to be made in potential mitigation, but there is no evidence that it was ever completed.)

46. An officer said Mr Atour always went to the servery to collect his food, but he would go back to his cell to eat it, without engaging with staff or other prisoners. She said he would usually only speak to staff when he needed to ask for something. As an example, she said that on the morning of 4 May he went to the wing office to find out how much money he had in his prison account. She said that she tried to interact with him and had asked him about whether he had family support, but he would not engage with her.

47. On 4 May, a manager and an SO held the second ACCT case review. Again there was no member of healthcare staff present, despite medication being Mr Atour's main concern. The manager noted that Mr Atour had said he was not "in a good place". He said that he had sold most of his possessions to buy drugs. Mr Atour said that he had no thoughts of self-harm but he needed help with his drug use and medication. He added a caremap action for Mr Atour to be referred to the drug misuse team and emailed a referral. Both said that he seemed optimistic about his medication review, which was to be held the next day, 5 May. Mr Atour said that he had no plans or thoughts of suicide or self-harm.

48. The panel assessed Mr Atour's risk of suicide and self-harm as low. They kept his daytime contact at three conversations, but reduced observations at night to five. The manager told the investigator that hourly observations meant that prisoners are disturbed throughout the night and, as Mr Atour was focussed on a positive review with the doctor the next day, he considered it appropriate to reduce the night-time observations. He set the next ACCT review for 6 May.

49. On 5 May, a prison GP and Mr Atour had a long discussion at the medication review. The GP re-prescribed amitriptyline and quetiapine and sent a referral to the mental health team to review if this was the appropriate treatment. In the

meantime, she told Mr Atour that she would not re-prescribe pregabalin. She noted that, although he was not happy about this, he understood the plan.

50. When Mr Atour got back to his wing, he told an officer that he was pleased to have been re-prescribed some medication. The officer told the investigator that he had known Mr Atour from previous sentences, but it had been around five years since he had last seen him. The officer said that he noticed a big change in Mr Atour. He said he seemed grey, down and sad but previously he had been bubbly and pleasant and polite to staff.

51. On 6 May, a custodial manager and an officer held an ACCT case review. Again, there was no member of healthcare staff present. The manager noted that Mr Atour had received medication that day for pain relief (amitriptyline) and depression (quetiapine). He recorded that Mr Atour had not said much at the review but said that he had no thoughts of suicide or self-harm. Again they assessed Mr Atour's risk as low. Staff were still required to have and record three conversations with Mr Atour during the day but the review reduced his observations to three during the night. The manager set Mr Atour's next review for a week later, on 13 May.

52. That afternoon, Mr Atour told an officer that he thought his new medicine prescription was wrong and he felt let down. The officer advised him to put in an application for a further doctor's appointment.

53. On 7 May, the substance misuse worker saw Mr Atour who said that he wanted to be prescribed subutex, which he had previously received in the community. The worker said that Mr Atour spent a lot of time talking about his life and drug use in the community and he was not able to complete his assessment before lock-up time. He told Mr Atour that he would see him again the next week to finish the assessment.

54. On 8 May, officers made several entries in Mr Atour's ACCT document suggesting that he had taken drugs and was "under the influence" for several hours. One of the officers on duty that afternoon said that Mr Atour had not caused any disturbance, but his pupils were dilated which he assumed was due to drug use.

55. On the morning of 9 May, Mr Atour attended a disciplinary hearing after an officer's jacket had been found in his cell the previous day. Erlestoke has not been able to find the records of the hearing but there is no evidence that he received any punishment as a result.

56. That afternoon, Mr Atour told an officer that he was unhappy that the situation with his medication had not been resolved but he had another doctor's appointment on 14 May to discuss this. The officer said he was quite chatty that day. He said that Mr Atour usually spent a lot of time alone in his cell and had limited interaction with other prisoners.

57. On the afternoon of Sunday 10 May, the officer spoke to Mr Atour and noted that he had helped another prisoner clean his cell and he seemed in good spirits. Mr Atour said that weekends were long and boring and he asked about getting a prison job. The officer told him that he would check with the work allocation team.

58. On Monday 11 May, a nurse saw Mr Atour in the healthcare centre and noted that he was unhappy and wanted to be re-prescribed pregabalin. He asked for paracetamol and ibuprofen. She gave him some paracetamol, but told him she would need to see the doctor to prescribe ibuprofen. She noted she was unable to get this prescription as the GP's clinic closed early due to a disturbance.

59. An officer noted in Mr Atour's ACCT record that he had tried to speak to Mr Atour in the afternoon and evening of 11 May, but Mr Atour did not want to talk. However, Mr Atour had told him that he was waiting for a further medication review on 14 May. This was the officer's last substantive interaction with him. He said that Mr Atour's demeanour did not change much. Sometimes he would have chatty days, but he was usually just preoccupied about getting his medication.

60. On 12 May, the substance misuse worker spoke to the prescribing nurse from the substance misuse team to see if it was possible for Mr Atour to be prescribed subutex. They agreed that the substance misuse worker would first see Mr Atour again on 14 May, to continue his assessment and then refer him to the clinical team to be prescribed either subutex or methadone.

61. On the evening of 12 May, after Mr Atour had collected his evening meal, an officer recorded in his ACCT document that she had not been able to have a conversation with him that day. This was because prisoners had been locked up all day to allow staff training.

Events on Wednesday 13 May

62. At 8.20am on 13 May, Mr Atour had his first meeting with his offender supervisor to discuss his sentence plan. The offender supervisor said that Mr Atour seemed low. He asked him how he was coping and Mr Atour said he was annoyed and would not be going to his appointment the next day to discuss his medication, as he would "not be here tomorrow". The offender supervisor asked him what he meant by that and Mr Atour said that was obvious. He encouraged Mr Atour to be positive and said he should go to the appointment to focus on getting stable on his medication. Mr Atour indicated that he would, but declined the offender supervisor's offer to go with him to the appointment. They agreed to meet a week later.

63. The offender supervisor noted their conversation in Mr Atour's ACCT document and took him back to his wing. He spoke to an officer and telephoned a custodial manager, who was the orderly officer that day, to tell her what Mr Atour had said. She told him that Mr Atour was due to have an ACCT review that afternoon and he offered to attend the review. He added that as things stood, Mr Atour had agreed to go to his medication review the next day. The offender supervisor said that he felt reassured by this and that Mr Atour had agreed to attend a sentence-planning meeting the next week.

64. The custodial manager confirmed that the offender supervisor had spoken to her that morning and had told her that Mr Atour had said he would not be around the next day. She said she had asked him to clarify the conversation and how it had ended. He had said that Mr Atour had agreed to see the doctor the next day for a medication review and he thought that the review would be a significant event,

which would determine Mr Atour's frame of mind. They agreed that it would be a good idea for him to attend the ACCT review scheduled for later that day. She told the investigator that on the clarification he had given, she did not consider there was a need for an immediate ACCT case review. She spoke to the custodial manager who was due to chair the ACCT review and briefed her about the situation. This custodial manager was not in a position to hold the review immediately and, as she was covering the other custodial manager's orderly officer duties over lunchtime, intended to hold the review that afternoon.

65. An officer said that the offender supervisor had spoken to her when he brought Mr Atour back to the wing, but she had understood that Mr Atour had said that he did not intend to see the doctor the next day, not that he was not going to be around for the appointment. She said that if she had understood precisely what Mr Atour had said she would have increased the frequency of his observations until the ACCT review. The offender supervisor took Mr Atour back to his cell after he spoke to the officer. The cells on Mr Atour's wing were fitted with standard prison locks and courtesy locks. The courtesy lock allows the prisoner to lock his cell to stop other prisoners from coming in during periods when prisoners are not locked in their cells. The courtesy lock can be overridden by staff. When he returned Mr Atour to his cell, he did not lock the cell.

66. Officers unlocked the cells of prisoners on the wing just after 11.00am and prisoners began collecting their lunch shortly before 11.30am. An officer reached Mr Atour's cell at about 11.05am. It seems that Mr Atour had locked his cell using the courtesy lock and he used his key to unlock the courtesy lock, but he did not look inside or speak to Mr Atour at the time.

67. Two prisoners worked on the wing servery. They said that they ticked off prisoners' names as they collected their lunches and then shouted out the names of those who had not. When Mr Atour still did not respond they asked Officer A to check whether he wanted lunch. The officer said that he went to check three prisoners who had not collected lunch, including Mr Atour.

68. When the officer looked into Mr Atour's cell, he was hanging from a ligature, made from a bed sheet and tied to the window frame. His legs were stretched out in front and bearing no weight. He radioed a code blue emergency alarm at 11.37am and went into the cell. He cut the sheet, lowered him to the floor and then cut the remainder of the sheet from around Mr Atour's neck. He checked Mr Atour's neck and wrist for a pulse but found no signs of life. He thought that it was likely that Mr Atour had died, but started chest compressions to try to resuscitate him. He estimated that he had given around five compressions when other officers and nurses came into the cell. He asked one of the nurses to take over resuscitation as he was not sure what to do.

69. A nurse said that she was in the healthcare unit when she heard the code blue alarm and estimated that it took her and a colleague 60 to 90 seconds to reach the cell. After checking Mr Atour for signs of life, they started chest compressions. Another nurse also arrived. The nurses inserted an airway to help give oxygen and checked Mr Atour with a defibrillator (a life saving device that gives the heart an electric shock in some cases of cardiac arrest) but found no shockable heart rhythm. They continued giving chest compressions and

oxygen until paramedics arrived and took over. A nurse said that she thought it was likely that Mr Atour was already dead when she first assessed him, but considered it was appropriate to try to resuscitate him.

70. An officer was working in the control room. When he heard the code blue he did not call an emergency ambulance immediately, but first checked with staff at Mr Atour's cell that one was needed. He called an ambulance at 11.40am; three minutes after the code blue had been broadcast. Paramedics reached Mr Atour at 11.56am and took over emergency treatment. At 12.25pm, the paramedics recorded that Mr Atour had died.

Contact with Mr Atour's family

71. Mr Atour had named his sister as next-of-kin. The prison was concerned that his family might learn of Mr Atour's death through other prisoners speaking to their families. His family lived a long distance from the prison and they asked the police to break the news to Mr Atour's sister in person. The Governor of Erlestoke and a family liaison officer visited Mr Atour's mother and two sisters the next day and offered condolences and support. The prison contributed towards funeral expenses, in line with national policy.

Support for prisoners and staff

72. A prison manager debriefed the staff involved in the emergency response and informed them of his support and that of the prison's care team. Staff reviewed all prisoners assessed at risk of suicide or self-harm in case they had been affected by Mr Atour's death.

Toxicology report

73. A toxicology report showed no evidence of drugs, drug metabolites or alcohol in Mr Atour's blood.

Findings

Assessing and managing risk of self-harm

74. Mr Atour had been managed under suicide and self-harm prevention procedures a number of times during previous sentences, up to December 2014, just before his release from HMP Exeter. In January 2015, when he was recalled to prison, he had a number of factors known to increase the risk of suicide and self-harm, including that he had been recalled to prison and had arrived at Bristol with a self-harm warning form. He had a history of depression, mental health issues, and addiction to drugs and it is not clear that staff at Bristol took all these into account. We are surprised that Bristol did not begin ACCT procedures when Mr Atour arrived there, but recognise that this had no bearing on the eventual outcome.

75. On 27 April, Erlestoke appropriately began ACCT procedures when Mr Atour reported feeling suicidal. We have some concerns about the management of the ACCT procedures, which were not fully in line with Prison Service Instruction (PSI) 64/2011. Mr Atour had a case review the day the ACCT was opened and further case reviews on 4 May and 6 May. Each of the reviews were chaired by different managers so there was no continuity of case manager.

76. PSI 64/2011 requires a multidisciplinary approach for case reviews and it is mandatory for a member of healthcare staff to attend at least the first ACCT case review. There was no healthcare representative at the first ACCT case review. A custodial manager said that a nurse briefed her before the review, but there is no evidence of this. No other disciplines were represented at any of the case reviews and, although Mr Atour's main concern was about his medication there was no healthcare involvement in any of the case reviews. Healthcare staff said that they were not routinely invited to ACCT reviews and we are concerned that after Mr Atour was identified as at risk of suicide and self-harm and his problems with medication, including for depression, no one referred him for a mental health assessment, either as an ACCT caremap action or following healthcare appointments.

77. The prison staff would not have had access to Mr Atour's clinical records and would not have had the expertise to understand the potential physiological and psychological effect on Mr Atour of not receiving some of the medication he had been previously prescribed. Although Mr Atour had been assessed as at risk of suicide and self-harm because of medication issues, ACCT caremaps did little to address this and no one asked for an urgent review of his medication in the light of his vulnerability, although he had made it clear that he was "self-medicating" by taking illicitly obtained medication. The caremap action simply noted that the medication review would determine the outcome. A week later, at the time of the second ACCT review on 4 May, Mr Atour had still not had a medication review, which took place on 5 May.

78. PSI 64/2011 also makes it clear that the ACCT document must travel to and from any location the prisoner moves to. This ensures that the receiving member of staff is aware of the prisoner's risk status and is able to note their observations and any relevant comments in the ACCT record. We understand that this is a

problem at Erlestoke as prisoners often attend healthcare appointments unescorted with a movement slip and taking the ACCT document would require an officer to attend also. One of the GPs and two nurses said that prisoners being monitored under ACCT procedures often attended healthcare appointments without the ACCT document so healthcare staff were unaware of any particular concerns and were unable to contribute to the ACCT process. Combined with the lack of healthcare staff attendance at ACCT reviews this is a concern.

79. In addition to planned case reviews, ACCT procedures require a case review to be held where further concerns arise to suggest the prisoner might be at increased risk. The case review will then consider if another assessment is required and whether there is a need to adjust the frequency of observations. On 13 May, Mr Atour told his offender supervisor that he would not be around for his medication review the next day, which the offender supervisor understood as a suicide threat. However, by the end of their meeting, the offender supervisor believed that Mr Atour was more positive and that he had persuaded him to see the doctor the next day. He did not consider that Mr Atour was at any imminent risk of suicide.

80. After their conversation, the offender supervisor telephoned the custodial manager to tell her about his discussion with Mr Atour. As Mr Atour's next ACCT review was already planned for later that day, neither of the staff thought there was a need for an immediate ACCT review. We agree that this was a reasonable decision but we are concerned that they did not discuss whether there was a need to increase the level of observations to keep him safe until the review. The custodial manager was reassured that his risk would be considered again at his ACCT review. Sadly, just a few hours later, Mr Atour killed himself, before the review was held.

81. The offender supervisor had been reassured by Mr Atour's later presentation at their meeting. However, he was concerned enough about what Mr Atour had said to discuss this with the custodial manager. This was commendable and appropriate. After discussion, they both considered that Mr Atour did not present as an immediate risk of suicide or self-harm, but we believe they should have reviewed his level of observations until the case review. We accept that there was little to indicate that Mr Atour was at very high risk, and even if additional checks had been introduced, it is unlikely that they would have been set at such as level as to prevent his actions.

82. We make the following recommendations:

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

- **A multi-disciplinary approach for all case reviews with continuity of case management.**
- **Healthcare staff attending at least all first case reviews.**
- **Setting caremap actions, which are specific and meaningful, aimed at reducing prisoners' risks and actively followed up.**

- **Reviewing levels of observations whenever an event occurs which indicates an increase in risk.**
- **All staff, including healthcare staff, recording relevant information about risk, observations and interactions with prisoners in ACCT documents, which accompany the prisoner.**

The Governor and Head of Healthcare should ensure that the prisoners identified as being at risk of suicide and self-harm are referred urgently for a mental health assessment.

Risk assessment for medication

83. When Mr Atour arrived at Erlestoke he signed a compact to allow him to keep his medication in his cell. The compact explained that:

> "It is the policy of the prison that medication should be held in the possession of the prisoner whenever possible. All prisoners will be risk assessed [taking] into account the medication, the prisoner's behaviour and ability to responsibly look after their medication."

84. In assessing Mr Atour's suitability to hold his medication, a nurse said that she had followed the risk assessment flow chart. One of the flow chart considerations is whether the prisoner had a previous history of secreting medication.

85. Mr Atour had a well-documented history of misusing and concealing prescribed medication throughout his time in prison. This should have been taken into account in this assessment. This had been noted most recently at Bristol, just the month before, when he had been placed on a rapid detoxification programme for trying to conceal subutex. There is no evidence that the assessment took into account this previous information. We consider that there was sufficient evidence for staff to conclude that Mr Atour was not suitable to hold stocks of medication in his cell and that he should have been issued with his medication daily.

86. On 22 April, Mr Atour had his medication stopped because he said his pregabalin had been stolen from his cell. We do not know exactly what happened to the pregabalin, but the lack of medication then became a major issue for Mr Atour. It seems likely that this issue could have been avoided had there been an appropriate assessment which properly considered his risks. We make the following recommendation:

The Head of Healthcare should ensure that medication risk assessments take full account of a prisoner's history of drug misuse and compliance with medication.

Clinical care

87. The clinical reviewer noted that Mr Atour had a long history of depression and illicit drug misuse. He had been treated in the community and in prison with subutex (an opiate substitute) and conventional antidepressants until April 2015.

He found that it was difficult to be clear about the starting and finishing times of some of Mr Atour's prescribed medications, as his medicine administration charts had mistakenly been destroyed and not scanned on the SystmOne electronic medical record. Healthcare staff had different accounts. He had a number of concerns about prescribing practice.

88. The clinical reviewer noted that a doctor at Bristol had prescribed quetiapine when Mr Atour said that mirtazapine was no longer effective. He said he had used quetiapine illicitly in the past and found it had helped his depression. It was agreed that he should reduce the mirtazapine and transfer to quetiapine and he continued quetiapine when he transferred to Erlestoke.

89. The clinical reviewer noted that quetiapine is not usually prescribed as an antidepressant in unipolar depression (major or clinical depression). It is an antipsychotic usually used for schizophrenia or bipolar depression. The medication was prescribed after Mr Atour self-reported that it had helped him, without any check of his medical history or whether it was appropriate. It was unclear how long he had used it illicitly in the in the past and because he used it illicitly the side effects and effectiveness would not have been monitored.

90. The manufacturer's advice notes that the side effects include headache, dizziness and increased suicide ideation. Mr Atour reported these symptoms but there is nothing in his medical records to indicate that healthcare staff were aware that these symptoms could be linked to quetiapine and no evidence that they monitored him for any side affects. Staff did not review and increase the dosage, or take blood tests in line with the advice in the medicine information sheet for quetiapine.

91. It is not clear from Mr Atour's records whether he consistently received and took the medicine from the time it was prescribed to the time he took his life. A doctor did not think that Mr Atour was taking mirtazapine when he transferred from Bristol but nurses said that he was. The lack of records has made this impossible to be sure. On 22 April, a prison GP cancelled his prescription of pregabalin when he reported having it stolen. It is not clear whether the quetiapine was also stopped at that time. (Advice is that physicians should consider the potential risk of suicide if quetiapine is stopped abruptly.) Nurses said that he continued to receive it, but a prison GP said that she thought it had been stopped and she prescribed it again from 5 May. Again there is no clear record of this.

92. The clinical reviewer described the prescription, administration and monitoring of Mr Atour's quetiapine as chaotic, and noted that poor administration of antidepressants can have an adverse effect on mental health. In his review, he noted other weaknesses in Mr Atour's clinical care, including the lack of mental health review and the lack of healthcare staff involvement in ACCT procedures. He concluded that Mr Atour's care was not equivalent to that he could have expected to receive in the community. We make the following recommendation:

The Head of Healthcare should ensure a consistent approach to prescribing antidepressant and antipsychotic medication that is in the patient's best interests, in line with clinical guidance and properly recorded. Clear reasons for prescribing decisions should be entered on the SystmOne

medical record and prisoners on antidepressant and antipsychotic medication should be reviewed regularly and monitored for known side effects.

Unlocking prisoners

93. When the officer unlocked the courtesy lock on Mr Atour's cell at about 11.05am on 13 May, he did not look in the cell to check his wellbeing. We do not know whether Mr Atour had already hanged himself at that time, or whether a check and possible intervention at the time might have changed the outcome. Prison officers are trained that they should usually get a response from prisoners before they open a cell door and Prison Service Instruction 10/2011 states that "there need to be clearly understood systems in place for staff to assure themselves of the wellbeing of prisoners during or shortly after unlock ... Where prisoners are not necessarily expected to leave their cell, staff will need to check on their wellbeing, for example by obtaining a response during the unlock process".

94. We recognise that Mr Atour was not locked in his cell and was free to leave it at any time. We also recognise that staff at Erlestoke identified that Mr Atour had not left his cell to collect his lunch and this led to the officer going back to check Mr Atour, but this was over half an hour later, at 11.37am. If it is staff's practice to unlock courtesy locks, we consider that the obligation to check the prisoner's welfare when they do so remains. While it appears that Mr Atour might already have been dead at this time, we cannot know this for sure and this was a potential missed opportunity to save him. In the investigation into a death at Erlestoke in May 2014, we made a recommendation about the need to check prisoners' welfare when unlocking their cells and the prison accepted the recommendation. Although the circumstances in this investigation are slightly different, we repeat the same recommendation:

    The Governor should ensure that, when a cell door is unlocked, staff satisfy themselves of the wellbeing of the prisoner and that there are no immediate issues that need attention.

Emergency response

95. PSI 3/2013 requires prisons to have a medical emergency response code protocol, which should ensure that an ambulance is called automatically in a life-threatening medical emergency. The PSI explicitly states that when a medical emergency is called over the radio network, an ambulance must be called immediately and local procedures should ensure this. There should be no requirement for control room staff to check with managers, healthcare staff or others at the scene before calling an ambulance, but they should wait for updates and keep the ambulance service informed. The PSI notes that it is better to act with caution and request an ambulance that can be cancelled later if it is not needed.

96. The officer radioed a code blue as soon as he found Mr Atour hanged, which should have resulted in the control room calling an ambulance immediately. However, the control room officer first checked that one was needed before calling the ambulance service three minutes later. There is no evidence this

delay affected the outcome for Mr Atour but in other emergencies, checking with staff at the scene first could cause a critical delay.

97. We are also concerned that Erlestoke's local protocol builds in an unnecessary delay as it states that that the person discovering a medical emergency should tell the control room whether the person is breathing or not and the control room will then call an ambulance. For staff to comply with the local protocol, they would first have to go into a cell and check a prisoner for signs of breathing before an ambulance is called. The PSI makes it clear that, if staff are in any doubt about the nature of the injury, they must call an ambulance. We make the following recommendation:

The Governor should ensure that control room staff call an ambulance as soon as an emergency medical code is called and that the local emergency protocol properly reflects the requirements of PSI 3/2013.

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