Prisons & Probation
Ombudsman
Independent Investigations

Independent investigation into the death of Mr Daniel Tudor a prisoner at HMP Highpoint on 28 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.

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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 Daniel Tudor died on 28 November 2015, from complications arising from acute pneumonia and dehydration while a prisoner at HMP Highpoint. He was 28 years old. I offer my condolences to Mr Tudor's family and friends.

During his time in custody, Mr Tudor's behaviour deteriorated significantly and rapidly following his move to the prison's segregation unit where he refused all treatment, food and fluids (although he ate a little fruit and drank some water and milk) and would not engage with the mental health nurses and healthcare staff who saw him regularly. This caused Mr Tudor's condition to deteriorate significantly, leading to his death.

I have a number of concerns about the Mr Tudor's management and the care he received at Highpoint. The prison did not assess and manage Mr Tudor's risk of suicide and self-harm appropriately. Most particularly, they did not manage him under the enhanced case review process. I am very concerned that Mr Tudor was moved to the segregation unit without staff considering whether there were exceptional reasons that meant he could not be located elsewhere in the prison and I am troubled by the very limited options which were apparently open to the prison to secure the one concrete recommendation which was made – transfer to a prison with 24 hour healthcare – which might have addressed his declining condition.

Healthcare staff's focus was on Mr Tudor's mental health but despite this there is no record that any clinician at the prison considered whether Mr Tudor had the mental capacity to refuse treatment, food and fluid in line with Prison Service Instructions and the healthcare provider's own internal guidance. The prison did not effectively monitor Mr Tudor's physical health. There were no care plans in place (especially in relation to the risk of dehydration) and a lack of multidisciplinary meetings to discuss and plan his care. Clinical staff did not investigate high blood sugar levels, had they have done so it may have resulted in an earlier admission to hospital.

I am also concerned, that although the hospital informed Mr Tudor's brother that he was seriously ill, no one from the prison contacted him until after Mr Tudor's death.

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 **February 2017**

Contents

Summary 1
The Investigation Process 4
Background Information 5
Key Events 7
Findings 16

Summary

Events

1. Mr Daniel Tudor had been in prison since 11 April 2015 and had been at HMP Highpoint since 13 October. Prior to and following his transfer to Highpoint, Mr Tudor harmed himself after raising concerns about his health and asking to see prison GPs. Both mental health and healthcare staff saw him frequently to try and monitor and assess him. When Mr Tudor harmed himself, staff placed him on suicide and self-harm prevention procedures, known as ACCT, though healthcare staff often did not attend case reviews and they often did not identify or include meaningful support.

2. On 5 November, Mr Tudor’s attacked a member of staff. He was moved to the prison’s segregation unit where his behaviour deteriorated significantly and swiftly. He removed all of his clothes, refused medication, refused food and fluids, would not allow healthcare staff to review him, declined offers of a translator and covered himself and his cell with faeces and food. Staff started a food refusal log, but noted it was difficult to assess how much or little Mr Tudor was consuming, because he was spreading food over his cell. It was not until 18 November that a psychiatrist tried to assess Mr Tudor and recommended that he be moved to a prison with 24-hour healthcare but with no diagnosis or treatment recommendations. Highpoint contacted HMP Chelmsford, but there were no beds available at the time. They also considered HMP Warren Hill and HMP Hollesley Bay, but neither could provide the level of psychiatric care they considered Mr Tudor required.

3. Mr Tudor’s health was declining, but despite the efforts of both mental health and healthcare staff to assess him, he continued to refuse to engage with them. On 22 November, a nurse managed to obtain a blood sample which showed raised blood sugars, but apart from noting this she did not take any action. A doctor saw the results the next day and also took no action to investigate them further.

4. By 24 November, a nurse and doctor were very concerned about Mr Tudor’s condition and he deteriorated further while they were assessing him. An ambulance was called and paramedics attended. Paramedics considered Mr Tudor may have ketoacidosis (where a lack of insulin causes the body to break down other body tissue for energy). Once is hospital, doctors initially diagnosed acute pneumonia, possible ketoacidosis and kidney failure. Despite efforts by hospital staff, Mr Tudor refused all treatment. He disconnected monitoring equipment and removed his cannula (inserted to provide medication intravenously). Hospital clinicians considered he lacked the mental capacity to make informed choices about his care and took the decision to sedate and treat him in his best interests.

5. Hospital staff sedated Mr Tudor and gave him medication in an attempt to stabilise his condition. However, his condition continued to deteriorate. At 4.00am on 28 November, hospital staff placed him on a life support machine. Mr Tudor did not recover and he died at 1.42pm the same day.

Findings

6. Accepting that Mr Tudor was a challenging prisoner, we found a number of areas of concern around Mr Tudor's care at Highpoint. The clinical reviewer was concerned that healthcare staff concentrated on Mr Tudor's mental health and did not effectively monitor his physical health. High blood sugar levels were not investigated, which could have resulted in an earlier hospital admission. When Mr Tudor began to refuse medication, food and fluids, staff started an appropriate food log. However, there were only two multidisciplinary meetings to discuss and plan his care, which seemed limited to moving him to a prison with 24-hour healthcare, when a bed was available. Healthcare staff did not monitor and record the key indicators of dehydration. There is no record that anyone advised Mr Tudor of the likely consequences of his food/fluid refusal and no record that any clinician at Highpoint considered whether he had the mental capacity to refuse medication, food or fluids.

7. In light of Mr Tudor's challenging behaviour, we believe that staff should have made full assessments of all aspects and causes of his behaviour. Mr Tudor did not receive sufficient and meaningful support under the ACCT process and the prison should have managed him under the enhanced case review process.

8. We are also concerned that prison staff moved him to the segregation unit without considering whether there were exceptional reasons that meant he could not be located elsewhere in the prison.

9. We are also concerned that no one from the prison informed Mr Tudor's family that he was seriously ill in hospital. A family liaison officer only spoke to Mr Tudor's brother after his death.

Recommendations

- The Head of Healthcare should ensure that detailed care plans are implemented for prisoners with complex needs to ensure both mental and physical health are appropriately monitored.

- The Head of Healthcare should ensure that clinicians appropriately follow up abnormal blood test/monitoring results.

- The Governor and Head of Healthcare should ensure there are regular multidisciplinary meetings to discuss and plan the care of complex prisoners, especially those refusing medication, food and fluid.

- The Head of Healthcare should ensure there is an appropriate care plan in place when a prisoner is refusing food and fluids, which is reviewed daily and includes key indicators of dehydration.

- The Governor and Head of Healthcare should ensure that when a prisoner consistently refuses medication, food or fluids, they are advised of the likely consequences and a mental capacity assessment is carried out and recorded.

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

  - ACCT case reviews are multidisciplinary where possible and include all relevant people involved in the prisoner's care, including a named case manager, with healthcare staff attending all first case reviews.
  - Prisoners at risk are not held in the segregation unit unless all other options have been considered and excluded and there are fully documented reasons to explain the exceptional circumstances.
  - Staff use enhanced case management procedures for prisoners held in unfurnished accommodation and in other more complex cases.
  - ACCT monitoring does not stop until all caremap actions have been completed and all identified issues that might increase risk have been addressed.
- The Governor and Head of Healthcare should ensure that staff manage prisoners held in the segregation unit in line with national guidelines, including that:
  - Prisoners are held in unfurnished cells for the shortest time possible, and that all the provisions and safeguards of PSO 1700 apply.
  - Segregation review boards are held more frequently than the minimum requirement for prisoners on open ACCT documents, include the ACCT case manager, and consider and record whether there are exceptional reasons to authorise continuing segregation.
  - ACCT case reviews are held at the same time as segregation review boards.
  - Segregation health screens consider all relevant information about a prisoner, including any recent changes to their mental and physical health or their behaviour.
- The Governor should ensure that an appropriate member of staff is appointed promptly to engage with and support the families of seriously ill prisoners.

The Investigation Process

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

11. The investigator obtained copies of relevant extracts from Mr Tudor's prison and medical records. He interviewed five members of staff at Highpoint on 20 January 2016 and three members of staff on 17 October.

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

13. We informed HM Coroner for Greater Suffolk of the investigation. Our investigation was suspended for over five months until we received the post-mortem report from the coroner. We regret the consequent delay in issuing this report. We have sent the coroner a copy of this report.

14. One of the Ombudsman's family liaison officers contacted Mr Tudor's sister to explain the investigation and to ask if she had any matters she wanted the investigation to consider the following points:

- How had healthcare staff assessed Mr Tudor when he arrived at Highpoint and what medication was prescribed?
- Was he on hunger strike and how was it managed?
- What happened when he begged to go to hospital?
- Mr Tudor said that staff and prisoners were tampering with his food, was this correct?

15. Mr Tudor's family and legal representatives received a copy of the initial report. The legal representative acting for the family did not raise any issues with the factual accuracy of the report.

16. The initial report was shared with the Prison Service. The Prison Service did not find any factual inaccuracies.

Background Information

HMP Highpoint

17. HMP Highpoint is a medium security prison on two sites; Highpoint South which was the original HMP Highpoint and Highpoint North, previously known as HMP Edmunds Hill. Highpoint holds up to 1,319 men. Care UK provides general and mental healthcare services at the prison. The healthcare centre is open from 7.45am to 6.15pm, Monday to Friday, and from 8.00am to 6.00pm at weekends. A local practice provides GP services, and there is a range of nurse-led clinics. There are no inpatient beds at the prison.

HM Inspectorate of Prisons

18. The most recent inspection of HMP Highpoint was in October 2015. The Inspectorate found that despite some serious challenges the prison was working hard to sustain generally reasonable outcomes. Inspectors considered that the provision of health services was reasonable and well governed. Mental health provision was adequate. However, inspectors noted that while prisoners were referred to the mental health team, there was no evidence of dual diagnosis expertise or any care pathway.

19. Inspectors found that ACCT documents were poor, with caremaps not addressing the key needs of the prisoner and case reviews poorly conducted. They also found that too many prisoners on open ACCT documents were held in the segregation unit. However, they found excellent complex care planning for more vulnerable prisoners.

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 December 2015, the IMB reported that a strong mental health team worked hard to meet the needs of prisoners. They reported that a changing population of prisoners meant that more challenging and volatile prisoners were now resident at Highpoint. The IMB reported that staff are sometimes seconded to the segregation and are not therefore always familiar with procedures.

Previous deaths at HMP Highpoint

21. Mr Tudor was the sixth prisoner to die at Highpoint since January 2014; there has been one death since. We have raised the issue of the prison failing to manage prisoners at risk of suicide and self-harm in line with national guidelines and failing to contact a prisoner's next of kin when they are seriously ill before.

Assessment, Care in Custody and Teamwork

22. Assessment, Care in Custody and Teamwork (ACCT) is the care planning system the Prison Service uses to support prisoners at risk of suicide or self-harm. The purpose of ACCT is to try to determine the level of risk posed, the steps that might be taken to reduce this and the extent to which staff need to

monitor and supervise the prisoner. Checks should be irregular to prevent the prisoner anticipating when they will occur. Part of the ACCT process involves drawing up a care map 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 of the actions on the care map have been completed. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011.

Segregation units

23. Segregation units are used to keep prisoners apart from other prisoners. This can be because they feel vulnerable or under threat from other prisoners or if they behave in a way that prison staff think would put people in danger or cause problems for the rest of the prison. They also hold prisoners serving punishments of cellular confinement after disciplinary hearings. Segregation is authorised by an operational manager at the prison who has to be satisfied that the prisoner is fit for segregation after an assessment by a member of healthcare staff. Segregation unit regimes are usually restricted and prisoners are permitted to leave their cells only to collect meals, wash, make phone calls and have a daily period in the open air. The unit at Highpoint is known as the Care and Separation Unit and compromises 17 cells.

Key Events

24. On 11 April 2015, Mr Daniel Tudor was remanded to HMP Pentonville, charged with robbery. On 17 July, he was sentenced to three years in prison. The Immigration Service planned to deport Mr Tudor back to his home country of Romania on completion of his prison sentence.

25. At an initial health screen at Pentonville, Mr Tudor did not report any health issues. The nurse carrying out the health check noted that he spoke a reasonable level of English and he was able to understand most of what she said to him. There was evidence of some previous attempts at self-harm on Mr Tudor's arms, which he told her he had inflicted following his father's death. He told the nurse he did not have any current thoughts of self-harm.

26. On 14 April and 7 May, Mr Tudor made superficial cuts to his right arm because of problems that he had faced contacting his relatives. Staff placed him on suicide and self-harm preventions procedures, known as ACCT, and reviewed him regularly each day. On 3 June, a custodial manager reviewed Mr Tudor who said he felt much better despite still having issues contacting his family. He told Ms Foley he had no desire to harm himself and she closed the ACCT plan.

27. On 9 October, a nurse reviewed Mr Tudor after he reported suffering from stomach pains. She tested Mr Tudor's urine for the presence of blood, ketones, protein and glucose (used as an indicator for diabetes and kidney disease) all of which were negative. She made an appointment for a prison GP to review Mr Tudor on 13 October.

28. The following day, a nurse reviewed Mr Tudor as he had again complained of stomach pain. He told the nurse he had been experiencing pains in his stomach for the previous two weeks and had not opened his bowels for four days, though he had no issues passing urine. The nurse examined him and noted he had a scheduled appointment with a prison GP so prescribed him lactulose (a laxative).

29. On 12 October, Mr Tudor made superficial cuts to his right arm and tied a ligature around his neck but did not tighten it. A prison GP reviewed Mr Tudor. He told him that he had harmed himself so he could see a GP (although he already had an appointment planned for the following day). He told him he had been experiencing stomach pain for three weeks, he had also experienced a feeling of tingling in his throat when eating and that he vomited after every meal. He stated he had been experiencing the symptoms for the past 18 months.

30. The prison GP noted that despite the claimed vomiting, there was no sign of significant weight loss. He recorded Mr Tudor's weight as 69.4kg (on reception into prison he weighed 63.74kg) there was no indication of any form of swelling or mass in Mr Tudor's stomach. He prescribed him lansoprazole (medication to reduce stomach acid) and told him to continue taking lactulose in an effort to treat his symptoms. An officer opened at ACCT plan which required officers to speak to Mr Tudor each hour.

31. On 13 October, Mr Tudor transferred to HMP Highpoint. At the initial health screen, Mr Tudor reported his concerns about ongoing abdominal pain. He told the nurse carrying out the health check that he had harmed himself so he could see a doctor. He asked to see a doctor and the nurse told him there was no doctor on duty in Highpoint until the following day. He told her that despite feeling low in mood, he had no intention of harming himself. She did not report any issues communicating with Mr Tudor during her review. She recorded his weight as 73kg. The nurse referred him to the prison's mental health team for assessment and to a GP for review. Prison staff continued to review him in line with the ACCT plan.

32. On 14 October, a mental health nurse assessed Mr Tudor. She noted he was on an ACCT plan and subject to hourly checks. She spoke with him about the reasons for his attempts at self-harm. He told her he was not mentally unwell but was physically unwell and felt that no one was taking him seriously. She noted that a GP was due to review Mr Tudor the same day. She planned for someone from the mental health team to reassess Mr Tudor once that review had taken place.

33. A prison GP saw Mr Tudor later that day. She noted that he complained of constant pain in the left side of his chest and sharp abdominal pain, although at the time she saw him he was not in distress or in significant pain. She considered he may be suffering from a peptic ulcer (an open sore in the lining of the stomach). To assist her to make a possible diagnosis, she carried out a number of blood tests. The results were all normal. The doctor prescribed omeprazole (to reduce stomach acid), peptic liquid (to help relieve indigestion and heartburn) and senna tablets (a laxative).

34. At an ACCT case review on 14 October, Mr Tudor said that he had harmed himself because he wanted to see the GP. He said that, as he had now seen the GP, he no longer had any thoughts of harming himself. A nurse ended ACCT monitoring.

35. On 18 October, a nurse reviewed Mr Tudor, who complained of chest and stomach pain, an erratic heartbeat and a headache. He examined Mr Tudor and could find nothing of note. He considered that his symptoms were stress related and referred him to the mental health team.

36. On 23 October, a mental health nurse saw Mr Tudor in his cell after he had made superficial cuts to his right arm. Mr Tudor told him that he had self-harmed so that he could see a doctor. The next available non-urgent appointment to see a doctor was on 9 November. He referred Mr Tudor to the prison's mental health team but did not recommend any other actions. (There is no record that Mr Tudor saw anyone from the mental health team until he was segregated two weeks later.) An officer began ACCT procedures.

37. On 24 October, a nurse reviewed Mr Tudor after he made several cuts to his arms. He told the nurse he had cut his arm because he had stomach pain and wanted to see a doctor or go to hospital. He said he did not want to die and he just wanted to see a doctor.

38. Later that morning, a Supervising Officer (SO) held the first ACCT case review. Prison Service Instruction (PSI) 64/2011 has a mandatory instruction that the assessor attend with, wherever possible, the member of staff who raised the initial concern, and a member of healthcare staff. If those invited cannot attend in person, exceptionally they can give a written account of their input. He and Mr Tudor were the only attendees.

39. The SO recorded that Mr Tudor was in a "better frame of mind" and had no thoughts of self-harm. Mr Tudor asked that he refer him to the mental health team, although he noted that a nurse Sebastian had already completed a referral. He entered one action on the ACCT caremap: that Mr Tudor should have a healthcare appointment to discuss medication. He recorded that an appointment was booked for 26 October. However, the only appointment that took place on this date was when a nurse changed Mr Tudor's dressings.

40. On 26 October, a SO held an ACCT case review. An officer and Mr Tudor also attended but, again, there was no healthcare representative. She recorded that Mr Tudor was now sharing a cell, and was happy about this. Mr Tudor said he was frustrated at not seeing a doctor, and she recorded that he had an upcoming appointment (on 9 November). Mr Tudor said he had no thoughts of harming himself. She stopped ACCT monitoring.

41. Over the days that followed, Mr Tudor became increasingly demanding towards healthcare staff. Records show that each time he collected his medication he was aggressive and demanded to see a doctor. Healthcare staff reminded him he had an appointment on 9 November, but arranged for him to see a doctor earlier.

42. A prison GP saw Mr Tudor on 30 October. Mr Tudor told him that he felt as if his heart was 'pounding in his chest', his back was hurting and he was unable to eat. He examined Mr Tudor, but could not find anything of note and advised him to carry out exercises to ease his back pain.

43. On 1 November, Mr Tudor harmed himself by superficially cutting his right arm. He told the nurse who treated his wounds that he had done this because he was unable to see a GP, despite a GP seeing him the previous day. He demanded that healthcare staff take him to hospital. The nurse explained to him he could not attend hospital without a referral from a doctor or it being a medical emergency. A unit manager reopened ACCT procedures, although no one held an ACCT case review.

44. A SO held an ACCT case review on 3 November. A prison chaplain and Mr Tudor attended. There was no healthcare representative. Mr Tudor said he had stomach pain and needed to see a doctor, and that he would cut himself in order to go to hospital. The SO recorded that Mr Tudor had an appointment booked with a doctor on 6 November, and added this as a caremap action. He recorded that prison staff check Mr Tudor at least every half an hour.

45. On 4 November, an officer found Mr Tudor in possession of a razor blade and 21 Ibuprofen tablets which had not been prescribed to him. She charged him with a disciplinary offence.

46. On 5 November, an officer checked on Mr Tudor as part of his ACCT plan. She discovered him lying on his cell floor, and he did not respond to her calling him. She entered the cell and attempted to check his pulse, at which point Mr Tudor jumped up and tried to assault her with a razor blade. Staff admitted Mr Tudor to the segregation unit. A nurse assessed that there were no health reasons to indicate that Mr Tudor should not be segregated. She completed a referral to the mental health team.

47. PSI 64/2011 has a mandatory instruction that prisoners being managed under ACCT procedures should be held in segregation units only in exceptional circumstances. It states that the reasons must be clearly documented in the ACCT plan. A SO held an ACCT case review following Mr Tudor's segregation, with an officer and Mr Tudor also present. There was no healthcare representative at the case review and no one recorded the reasons for the exceptional circumstances. The SO recorded that Mr Tudor's current risk was low and they would "look for a period of stability in the short term". He reduced the level of observations to at least one per hour.

48. Later that day, a nurse reviewed Mr Tudor after he had harmed himself by biting his left forearm. The nurse discussed Mr Tudor with a prison GP and a senior nurse. The nurse was concerned that there was no mental health or psychiatric history in Mr Tudor's medical records. Mr Tudor did not give any details of his community GP when he arrived at Highpoint and refused to speak to the nurse about this. The nurse tried to obtain this information from Mr Tudor's probation officer who had no information. The nurse contacted every GP practice in Mr Tudor's home area, but he was not registered as a patient with any of them.

49. The nurse was concerned that Mr Tudor's agitated state was exacerbating his behaviour. A prison GP prescribed promethazine (medication often used as a mild antipsychotic and sedative). However, Mr Tudor refused to take it. The nurse created a crisis care plan to ensure Mr Tudor had daily input from both the mental health team and healthcare staff. In line with segregation guidance, a GP saw him three times a week. Mr Tudor did not always engage with GPs but occasionally requested painkillers. The nurse also referred Mr Tudor to a visiting psychiatrist. In accordance with prison service guidelines, the duty prison governor reviewed Mr Tudor each day.

50. Over the days that followed, Mr Tudor's behaviour became increasingly erratic and difficult to manage. He removed all of his clothing, refused medication, refused to comply with staff instructions, became violent and made claims that prison staff and other prisoners were poisoning his food. We could find no evidence to substantiate Mr Tudor's claims. Despite repeated efforts from all staff, he also refused to engage with staff from any department.

51. On 7 November, Mr Tudor smashed his cell furniture and damaged his mattress. The Head of Segregation authorised the removal of the furniture from the cell, with the exception of a plastic chair, meaning that Mr Tudor was now, effectively, in an unfurnished cell (known as special accommodation). Prison Service Order 1700, which covers segregation, instructs that an enhanced ACCT case review must be held within two hours of a decision to

hold a prisoner on ACCT in special accommodation. No case review took place.

52. PSO 1700 states that a prisoner's location in special accommodation must be reviewed every 24 hours. The Head of Segregation completed a review on 8 November, and concluded that no change was necessary. There is no record of any further reviews and when normal furniture was returned to Mr Tudor.

53. On 9 November, the Head of Segregation chaired a segregation review board, which should be held within 72 hours of first segregation and then at least at 14-day intervals afterwards, with the aim of returning the prisoner to standard prison accommodation. Other staff were also present. The Head recorded that Mr Tudor refused to dress or engage with the regime, and that he displayed "bizarre and erratic behaviour". He authorised Mr Tudor's continuing segregation until 23 November. There is no evidence that he considered that the exceptional circumstances to segregate a prisoner being managed under ACCT procedures remained in place, or that anyone held an ACCT case review after the review board, as PSO 1700 requires.

54. A nurse reviewed whether there were any healthcare reasons not to segregate Mr Tudor. One of the questions on the assessment asks, 'Do you think the prisoner's mental health will deteriorate significantly if segregated?', to which she answered 'no'. Another question asks, 'Do you think the prisoner will be able to 'cope' with a period of segregation?', to which she answered 'yes'. It is not clear whether she considered the recent changes to Mr Tudor's behaviour when answering these questions. She concluded that there were no healthcare reasons not to segregate Mr Tudor.

55. On 10 November, a custodial manager and a nurse visited Mr Tudor to conduct an ACCT case review. He refused to engage and became aggressive towards them. In an attempt to encourage him to interact with them, the manager offered him the opportunity to telephone his family, but he refused (there are several instances of staff trying to encourage Mr Tudor to speak to his family without success). The nurse attempted to give Mr Tudor his medication and water; however, he threw the water in the nurse's face. They did not complete the review and recommended no additional actions.

56. The same day, Mr Tudor began to refuse food. In line with Prison Service Instructions, officers started a food refusal log and delivered Mr Tudor's meals to him each mealtime, collecting what remained later in the day. The purpose of the log is to record if a prisoner is refusing all food and drink, or to record the amount they are consuming. Officers noted that although he was not eating meals, he was requesting and eating a little fruit and drinking milk and water. Segregation unit staff were becoming increasingly concerned that the segregation unit was not the right environment for Mr Tudor.

57. On 11 November, a multidisciplinary team met to discuss Mr Tudor's case. Representatives from healthcare, the mental health team, safer custody, the segregation unit and the chaplaincy department attended. The minutes of that meeting noted that the visiting psychiatrist was due to review Mr Tudor the following week. They also noted that the Safer Custody department would arrange an interpreter in an attempt to encourage Mr Tudor to engage with staff.

58. Mr Tudor became increasingly difficult to manage over the days that followed. He continued to refuse medication, would only eat fruit and drink milk, and refused to engage with staff. He began to use less and less English and claimed to be having difficulty understanding staff, but refused the offer of an interpreter. Staff noted in the food refusal log, that it was difficult to accurately measure his food and drink intake, as Mr Tudor was spreading it on the floor and walls.

59. An ACCT case review was held on 13 November. We have not seen a copy of the case review and do not know who attended, whether Mr Tudor participated and what the outcome was. On the front of the ACCT document, a custodial manager recorded that staff should now observe Mr Tudor at least every two hours.

60. On 18 November, the visiting psychiatrist, accompanied by a nurse, reviewed Mr Tudor. He noted Mr Tudor was lying naked on the floor of his cell and, despite repeated attempts, he refused to speak with them. The psychiatrist recommended that Mr Tudor be transferred to a prison with 24-hour healthcare. The nurse contacted HMP Chelmsford, but they had no spaces available at that time. The prison's Offender Management Unit made enquiries with other prisons that could provide 24-hour healthcare, including HMP Warren Hill and HMP Hollesley Bay, but there were no beds available and they could not provide the level of psychiatric care that Mr Tudor required. There is no record that the psychiatrist considered if Mr Tudor was capable of making rational decisions about his health and well being. He did not provide any diagnostic or treatment advice.

61. On the same day, a multidisciplinary team met to discuss Mr Tudor. However, there are no records as to the content of those discussions.

62. A residential manager held an ACCT case review on 19 November. Also present were two nurses. Mr Tudor did not engage with the review, and the manager made no changes to the ACCT arrangements, maintaining staff observations every two hours.

63. On 21 November, Mr Tudor's behaviour deteriorated further. He covered himself, and the walls of his cell, in faeces. Prison staff offered him a shower and a move to a clean cell but he refused. He also continued with his food and medication refusal. However, staff noted that he continued to eat fruit and drink milk.

64. On 22 November, officers forcibly carried Mr Tudor to a clean cell. Once in the cell they offered him the chance of a shower and fresh clothing. He again refused. While the staff were moving him, a nurse took the opportunity to review Mr Tudor. She noted his blood glucose levels were high but did not seek further advice from a doctor.

65. A prison GP attempted to review Mr Tudor the following day. He noted that Mr Tudor made no effort to communicate with him, or to let him examine him. Mr Tudor's weight loss was noticeable; however due to Mr Tudor's behaviour he was unable to formally record his weight. He also noted the raised blood glucose level from the day before but did not take any action. He noted that Mr

Tudor continued to smear himself, and his cell, with faeces. He prescribed Mr Tudor a diet supplement drink (providing high levels of nutrients) and staff noted he was drinking this.

66. The Head of Segregation chaired a segregation review board on 23 November. Also present were several staff. He recorded that Mr Tudor's behaviour was "unacceptable" and authorised his continuing segregation. As previously, there is no evidence that he considered that the exceptional circumstances to segregate a prisoner being managed under ACCT procedures remained in place or that alternative locations were considered and discounted. There was no ACCT case review after the review board.

67. A nurse assessed whether there were healthcare reasons not to segregate Mr Tudor. She answered 'yes' to the question, 'Does the prisoner show signs of being acutely unwell?' This answer leads the assessment algorithm to conclude that there are healthcare reasons not to segregate and this should be discussed with the healthcare team. Healthcare staff recorded that they would speak to colleagues at Chelmsford to see if they could take Mr Tudor in their inpatient unit.

68. At around 8.30am on 24 November, a nurse saw Mr Tudor. She noted he was lying on a mattress and looked dehydrated with cracked lips and sunken eyes. She returned at 9.10am and noted Mr Tudor's temperature was 34.4c (low). She was concerned that Mr Tudor was becoming hypothermic (a condition in which a person's body temperature drops below 35°C).

69. At about 10.00am on 24 November, both a nurse and a prison GP reviewed Mr Tudor. She recorded that he had a blood pressure reading of 85/60 (a reading of 120/80 to 140/90 is considered normal for the average adult). While they were assessing him, Mr Tudor's condition began to deteriorate and at 10.45am, the nurse radioed a code blue emergency (code blue indicates a prisoner is unresponsive or having difficulty breathing) and the control room called an ambulance immediately. While waiting for the ambulance to arrive, the Head of Healthcare e-mailed an extensive note to the hospital about Mr Tudor's condition and behaviours to ensure they had as much information as possible.

70. At 11.15am, an air ambulance arrived, followed shortly afterwards by an ambulance. The paramedics took Mr Tudor to hospital at 12.10pm.

71. Because of Mr Tudor's history of aggressive behaviour, a prison service manager authorised two prison officers to accompany him and restrain him with handcuffs for the journey. They arrived at hospital at 12.35pm and replaced the handcuffs with an escort chain (an escort chain is a long chain with a handcuff at each end, one end attached to the prisoner and the other to an officer).

72. Hospital staff noted Mr Tudor was calm and alert on arrival, though he refused all treatment. They diagnosed hypothermia with possible diabetic ketoacidosis. Blood tests revealed very abnormal kidney function and some kidney failure. While at the hospital, Mr Tudor became agitated and abusive to staff. He refused all treatment and attempted to disconnect hospital equipment.

73. After considerable discussion, hospital doctors concluded that Mr Tudor did not have the mental capacity to make decisions about his care. At 1.20am on 25 November, they took the decision to sedate and treat him 'in his best interests'.

74. At 2.00am, hospital staff sedated Mr Tudor and moved him to the intensive care unit. The prison officers accompanying Mr Tudor removed the escort chain at the request of the hospital staff.

75. At 4.00am on 28 November, Mr Tudor's health began to deteriorate further. He died at 1.42pm.

Contact with Mr Tudor's family

76. Hospital staff telephoned Mr Tudor's brother on 25 November to inform him of his brother's admission to hospital, and the seriousness of his condition. He visited Mr Tudor at 6.00pm the same day.

77. Mr Tudor had not clarified who his next of kin was. There were incomplete details for his mother and brother, who both lived in Romania, and a telephone number for a brother in England.

78. On 28 November, the day Mr Tudor died, the prison appointed a prison chaplain as the family liaison officer. He could not find an address for Mr Tudor's brother so telephoned him to inform him of Mr Tudor's death and offer his condolences and support. Mr Tudor's brother told the chaplain that his sister would be acting as the next of kin. However, she lived in Germany and would not arrive in the United Kingdom until the following day.

79. The chaplain tried to telephone Mr Tudor's sister on 28 and 29 November, but there was no reply. He eventually got through on 30 November and offered his condolences and support. On 3 December, he and a prison manager met Mr Tudor's brother and sister at the hospital.

80. Mr Tudor's body was repatriated to Romania on 9 January 2016. The prison contributed to the costs of Mr Tudor's repatriation and his funeral in Romania in line with national policy.

Support for prisoners and staff

81. After Mr Tudor's death, prison managers debriefed the staff who had been involved with his care and escort to give them the opportunity to discuss any issues they may have and to offer them support. They were also offered the support of the staff care team.

82. The prison posted notices informing staff and prisoners of Mr Tudor's death, and offering support. Staff reviewed all prisoners assessed as at risk of suicide or self-harm, in case they had been adversely affected by Mr Tudor's death.

Post-mortem report

83. A post-mortem examination found that the cause of Mr Tudor's death was from complications arising from pneumonia and acute dehydration. The pathologist in his conclusions said "consideration should be given as to why the deceased presented so late to hospital moribund [near death] and already suffering from

major complications of sepsis/dehydration, in particular acute renal failure and rhabdomyolysis [breakdown of muscle tissue which can affect kidney function]'.

Findings

Clinical care

84. The clinical reviewer noted that Mr Tudor presented huge problems to both prison and healthcare staff at Highpoint. He stripped naked in his cell, refused medication, refused to engage with staff, refused to follow the prison regime, refused to let nursing staff complete observations or assess him and increasingly used less English but declined the use of a translator.

85. The clinical reviewer stated that Mr Tudor's care in prison, particularly in the segregation unit, cannot be compared to the care he would have received in the community. However, the clinical reviewer believed that healthcare staff concentrated on Mr Tudor's mental health but did not adequately assess his deteriorating physical health. While the clinical reviewer felt that a nurse's attempts to engage with Mr Tudor demonstrated good practice, staff should have taken a holistic view of the care of Mr Tudor looking at both his mental and physical health and, in particular, monitoring the risk of dehydration. In addition there were two missed opportunities for further investigation, when the nurse found his blood sugars were raised on 22 November and, again, when a prison GP saw him on 23 November and noted the raised blood sugar levels. Mr Tudor was not diagnosed with diabetes and the high blood sugar levels should have prompted further investigation which may have resulted in him being admitted to hospital earlier, yet no one took any action. The clinical reviewer felt that earlier action may have prevented Mr Tudor's death.

86. The clinical reviewer also noted that the multidisciplinary team meetings planned for him to be reviewed by a psychiatrist and moved to a prison with 24-hour healthcare but that there was no alternative plan if these were unsuitable. We make the following recommendations:

    The Head of Healthcare should ensure that detailed care plans are implemented for prisoners with complex needs to ensure both mental and physical health are appropriately monitored.

    The Head of Healthcare should ensure that clinicians appropriately follow up abnormal blood test/monitoring results.

Food refusal

87. Guidance to staff on prisoners who refuse food is contained in Prison Service Instruction (PSI) 64/2011, which says:

    > *"Some prisoners may decide to refuse food and/or fluids, or medical treatment for a variety of reasons. These decisions will be valid provided that the prisoner is deemed to have the mental capacity to make the decision. Mental capacity can only be assessed by a healthcare professional."*

88. The PSI also notes that the decision to refuse food is not considered in law to be a form of self-harm. Regarding mental capacity the instruction states:

    > *"The Mental Capacity Act 2005 provides clear guidance that any individual has the legal right to refuse any treatment including food and/or fluid or*

resuscitation if they are mentally capable. The Act states that a person is assumed to have capacity unless it is established that they lack capacity and must not be considered unable to make a decision merely because they make an unwise decision."

89. Further guidance is contained in the 2010 Department of Health document "Guidelines for the clinical management of people refusing food in immigration removal centre and prison", which state:

    "A thorough assessment of nutritional status should be undertaken at the outset of the fast, including establishing levels of recent food intake and usual body weight and performing a specific nutritional examination. Regular reassessments of a food-refusing individual's physical and mental state should be undertaken within limits dictated by the individual's compliance. Soon after an individual is identified as embarking on a period of refusing food, a case conference should be considered to explore further any ameliorating factors and assist care planning."

    "Full documentation of the individual's wishes is essential to demonstrate that the individual is not only refusing all forms of feeding but understands the likely consequences of doing so."

90. When Mr Tudor began refusing food on 10 November, staff began a daily log of his food and fluid intake, in accordance with PSI 64/2011. However, because Mr Tudor was smearing his food over the cell floor and walls, it was not possible to keep a clear record of what he was eating and drinking. Staff did note that he was drinking some milk and water and eating fruit. He also drank the nutritional supplement prescribed by a prison GP from 23 November.

91. However, only two healthcare multidisciplinary meetings were held, and the only plan was for Mr Tudor to see a psychiatrist and then be transferred to a prison with 24-hour health cover. There were no places available and no alternative plan to the transfer if Mr Tudor deteriorated. We consider that there should have been more regular multidisciplinary meetings to discuss and plan Mr Tudor's care. The lack of more regular multidisciplinary meetings also meant that the prison missed the opportunity to manage Mr Tudor's risk of suicide and self-harm under the enhanced case review process.

92. The clinical reviewer was concerned that despite Mr Tudor's recorded lack of fluid intake, there was no record that healthcare staff were properly monitoring the indicators of dehydration (some of which are easily observed, for example, dry lips and lack of urinary output). Dehydration can lead to a number of complications including kidney failure and sepsis (two of the complications noted in the post-mortem report). The clinical reviewer points out that Care UK (the healthcare provider at Highpoint) has a clear policy in respect of food refusal which should have been used to create a care plan following Mr Tudor's decision to refuse food and drink. The clinical reviewer makes a number of suggestions on how the healthcare department at Highpoint can improve their monitoring of prisoners refusing food and drink, which the Head of Healthcare will need to consider. We make the following recommendations:

The Governor and Head of Healthcare should ensure there are regular multidisciplinary meetings to discuss and plan the care of complex prisoners, especially those refusing medication, food and fluid.

The Head of Healthcare should ensure there is an appropriate care plan in place when a prisoner is refusing food and fluids, which is reviewed daily and includes key indicators of dehydration.

Mental capacity

93. It is clear from the records that mental health staff saw and tried to assess Mr Tudor regularly. A psychiatrist also saw him. The clinical reviewer points out that a nurse saw Mr Tudor several times a day and made great efforts to try and persuade him to engage with staff. However, we are concerned that there is no record that any clinician at Highpoint formally assessed Mr Tudor's mental capacity to make decisions about his healthcare, especially in light of his bizarre behaviour, refusal to take medication, food or fluid. We also can find no record of anyone advising Mr Tudor of the likely consequences of his food and fluid refusal. We note that once Mr Tudor was in hospital, clinicians considered he did not have mental capacity and began treatment in his best interests. Both PSI 64/2011 and the internal Care UK policy note that a prisoner's capacity to refuse treatment, food or fluids should prompt a mental capacity assessment. We make the following recommendation:

The Governor and Head of Healthcare should ensure that when a prisoner consistently refuses medication, food or fluids, they are advised of the likely consequences and a mental capacity assessment is carried out and recorded.

Managing the risk of suicide and self-harm

94. Prison staff managed Mr Tudor under ACCT procedures in the weeks before his death. We are concerned that the procedures were poorly managed. While this might not have affected the eventual outcome, it would have given prison managers and staff a better chance of producing a coordinated and effective care plan aimed at addressing his issues and reducing his risk.

95. PSI 64/2011 requires ACCT case reviews to be multidisciplinary where possible and says that, for the first case review, the assessor, the person who raised the initial concern, and a healthcare representative must attend. Only a SO attended the first case review. We are concerned that there was no healthcare representative, especially given that the assessment interview was clear that a wish to see the GP was the motivating factor behind Mr Tudor's recent self-harm.

96. A SO closed ACCT procedures on 26 October, at a case review that again was not multidisciplinary and with no healthcare representative. PSI 64/2011 states that ACCT procedures must only be closed when caremap actions are complete. The one and only action on Mr Tudor's caremap (at the time) was for him to have a healthcare appointment. This had not yet happened. We are concerned that the SO Archer closed the ACCT despite recording that Mr

Tudor was frustrated that he had not yet seen a GP – which is what had led to his self-harm two days earlier.

97. When prison staff reopened the ACCT on 1 November, following another act of self-harm, they did not hold a case review for two days. Again, this case review was not multidisciplinary and included no healthcare representative despite Mr Tudor's complaints of stomach pain leading to his self-harming behaviour. There was no healthcare representation at any case review until after Mr Tudor's admission to the segregation unit.

98. PSI 64/2011 instructs that a case manager be appointed at the first case review. There was no named case manager on the front cover of the ACCT document and, although a SO named herself as case manager at the case review on 26 October, she had no further involvement in the ACCT procedures. There was little consistency in attendance at case reviews – only two staff attended more than one case review. The lack of clear case management and consistent attendance meant there was little ownership of Mr Tudor's case and it seems this contributed to the lack of care planning.

99. PSI 64/2011 requires that prisoners assessed as at risk of suicide and self-harm should be held in segregation units only in exceptional circumstances and that the reasons must be clearly documented in the ACCT record and include other options that were considered but discounted. Mr Tudor was not in the segregation unit when the ACCT was opened, but moved there shortly afterwards. There was nothing in the ACCT document to indicate that staff recognised that his location in the segregation unit was exceptional, that any other options were considered, or that these exceptional reasons were reconsidered at any stage.

100. PSI 64/2011 highlights that staff should consider managing prisoners under the enhanced case review process if they display complex behaviour, or spend lengthy periods in the segregation unit due to extreme acts of anti-social behaviour. Enhanced case reviews should be chaired by a senior manager and should include more specialists and a higher level of operational management than a standard ACCT case review. The aim of enhanced case management is to provide a flexible but consistent approach to achieve the desired changes in a prisoner's behaviour. No enhanced case review was held for Mr Tudor, and the routine case reviews did little to address his issues. Indeed routine case reviews were often not held at key stages, such as when Mr Tudor began to dirty his cell.

101. Moreover, Prison Service Order (PSO) 1700, which covers segregation, says that staff should hold an enhanced ACCT case review within two hours of a decision to hold a prisoner on an ACCT in special (unfurnished) accommodation. As noted, no one held such a review. We consider that Mr Tudor fully met the criteria for enhanced case management, which would have ensured that senior managers at Highpoint and other relevant specialists took an active part in his care planning.

102. In a PPO Learning Lessons Bulletin, published in March 2015, about the self-inflicted deaths of prisoners in 2013-14, we found that staff should ensure that prisoners at risk of suicide and self-harm are managed in line with national

instructions and guidance. We found that this should include holding multidisciplinary case reviews, using enhanced case reviews for prisoners who present complex issues and behaviours, and that prisoners on open ACCT documents should only be segregated in exceptional circumstances.

103. Mr Tudor was a very challenging prisoner. In order to deal with disruptive prisoners assessed as at risk of suicide and self-harm, staff need to make a full and proper assessment of all aspects and causes of their behaviour. We consider that Mr Tudor did not receive sufficient and meaningful support through appropriate use of the ACCT process and staff did not always follow national instructions for managing ACCT procedures. We consider he should have been managed under the enhanced case review process. While we cannot say that this would have made a significant difference, it would have given prison managers and staff a better chance of producing a coordinated and effective care plan aimed at addressing his issues and reducing his risk. We make the following recommendation:

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

- **ACCT case reviews are multidisciplinary where possible and include all relevant people involved in the prisoner's care, including a named case manager, with healthcare staff attending all first case reviews.**
- **Prisoners at risk are not held in the segregation unit unless all other options have been considered and excluded and there are fully documented reasons to explain the exceptional circumstances.**
- **Staff use enhanced case management procedures for prisoners held in unfurnished accommodation and in other more complex cases.**
- **ACCT monitoring does not stop until all caremap actions have been completed and all identified issues that might increase risk have been addressed.**

Mr Tudor's segregation

104. Mr Tudor moved to the segregation unit on 5 November. As noted, no one considered whether there were exceptional reasons that meant he could not be located elsewhere in the prison.

105. PSO 1700 requires that an initial segregation review board must be held within 72 hours of a prisoner being placed in segregation. It states that the frequency of future boards should be decided locally, but should be at least every two weeks. Segregation review boards should consist of, among others, a chairperson, healthcare representative, segregation officer and, where relevant, the ACCT case manager. PSO 1700 also states that the board should ensure there are exceptional circumstances to segregate a prisoner being managed under ACCT procedures, and that an ACCT case review must take place at the same time as the segregation review board.

106. Mr Tudor's first segregation review board took place on 9 November, four days after his initial segregation. There was one more board, held two weeks later on 23 November. Given that Mr Tudor was segregated on an open ACCT

document, and was therefore at increased risk, we would expect his location to have been reviewed more frequently than the minimum requirement. The ACCT case manager was not present at the review boards, and there was no concurrent ACCT case review.

107. Healthcare staff did reassess whether there were health reasons not to segregate Mr Tudor at the same time as the review boards. However, some of their conclusions concern us. On 9 November, a nurse noted that she did not think Mr Tudor's mental health would deteriorate significantly if segregated and that she thought he would be able to cope with a period of segregation. Mr Tudor's behaviour had changed significantly in the days since his initial segregation, as he had removed his clothes, was living in an unfurnished cell, and had claimed that staff and prisoners were trying to poison him. It is not clear whether she considered this when she concluded that there were no healthcare reasons not to segregate Mr Tudor.

108. PSO 1700 states that special (unfurnished) accommodation should only be used for the shortest time possible, to hold a violent or refractory prisoner in order to prevent them from injuring others or damaging property. A prisoner's location in special accommodation must be reviewed every 24 hours. It is unclear how long Mr Tudor remained in an unfurnished cell. Only one review was recorded, on 8 November, which suggested that there should be no change to the conditions. PSO 1700 lists numerous other safeguards for prisoners held in special accommodation, including for those managed under ACCT procedures, many of which were not followed. These include holding enhanced case reviews, recording and considering alternatives in the ACCT caremap, and completing an initial health screen to determine whether there are any clinical reasons to advise against the use of special accommodation.

109. In a PPO Learning Lessons Bulletin, about segregation, published in June 2015, we found that special accommodation should only be used if absolutely necessary, with an enhanced case review held straight away. We also found that during the initial segregation health screen, and at ensuing segregation review boards, staff should base decisions about fitness for segregation on the prisoner's full mental health history and other relevant factors that could potentially compromise their ability to cope. We make the following recommendation:

The Governor and Head of Healthcare should ensure that staff manage prisoners held in the segregation unit in line with national guidelines, including that:

- **Prisoners are held in unfurnished cells for the shortest time possible, and that all the provisions and safeguards of PSO 1700 apply.**
- **Segregation review boards are held more frequently than the minimum requirement for prisoners on open ACCT documents, include the ACCT case manager, and consider and record whether there are exceptional reasons to authorise continuing segregation.**
- **ACCT case reviews are held at the same time as segregation review boards.**

- **Segregation health screens consider all relevant information about a prisoner, including any recent changes to their mental and physical health or their behaviour.**

Informing Mr Tudor's family

110. PSI 64/2011 states that prisons must have arrangements for an appropriate member of staff to engage with families of prisoners who are either terminally or seriously ill. Similarly, Prison Rule 22 states that when "a prisoner dies, becomes seriously ill or, sustains any severe injury or is removed to hospital on account of a mental disorder, the governor shall, if he knows his or her address, at once inform the prisoner's spouse or next of kin, and also any person who the prisoner may reasonably have asked should be informed".

111. On 24 November, Mr Tudor's health deteriorated to a point where he required emergency admission to hospital. Hospital staff contacted Mr Tudor's family to inform them of the seriousness of his condition.

112. After Mr Tudor died on 28 November, the prison appointed a prison chaplain to be the family liaison officer. He telephoned Mr Tudor's brother the same day. However, we are concerned that the prison did not contact Mr Tudor's family when he first went to hospital seriously ill. Although the hospital had already done this, it is important that the prison inform the next of kin and keep them updated when someone is seriously ill in hospital. We make the following recommendation:

    The Governor should ensure that an appropriate member of staff is appointed promptly to engage with and support the families of seriously ill prisoners.

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