Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr David Dunnings a prisoner at HMP Coldingley on 8 July 2017

A report by the Prisons and Probation Ombudsman

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Our Vision

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

Our Values

We are:

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

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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 David Dunnings died after he was found hanging in his cell at HMP Coldingley on 8 July 2017. He was 35 years old. I offer my condolences to Mr Dunnings' family and friends.

Mr Dunnings died in Coldingley's segregation unit while being monitored under suicide and self-harm prevention procedures (known as ACCT). I am concerned at the amount of time Mr Dunnings spent in segregation which should only be used in exceptional circumstances when a prisoner is subject to ACCT procedures. I am also concerned that Mr Dunnings was not sufficiently protected by the ACCT procedures which became formulaic and not focussed on his risk. There were also failures in the procedures and safeguards designed to provide additional protection for prisoners in the segregation unit.

Mr Dunnings had received an indeterminate sentence for public protection, following which he had been released and recalled to prison. He had served significantly longer time in prison than his tariff. It is clear that his indeterminate sentence and the uncertainty about how long he might have to remain in prison were significant sources of anxiety to him and it is hard not to conclude that they played a key role in his decision to kill himself.

Mr Dunnings was also re-categorised to a higher security level while he was segregated. There were a number of deficiencies in this process, which increased his anxiety. If staff had been open with him about his re-categorisation and explained to him why he continued to be segregated, his risk of suicide and self-harm may have been managed more effectively.

Finally, the clinical reviewer concluded that the healthcare Mr Dunnings received for his mental health problems was not equivalent to that which he could have expected to receive in the community. The clinical reviewer identified a number of areas in which the delivery of healthcare services could be improved.

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

Elizabeth Moody
Acting Prisons and Probation Ombudsman **October 2018**

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Summary

Events

1. On 3 January 2006, Mr Dunnings was convicted of robbery and received an indeterminate sentence of Imprisonment for Public Protection (IPP), with a minimum tariff to serve of two years and nine months before he could be considered for parole. He was released in 2011, but his licence was revoked in July 2014 and he was returned to prison. He was transferred to Coldingley on 8 September 2016. He had a history of self-harm, which manifested during times of emotional distress and anxiety.

2. On 14 June 2017, Mr Dunnings was moved to the segregation unit after he was involved in an incident on his wing. Staff began ACCT procedures after he made cuts to his wrist.

3. Mr Dunnings was a Category C prisoner. On 21 June, he was re-categorised to Category B on the basis of his disruptive behaviour, but was never formally notified of this decision and only learned about it the day before he took his life.

4. While segregated, Mr Dunnings was assessed by the mental health team, GPs and a psychiatrist. He was offered medication for symptoms of anxiety and depression but often refused to take his medication as he said that it did not help.

5. On 29 June, Mr Dunnings told staff that he would end his life after his next visit from his family. After his biological mother visited him on 7 July, an ACCT review considered that his risk had increased, but no additional safeguards were identified or proposed and he continued to be checked once an hour.

6. At around 1.05am on 8 July, an officer found Mr Dunnings hanged in his cell. Staff and paramedics tried unsuccessfully to resuscitate him. At 2.12am, paramedics confirmed that Mr Dunnings had died.

Findings

7. Mr Dunnings was subject to ACCT procedures at the time of his death in the segregation unit. There were failings in the way staff managed Mr Dunnings' risk, particularly in case reviews and caremaps. The level of observations at the time of Mr Dunnings' death did not reflect the elevated risk he posed to himself.

8. Important safeguards for segregated prisoners at risk of suicide or self-harm were not followed. For example, the mental health team did not assess Mr Dunnings within 24 hours of starting ACCT procedures, and segregation review boards did not take place when they should have.

9. There were a number of deficiencies in the way that Mr Dunnings' re-categorisation was considered and processed. Relevant prison staff were not involved in the process of re-categorising Mr Dunnings, and he was never formally told about his re-categorisation. He learned of it only the day before his death.

10. Mr Dunnings did not always agree with the various treatments that the healthcare team offered, and did not take prescribed medications for long enough for them

to be effective. The clinical reviewer highlighted numerous failings in Mr Dunnings' clinical care at Coldingley, and concluded that the care that he received was not equivalent to that which he could have expected in the community. He concluded that there were deficiencies in Mr Dunnings' diagnosis, treatment and in the communication between healthcare practitioners at the prison.

Recommendations

- **The Governor should ensure that staff manage prisoners at risk of suicide or self-harm in line with national guidelines. In particular, that:**
    - **Prisoners assessed as at risk of suicide or self-harm are not held in the segregation unit unless all other options have been considered and excluded. A senior manager of governor grade should record the exceptional circumstances for segregation.**
    - **Case reviews are multidisciplinary and include all relevant people involved in a prisoner's care, including mental health staff, where appropriate, and healthcare staff attend all first case reviews.**
    - **Staff read the ACCT document and familiarise themselves with all relevant issues and known risk factors before holding reviews, and ACCT case reviews should assess and record the level of risk, considering all risk factors.**
    - **Caremap actions, are specific, meaningful and time-bound, aimed at reducing prisoners' risks and review them at each case review.**
    - **The frequency of observations should reflect the prisoner's risk and be adjusted when that risk changes. Staff should check on prisoners, who are subject to ACCT procedures, at unpredictable intervals and record their observations.**
    - **The Governor should ensure that ACCT case managers consider involving the prisoner's family in the ACCT process and understand the procedures to do so.**
    - **The Governor should ensure that there are procedures in place to check the quality of ACCT procedures, identify bad practice, learn lessons, and where appropriate, provide staff refresher training on ACCT procedures.**

- **The Governor should ensure that staff understand and follow the procedures for the re-categorisation of prisoners, inform them of decisions and reasons for re-categorisation and provide them with information about the appeal process.**

- **The Governor and Head of Healthcare should ensure that staff manage prisoners held in segregation in line with national guidelines, including that:**
  - **A mental health assessment is carried out within 24 hours whenever ACCT procedures are started for a prisoner in the segregation unit.**
  - **Segregation algorithms are completed when prisoners in segregation become subject to ACCT procedures.**
  - **Segregation review boards include the ACCT case manager when a prisoner is identified as at risk of suicide and self-harm. The review chair should consider and record whether there are exceptional reasons to authorise continuing segregation.**
  - **All attendees at segregation reviews understand the purpose of the review and be confident about challenging continued segregation when they have concerns about a prisoner's vulnerability.**
  - **Healthcare representatives at segregation reviews are fully briefed about relevant aspects of the prisoner's health needs and where possible, should be the person responsible for the individual's care.**
  - **Segregation review boards are held more frequently than the minimum requirement for prisoners subject to ACCT procedures.**
  - **Authorisation for segregation is completed promptly and accurately, and set out in full the reasons for the decision.**

- **The Head of Healthcare and the Mental Health Team should ensure that all patients with mental health problems are assessed promptly in line with National Institute for Health and Care Excellence (NICE) guidance and a written care management plan is developed and actioned.**

- **The Head of Healthcare should ensure that:**
  - **GPs review prisoners' prescriptions when appropriate to ensure that their medication needs are addressed; and**
  - **healthcare staff regularly meet to review patient care, including holding multidisciplinary meetings, where appropriate**

The Investigation Process

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

12. The investigator visited Coldingley on 13 July 2017. He obtained copies of relevant extracts from Mr Dunnings' prison and medical records.

13. NHS England commissioned two clinical reviewers to review Mr Dunnings' clinical care at the prison.

14. The investigator interviewed 21 members of staff and six prisoners, some jointly with the clinical reviewers.

15. We informed HM Coroner for Surrey of the investigation and have sent him a copy of this report.

16. One of the Ombudsman's family liaison officers contacted Mr Dunnings' family to explain the investigation. They did not have any specific questions.

Background Information

HMP Coldingley

17. HMP Coldingley is a Category C prison in Surrey, holding just over 500 adult male prisoners. Coldingley's primary purpose is to provide prisoners with the opportunity to experience a typical working day to prepare them for a purposeful life on release. Central and North-West London Foundation Trust provide primary and mental healthcare.

HM Inspectorate of Prisons

18. The most recent inspection of HMP Coldingley was in February 2017. Inspectors reported a relatively small number of self-harm incidents. They found that procedures to manage those at risk of suicide and self-harm were generally appropriate, although too many ACCT documents had poorly considered care plans and there was not enough focus on effective interaction.

19. Inspectors found that staff had completed standard segregation paperwork but there were no care plans for men in segregation and little emphasis on reintegrating them into the mainstream population. They found that categorisation reviews were up to date and decisions justified but some cases would have benefited from more personal officer input.

20. Inspectors also found that the mental health treatment models and staffing profiles were appropriate to meet prisoners' needs.

Independent Monitoring Board

21. 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 July 2017, the IMB reported an increase in extreme behaviour, self-harm and threats to self and others in the segregation unit. They also reported that prisoners were generally satisfied with the quality of healthcare, and mental health provision was well regarded.

Previous deaths at HMP Coldingley

22. Mr Dunnings was the first prisoner to take his life at Coldingley since we began investigating deaths in custody in 2004. Three other prisoners have died at Coldingley since August 2015. One of these deaths was a homicide and the other two were from natural causes. There are no significant similarities between their deaths and the circumstances of Mr Dunnings' death.

Assessment, Care in Custody and Teamwork

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

24. After an initial assessment of the prisoner's main concerns, levels of supervision and interactions are set according to the perceived risk of harm. Checks should be

irregular to prevent the prisoner anticipating when they will occur. There should be regular multidisciplinary review meetings involving the prisoner. As part of the process, a caremap (plan of care, support and intervention) is put in place. The ACCT plan should not be closed until all the actions of the caremap have been completed.

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

Segregation units

26. Segregation units are used to keep prisoners apart from other prisoners. This can be because they feel vulnerable, 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 periods of cellular confinement after disciplinary hearings. Prisoners who are segregated are assessed by a member of healthcare staff. A senior operational manager must then be satisfied that the prisoner is fit for segregation. Segregation unit regimes are usually restricted and prisoners are permitted to leave their cells only to collect meals, wash, make phone calls and to exercise in the open air. The unit at Coldingley is known as the Care and Separation Unit and comprises 11 cells.

Parole Board

27. The Parole Board for England and Wales is an independent public body. Its role is to carry out risk assessments on prisoners to decide whether they can be safely released into the community once they have served the minimum term of their sentence. It also reviews the release dates of prisoners recalled into custody.

Indeterminate Public Protection Sentences (IPP)

28. Indeterminate sentences of Imprisonment for Public Protection (IPP) were created by the Criminal Justice Act 2003 and started to be used in April 2005. They were abolished in 2012. They were intended to protect the public from offenders whose crimes did not merit a life sentence. Those sentenced to an IPP were set a minimum term (tariff) which they had to spend in prison. After they complete their tariff, they can apply to the Parole Board for release. The Parole Board will release a prisoner only if it is satisfied that it is no longer necessary for the protection of the public for the prisoner to remain confined and therefore that the prisoner has sufficiently reduced their risk.

Key Events

Background

29. On 3 January 2006, Mr David Dunnings was convicted of robbery. On 10 February, he received an indeterminate sentence of Imprisonment for Public Protection (IPP) to serve a minimum tariff of two years and nine months in prison before parole could be considered. On 28 February 2011, Mr Dunnings was released on licence.

30. He was recalled to HMP Winchester on 4 July 2014 having breached his licence terms. At an initial health screen, he told a nurse that he did not want to take his antidepressants, but later agreed to. He said that he had no history of self-harm. On 25 November, the Parole Board directed that Mr Dunnings should not be released. His next parole hearing was scheduled for April 2016.

31. On 27 February 2015, Mr Dunnings was transferred to HMP Erlestoke. At an initial health screen, he said that he had a history of self-harm. On 1 June, he was diagnosed with general anxiety.

32. In March 2016, Mr Dunnings was told that his parole hearing had been deferred. On 27 March, he self-harmed and was monitored under suicide and self-harm procedures, known as ACCT. Mr Dunnings told staff that he was upset about his parole dossier as he felt it was inaccurate and staff were not communicating properly with him. On 1 April, ACCT monitoring was stopped.

33. On 12 June 2016, Mr Dunnings was moved to HMP Elmley after he was allegedly involved in a disturbance at Erlestoke. During a health screen, he said that he had no mental health issues and denied thoughts of suicide or self-harm.

34. On 21 August, Mr Dunnings was told that his parole hearing would be deferred pending police investigations into the alleged assault of another prisoner in December 2015 and his alleged participation in the disturbance at Erlestoke. That week, Mr Dunnings failed to attend two mental health appointments and was discharged from the mental health team's care.

HMP Coldingley

35. On 8 September 2016, Mr Dunnings was moved to HMP Coldingley. At a reception health screen, he told a nurse that he had no thoughts of suicide or self-harm, but she referred him to the mental health team because of his anxiety. On 18 September, Mr Dunnings did not attend his mental health appointment, and said that he was not interested in mental health support.

36. On 22 September, his offender supervisor told Mr Dunnings that his parole review hearing would not progress until the police had concluded their enquires. She said that his next hearing was likely to be in March 2017. Mr Dunnings said that he was happy at Coldingley as it made visits from his family easier. Mr Dunnings settled well at Coldingley.

37. On 28 November, Mr Dunnings asked to be referred to the prison's mental health team. On 5 December, a mental health nurse assessed him. Mr Dunnings said that he had anxiety, had previously worked with a psychologist and might need

medication. The nurse noted that Mr Dunnings understood his mental health issues, displayed no psychotic symptoms and had no thoughts of suicide or self-harm. The nurse told him to speak to the prison GP as he had never taken medication for anxiety. The nurse made plans to see Mr Dunnings two weeks later.

38. On 16 December, a prison GP assessed Mr Dunnings. She noted that he was a recalled IPP prisoner and had a history of anxiety. The GP noted that he appeared to be in crisis. Mr Dunnings said that he was very stressed and was not sleeping. He said that he had previously been prescribed venlafaxine and mirtazepine, both antidepressants, but neither had helped. The GP discussed other treatments, including trazodone, another antidepressant. The GP prescribed Mr Dunnings three nights of zopiclone, a sleeping tablet, and noted that the mental health team had agreed to see him the next week.

39. On 19 December, Mr Dunnings told a nurse that he was not coping and was in crisis. He said that he had assaulted a prisoner and was an IPP prisoner. Mr Dunnings said, “Well the way I think is that I can always kill myself if I can’t cope with things” and that he could see “no light at the end of the tunnel”. Mr Dunnings told her that he had thoughts of suicide but had no plans to act on them. She started ACCT monitoring. Mr Dunnings said that he was not happy that ACCT procedures had been started. They were stopped the next day.

40. On 23 December, a prison GP reviewed Mr Dunnings. She noted that he remained low but was less agitated and was relieved not to be monitored under ACCT procedures. She prescribed Mr Dunnings trazodone.

41. On 29 December, a prison GP reviewed Mr Dunnings’ medication. He said that he remained anxious about the police investigations and wanted treatment for his anxiety as he did not think his medication was working. The GP noted that Mr Dunnings had already been referred to the mental health in reach team and concluded that he should continue taking trazodone. The GP asked the mental health nurse to assess Mr Dunnings.

42. On 5 January, Mr Dunnings did not attend a follow-up appointment with the prison GP. The next day, he told a nurse that he did not attend as he felt anxious. He told his offender supervisor that he was feeling stressed and anxious, including about his outstanding parole hearing.

43. On 6 January 2017, the mental health nurse assessed Mr Dunnings, who told him that his medication was not working. The nurse explained that it would take at least four weeks before his medication would have an effect. He told him to keep taking his medication and that he would be reviewed in three weeks.

44. On 9 January, a nurse informed the GPs in writing that Mr Dunnings was not taking his antidepressants. The next day, a prison GP stopped Mr Dunning’s antidepressants as he had missed several doses. On 12 January, Mr Dunnings did not attend an appointment with the GP, as he said that he had to call his solicitor.

45. On 23 January, the mental health nurse reviewed Mr Dunnings, who said that he had not been taking his antidepressants as they were not working. Mr Dunnings

declined the offer of working with a psychologist. The nurse told him that the mental health inreach team would not be able to help him as he did not show signs of severe or enduring mental illness. He agreed that Mr Dunnings should discuss alternative medications with the GP, and discharged him to the care of the primary care team. He said that he could see the mental health team again if his situation changed.

46. On 26 January, a prison GP reviewed Mr Dunnings, who said he was depressed and anxious about issues relating to his sentence. The GP noted that he was unwilling to allow time for his antidepressants to work and had asked for sleeping tablets. He prescribed sertraline, an antidepressant.

47. On 6 February, Mr Dunnings told an officer that he wanted to go to the segregation unit as he felt something would happen to him if he stayed on the wing. Mr Dunnings was offered support but he rejected it. He refused an order to go to his cell and was taken to the segregation unit.

48. On 8 February, a prison GP reviewed Mr Dunnings' prescription of sertraline. Mr Dunnings said that he had stopped taking the medication as it was not relieving his anxiety symptoms. He said that his mind was racing and he was persistently worried. Mr Dunnings told the GP that mirtazapine had helped him in the past. The GP prescribed Mr Dunnings duloxetine, another antidepressant.

49. On 9 February, the offender supervisor talked to Mr Dunnings about his parole reports. Upset at what he read, Mr Dunnings told her that he could not cope and "couldn't do this anymore". He said that he would "end it all" while in the segregation unit. She started ACCT procedures.

50. At an ACCT assessment and review on 10 February, Mr Dunnings told a custodial manager that he was concerned about his negative parole review report, IPP sentence and potential police charges. Mr Dunnings said that his medication was not working and he was confused about why the GP had prescribed antidepressants when he had anxiety. A nurse who was also present, sent a note to the mental health nurse, setting out Mr Dunnings' situation, concerns and issues. Mr Dunnings told the nurse that he had no confidence in the mental health nurse's clinical decisions about his anxiety. (The nurse did not ask the mental health nurse to review Mr Dunnings.)

51. On 10 February, Mr Dunnings refused to take duloxetine. He said that the GP had agreed to give him mirtazapine and he needed something to help him sleep. A nurse asked the prison GPs to stop prescribing duloxetine.

52. At an ACCT review on 12 February, Mr Dunnings said that having to complete the RESOLVE course, an accredited offender behaviour programme which his parole report had recommended that he complete before he could be considered for release, was a significant factor in his threats to self-harm.

53. On 13 February, Mr Dunnings asked a prison GP for mirtazapine to help him sleep. The GP told him that he would only treat his specific symptoms of anxiety but noted that Mr Dunnings was not interested in this. Later that afternoon, Mr Dunnings told a nurse that he was anxious and needed sleeping tablets. The nurse reiterated what the GP had said.

54. On 15 February, a prison GP noted during a segregation round visit that Mr Dunnings was still asking for sleeping tablets. He explained again that the aim was to treat his anxiety and not to focus on specific symptoms by using addictive drugs. The GP re-prescribed a course of duloxetine.

55. On 17 February, a prison GP saw Mr Dunnings during a segregation round visit. The GP noted that he was felt anxious and stressed. Mr Dunnings told the GP he was not taking duloxetine because of its side effects and it took too long to be effective. The GP told Mr Dunnings that duloxetine was effective. Mr Dunnings again asked for medication to help him sleep but the GP explained that such drugs should be avoided. Mr Dunnings agreed to take his duloxetine and the GP prescribed him two days of sleeping tablets. Two days later, a nurse noted that Mr Dunnings still refused to take his duloxetine.

56. At an ACCT review on 20 February, Mr Dunnings said that he did not want to be monitored under ACCT procedures. A nurse asked the mental health team to review him and they decided to continue with ACCT procedures.

57. On 22 February, a psychiatrist responded to the nurse. He said that Mr Dunnings would be reviewed routinely. The psychiatrist assigned this task to the mental health nurse, who noted that this was completed on 27 February (although there is no evidence of this). On 23 February, Mr Dunnings was returned from the segregation unit to B wing.

58. Mr Dunnings continued to refuse to take his duloxetine as he said that it made him nauseous. On 24 February, a nurse asked the prison GPs to review his medication. On 27 February, a prison GP stopped the prescription of duloxetine and asked the nurse to book an appointment for him to review Mr Dunnings. That day, ACCT monitoring was stopped for Mr Dunnings.

59. On 27 March, an officer noted that Mr Dunnings had settled well on his new wing, was polite, co-operative with staff, attended work regularly, received regular visits and maintained appropriate standards.

60. On 12 April, Mr Dunnings started his RESOLVE course. The next day, he failed to attend an appointment with a prison GP, but there is no evidence to explain why. The GP did not make another appointment.

61. On 28 April, a prison GP saw Mr Dunnings, who told him that he was concerned about his levels of anxiety and the RESOLVE course was adding to this. Mr Dunnings told the GP that antidepressants had no effect on him and asked for pregabalin, a medication used to relieve neuropathic pain and to treat anxiety disorders. The GP told Mr Dunnings that the prison would not prescribe this treatment. Mr Dunnings asked to speak to a psychiatrist for advice. Because Mr Dunnings had tried to take a number of antidepressants, the GP asked the mental health nurse to assess him.

62. On 10 May, the mental health nurse assessed Mr Dunnings, who said that his levels of anxiety had risen and he was worried things would get worse. He said mental illness ran in his family, and although he had previously felt suicidal, he had never acted on the thoughts and had no plans to self-harm. The nurse noted

that Mr Dunnings presented with symptoms of anxiety and appeared fragile. The nurse referred him to the psychiatrist.

63. On 17 May, the psychiatrist assessed Mr Dunnings, who said that he was frustrated and was struggling with symptoms of anxiety and panic attacks. The psychiatrist noted traits of personality disorder. He prescribed pregabalin for a limited period of three weeks to help him cope with completing his RESOLVE course, which Mr Dunnings said was making him anxious.

64. On 25 May, a substance misuse support worker told the mental health team that Mr Dunnings had requested a review of his medication. She told Mr Dunnings that his medication would be reviewed by the psychiatrist four weeks after his last appointment, as time was needed for the medication to take effect.

65. On 1 June, an officer noted that Mr Dunnings had a positive attitude to his work, was engaging well in his RESOLVE course and was committed to making positive changes in his life.

66. On 9 June, a prison GP prescribed a further week's supply of pregabalin. Mr Dunnings also completed his RESOLVE course that day. On 11 June, Mr Dunnings asked for an appointment with the psychiatrist. An appointment was scheduled for 14 June.

67. On the morning of 14 June, Mr Dunnings was alleged to have assaulted another prisoner. He remained on the wing, where it was thought he could be better managed than in the segregation unit.

68. At around 1.30pm, Mr Dunnings was involved in an incident with a prisoner. They refused to leave the cell of another prisoner. It was first thought that the prisoners had barricaded themselves in the cell and might have taken a hostage. The prisoners refused to leave the cell and national resources were deployed to end the incident. However, Mr Dunnings and the other prisoners left the cell voluntarily before additional resources were deployed.

69. Because of the incident, the psychiatrist was unable to review Mr Dunnings, but discussed him with the mental health nurse. The psychiatrist created a care plan and noted that the nurse would lead Mr Dunnings' care, including considering psychological therapies. He noted that he would review Mr Dunnings when the nurse arranged it. The psychiatrist asked a GP to review the prescription of pregabalin, with a view to stopping it. The nurse noted no concerns about Mr Dunnings' mental state and that he would be reviewed after the ongoing incident.

70. At 5.00pm, Mr Dunnings was taken to the segregation unit under Rule 45 (which allows segregation for the purpose of good order and discipline), and he was charged under prison disciplinary procedures with barricading a cell.

71. At 5.10pm, a nurse assessed Mr Dunnings and concluded that there was no reason why he could not be segregated. Another nurse noted that the mental health team were due to see Mr Dunnings.

72. At 8.35pm, an officer started ACCT procedures after Mr Dunnings made cuts to his wrists because staff would not pass him tobacco from another prisoner. Mr Dunnings was checked five times an hour.

73. At 9.10pm, a custodial manager tried to speak to Mr Dunnings but he refused to engage and was abusive and threatening. He tried to reason with Mr Dunnings and offered to treat his cuts. Mr Dunnings told him that he would assault any officer who went into his cell and would cut his own throat. Mr Dunnings periodically covered his observation panel.

74. At around 11.00pm, the custodial manager prepared for staff, in personal protection equipment, to go into Mr Dunnings' cell as he continued to cover his observation panel. He tried to engage Mr Dunnings but he threatened to harm himself if staff went into his cell. He withdrew contact with Mr Dunnings but continued to check on him regularly. At around midnight, Mr Dunnings settled but continued to threaten staff. (Because no nurses are on duty during the night and because Mr Dunnings would not let staff go into his cell, a nurse treated his injuries the next morning.)

75. On 15 June, at 10.00am, a custodial manager carried out an ACCT assessment. Mr Dunnings told him that he had cut himself because he was "hysterical" and was frustrated that staff were not listening to him. Mr Dunnings said that he had no intention of taking his life and did not want to engage in the ACCT process.

76. An acting custodial manager chaired an ACCT review at 3.20pm. Other officers attended. Mr Dunnings said that he had self-harmed as he was not given tobacco and no one was listening to him. He said that he was looking forward to a visit from his daughter that weekend. He was told to speak with staff if his anxiety increased. She set a number of objectives on his caremap, including to budget appropriately for tobacco and to talk with staff and others, such as the Samaritans and Listeners. (Listeners are trained by the Samaritans to offer confidential support to other prisoners.) She assessed Mr Dunnings' risk as low, and agreed that he should be checked twice an hour.

77. During the day, Mr Dunnings told an officer that he was angry and frustrated about his IPP sentence and issues about his medication.

78. On 16 June, Mr Dunnings received his last dose of pregabalin.

79. Mr Dunnings was discussed at a management meeting that day. The Deputy Governor of Coldingley said that he asked a manager in the Offender Manager Unit (OMU) to review whether Mr Dunnings was suitable to remain at Coldingley, with a view that he might need to be re-categorised. The manager said, "…at the end of the meeting, it was agreed that Mr Dunnings would be re-categorised to B" and that the Deputy Governor of Coldingley asked him to complete the re-categorisation paperwork. (The Deputy Head of Coldingley told the investigator that the intention was that once Mr Dunnings' re-categorisation had been reviewed, he expected it to be discussed by a full re-categorisation panel and that no decision to re-categorise Mr Dunnings to a Category B prisoner was made at the meeting.)

80. During the morning, Mr Dunnings asked the mental health nurse for pregabalin. He was told that the psychiatrist had stopped his prescription. The nurse said that Mr Dunnings was not happy and noted that the GP had told him that he would consider the matter.

81. At 10.25am, the Head of Safer Custody adjourned Mr Dunnings' disciplinary hearing for barricading his cell on 14 June.

82. That morning, an officer spent some time with Mr Dunnings. She noted that he was calm and articulate but was emotional. He said that he sometimes felt hopeless, and was frustrated by his IPP sentence and was worried that his pregabalin might be stopped. Mr Dunnings agreed with her that counselling might be a step forward and she confirmed that she would let the mental health team know that she supported this. Mr Dunnings told her that his actions on 14 June were because he had "screwed his parole" and felt he was not being listened to.

83. At 11.40am, a SO chaired Mr Dunnings' second ACCT case review. He did not hold a formal review as Mr Dunnings was with the officer. He noted that Mr Dunnings had said that he was in good spirits. Mr Dunnings denied thoughts of suicide or self-harm his risk was assessed as low. It was decided that he should be checked hourly.

84. Later that morning, during a prison GP's segregation rounds, Mr Dunnings asked for pregabalin. The GP concluded that in light of Mr Dunnings' continuing symptoms of anxiety, he should take sertraline again, and see the psychiatrist.

85. That afternoon, the Head of Safer Custody held a 72-hour segregation review board which authorised Mr Dunnings' continued segregation. At the review, Mr Dunnings said that he wanted to stay at Coldingley as his family lived nearby and his parole hearing was due. A nurse confirmed that there were no healthcare reasons why Mr Dunnings could not continue to be segregated but noted his anxiety that his pregabalin had been stopped.

86. On 17 June, Mr Dunnings told a nurse that he was unhappy that his pregabalin had been stopped. Later in the day, he received a family visit and told staff that this had changed his perspective. Mr Dunnings slept through the night and raised no concerns over the following days.

87. On 19 June, Mr Dunnings told the mental health nurse that he wanted to see the psychiatrist about his medication but that his mood and mental state were stable. A prison GP also saw Mr Dunnings and noted no concerns. That day, Mr Dunnings discussed with his offender supervisor whether it would be in his interest to defer his parole hearing until his behaviour became stable.

88. On 20 June, Mr Dunnings told a nurse that he did not want to take his medication and that he felt like hanging himself. Mr Dunnings' observations were increased to four an hour. Later that day, he again asked a prison GP if he could have pregabalin. He was told it was not suitable and he would remain on sertraline.

89. That day, a manager completed Mr Dunnings' re-categorisation paperwork, and recommended that he should be re-categorised to Category B. The manager forwarded the paperwork to the Deputy Governor for approval.

90. At 4.00pm, a manager chaired Mr Dunnings' third ACCT review. A nurse attended. The manager noted that Mr Dunnings was anxious about his medication and had asked to see the psychiatrist. Mr Dunnings said that he wanted to end his life and saw no future but also talked about his daughter's visit

the previous weekend and his hope that he would stay at Coldingley. The manager noted that his risk had risen, and raised his observations to two an hour during the day and once an hour at night. She updated the caremap to note that Mr Dunnings should have regular contact with the psychiatrist.

91. At 5.30pm, the Deputy Head of Coldingley emailed the re-categorisation paperwork to a custodial manager in OMU. He wrote, “I feel Mr Dunnings would be more suitable in a more secure environment. Can I please ask you to act on the attached”. (He told the investigator that on forwarding the re-categorisation paperwork to her, his expectation was that a multidisciplinary re-categorisation board would be convened to consider and decide on the merits of re-categorisation.)

92. On the morning of 21 June, the custodial manager opened the Deputy Head of Coldingley’s email to her. Because a manager had already completed the re-categorisation form, she printed the re-categorisation paperwork and gave it to her line manager and Acting Manager of the Offender Management Unit to approve. He returned the re-categorisation paperwork to her and asked her to copy the information on to another template that had been used for other re-categorisations at the prison. She did so and gave it back to him. She said that he returned the form a second time, and asked her to sign the form as the manager who completed the form was not working that day. She did as instructed, and sent the form to him for a third time.

93. The Acting Manager reviewed the re-categorisation paperwork and the consideration. He approved the form, confirming that Mr Dunnings was now a Category B prisoner. (The custodial manager told the investigator that she did not review the paperwork, and that she signed a form that she had not completed.)

94. At 2.50pm, a custodial manager chaired Mr Dunnings’ fourth ACCT review. An interim healthcare manager and a mental health nurse attended. Mr Dunnings said that he did not want to attend the review. The manager later established that a prisoner who had been involved in the barricading incident with Mr Dunnings on 14 June, was being returned from the segregation unit to a standard wing and that Mr Dunnings was annoyed by this. She asked Mr Dunnings to consider whether his family should be involved in the ACCT process. She concluded that there was no change in Mr Dunnings’ risk of self-harm and his observations remained unchanged.

95. On 22 June, a custodial manager chaired Mr Dunnings’ fifth ACCT review. A nurse attended. Mr Dunnings did not attend the review but told the manager that talking to another of the prisoners with whom he had barricaded the cell, was all the support and help he needed. When asked how he was, Mr Dunnings said that he spent his time looking for something with which to hang himself. Those at the review interpreted this as bravado rather than intent. Mr Dunnings told the manager that he was looking forward to a visit that afternoon and did not want to spoil it by “going over old ground”. The manager noted that the caremap was not updated as Mr Dunnings was not willing to engage. His observations remained at two conversations an hour and once an hour at night, in line with normal segregation unit checks.

96. On 23 June, the mental health nurse saw Mr Dunnings but noted no concerns. Mr Dunnings asked a prison GP during a regular segregation unit round if he could take his sertraline in the evenings.

97. At 10.05am, a custodial manager chaired Mr Dunnings' sixth ACCT case review. Two officers attended. The mental health team did not attend. Mr Dunnings refused to attend as he said that the reviews took him to a "bad place". Mr Dunnings said that his visit the previous day had gone well, that he was okay and had no issues. It was decided that an officer would see Mr Dunnings at the weekend. (She said that she did not recall speaking to him that weekend.) No review of the caremap took place and it was considered that there was no change in Mr Dunnings' risk. His level of checks remained the same.

98. At 11.35am, a senior manager seconded to work at Coldingley adjourned Mr Dunnings' disciplinary hearing for a second time. During the day, officers noted that Mr Dunnings took exercise, asked if he could paint his cell, read and talked to a prisoner who lived in the adjacent cell.

99. At 9.10am on 24 June, Mr Dunnings told a nurse that he had no thoughts of self-harm or suicide. During the day, he was given a new pair of trainers, listened to his radio and was heard talking to other prisoners. In the afternoon, he did not take his medication, and told a nurse that he was feeling low in mood. The nurse messaged a prison GP, who responded two days later to say that he would review Mr Dunnings on 28 June.

100. On 25 June, Mr Dunnings took exercise in the morning. At 10.42am, a custodial manager carried out a management check. She noted in the ACCT record that Mr Dunnings had raised no concerns and due to his positive mood she had reduced his checks to hourly.

101. On 26 June, Mr Dunnings told an officer that he was upset that a prisoner had returned to a standard wing and that he was concerned that he would be moved to a prison away from his family. The office said Mr Dunnings was concerned that he was being treated differently from two prisoners.

102. At 2.15pm, a custodial manager chaired Mr Dunnings' seventh ACCT review with a nurse. Mr Dunnings attended the review but asked a worker from the substance misuse team and a member of IMB, who were also present, to leave as he only wanted to speak to people with whom he felt comfortable. The custodial manager noted that Mr Dunnings was very down and not happy that a prisoner had returned to a standard wing and that another prisoner was being moved to another prison. Mr Dunnings said that no one was being honest with him. Mr Dunnings said that he just wanted to die and had thoughts of hanging himself. She assessed that Mr Dunnings level of risk had increased and raised his checks to two an hour during the day and night.

103. The ACCT caremap was updated to note that OMU should be involved in Mr Dunnings' ACCT procedures. The custodial manager said that she spoke to a manager, who told her that Mr Dunnings had been re-categorised as a Category B prisoner.

104. At 10.30am on 27 June, Mr Dunnings spoke to the Head of Security during his management round of the segregation unit. Mr Dunnings asked him why a prisoner had returned to a standard wing while he and another remained segregated. The Head told Mr Dunnings that it was because the prisoner had been in his own cell during the barricade. Mr Dunnings also told him that he wanted to remain a Category C prisoner. The Head told him that this was unlikely given his recent behaviour.

105. Having been told that Mr Dunnings wanted to speak with her, his offender supervisor spoke to the Deputy Governor of Coldingley about what she should say to Mr Dunnings if he asked about re-categorisation, as she was aware that he was now a Category B prisoner. She said that he told her not to talk to Mr Dunnings about his re-categorisation and that he would try to see Mr Dunnings the next day. The Deputy Governor said that he recalled speaking to her, but did not remember the detail of their conversation. He said that he would not have expected her to have told Mr Dunnings about his re-categorisation. He said that the Head of OMU should have told Mr Dunnings.

106. The offender supervisor spoke to Mr Dunnings. He asked what was going to happen to him and why he was still in the segregation unit when other prisoners involved in the incident had been moved. She told him that she did not know but had spoken to the Deputy Governor of Coldingley, who would try and see him the next day. (She told the investigator that when she saw Mr Dunnings, he was not aware of his re-categorisation but thought that he might be transferred to another prison.)

107. On 28 June, the psychiatrist and mental health nurse discussed Mr Dunnings at the mental health inreach team meeting. The psychiatrist noted that Mr Dunnings was to be told about his re-categorisation at his ACCT review and was likely to be upset by the news. He said he would see him at his next clinic. They discussed Mr Dunnings' risk, which was considered not to be life-threatening and it was agreed that he should continue to be managed under ACCT procedures. They agreed that if he was moved to another prison, he would need mental health support.

108. Before Mr Dunnings' scheduled ACCT review, a custodial manager said that she asked a manager if she could tell Mr Dunnings about his re-categorisation. She said that the manager told her not to tell him but to "sow the seed" that re-categorisation was being considered. (The manager told the investigator that she could not recall the conversation with the custodial manager and would not have made the decision whether to if to tell Mr Dunnings about his re-categorisation.)

109. At 2.10pm, a custodial manager chaired Mr Dunnings' eighth ACCT review. Another custodial manager, a nurse and the offender supervisor attended. The custodial manager noted that Mr Dunnings was not "in a good way" and looked tired. He was told that his re-categorisation was being considered and arrangements were being made to try and transfer him to Winchester to be near his family. Mr Dunnings was told that he would not be able to see the psychiatrist for another two or three weeks. This upset Mr Dunnings, who left the review. She noted that his risk had increased and his observations were

increased to four an hour. No review of his caremap took place. Another custodial manager told the investigator that she felt Mr Dunnings already knew that he would be re-categorised.

110. When Mr Dunnings returned to his cell, he punched the walls. An officer spoke to him after he had calmed down and offered to ask a nurse to look at his hand. Mr Dunnings said that it was his own fault and that there was no need to see the nurse. Later that afternoon, Mr Dunnings was moved to a cell with a television. He did not eat his evening meal but he raised no concerns with staff.

111. The psychiatrist noted that before his clinic, he had spoken to a custodial manager, who said that the mental health nurse had told the review of the psychiatrist's plans, and asked if he could speak to Mr Dunnings as he was "distressed". The psychiatrist said that Mr Dunnings should be told about his re-categorisation, and that he would see him at his next available appointment rather than as an emergency.

112. On 29 June, Mr Dunnings told a nurse he had been anxious during the ACCT review the previous day as there were too many people which meant that he had not fully engaged. He told an officer that he had been willing to take part in programmes and did what was asked of him. He told the officer that he would say goodbye to his family during their next visit and did not want any more contact with them. The officer, who described Mr Dunnings' moods as "up and down", tried to reassure him and told him not to break ties with his family as they needed each other.

113. Later that morning at a disciplinary hearing, a custodial manager found Mr Dunnings' guilty of barricading his cell and gave him14 days cellular confinement. Healthcare staff confirmed that there was no reason why Mr Dunnings could not remain segregated, and the manager authorised Mr Dunnings' segregation under Rule 55 (for the purpose of cellular confinement).

114. During the lunch period, Mr Dunnings told a nurse that he would kill himself after his next family visit, but had no current thoughts of suicide. In the early afternoon, the substance misuse support worker told Mr Dunnings that she would share his RESOLVE report with him the next day. She said that he did not talk about his re-categorisation, was anxious about being moved away from his family but was looking forward to a visit and appeared calm. After his visit in the afternoon, Mr Dunning said it was "brilliant" and it was noted that he seemed in good spirits.

115. At 6.45pm, a custodial manager chaired Mr Dunnings' ninth ACCT review. An officer and a nurse attended. Mr Dunnings said that he was frustrated at the possibility that he might be re-categorised, and said that it was unfair. Mr Dunnings said that as soon as he had had a visit from his biological mother and daughter, he would kill himself as his sentence had "done him in". A further ACCT review was scheduled to take place in two days. The manager noted that Mr Dunnings' risk remained raised and although the caremap was reviewed, no changes were made. His observations remained unchanged at four an hour.

116. On 30 June, it was noted that Mr Dunnings was not interacting with staff. The mental health nurse saw him and noted that his mental state appeared stable. A

prison GP saw Mr Dunnings during a routine segregation visit but noted no concerns.

117. At around 11.30am, the substance misuse support worker gave Mr Dunnings his RESOLVE report, which he did not want to read. Mr Dunnings told her that he would not be able to attend his parole hearing as he would end his life after his next family visit. Mr Dunnings told her that he had made up his mind and felt at peace for the first time in a long time.

118. At 2.00pm, a custodial manager chaired Mr Dunnings' tenth ACCT review, which was brought forward. Another manager attended. Mr Dunnings refused to attend. His level of risk remained unchanged as did his level of checks at four an hour. The next ACCT review was scheduled for 3 July.

119. Later that afternoon, Mr Dunnings told a friend by telephone that Coldingley was trying to take his Category C status from him, that he might be moved to a prison in the north of England and that she and family members needed to visit him before this. Mr Dunnings also called his biological mother and left a message to say that he might be re-categorised, that he would challenge it and asked her to visit him sooner rather than later.

120. During a conversation with an officer later that afternoon, Mr Dunnings repeated that he would take his own life after his next visit. Staff later noted that Mr Dunnings was writing letters on his bed and gave them one to be posted. During the evening, Mr Dunnings watched television and spoke to other prisoners through the cell window.

121. On 1 July, during a routine segregation unit visit, an unidentified governor noted that Mr Dunnings was frustrated that he was in the segregation unit, wanted to remain at Coldingley and felt that he was not being listened to. He noted that Mr Dunnings had said that an ACCT review was not the best time to have been told that he would be a Category B prisoner as he was talking about his issues. A nurse noted that Mr Dunnings was low in mood at losing his Category C status. The nurse told him to persevere with taking sertraline, even thought he might feel low in mood for the first couple of weeks, and that he should keep engaging with staff. (There is no evidence that staff had told him that he had been re-categorised but Mr Dunnings was most likely referring to the ACCT review of 28 June, when he was told his re-categorisation was being considered.)

122. At 2.10pm, a custodial manager, at Mr Dunnings' request, chaired his eleventh ACCT review, as he said he was tired of ACCT checks. A nurse attended. Mr Dunnings said that he still intended to take his life but would not do so until his biological mother and daughter had visited him. Mr Dunnings asked for his adoptive parents to be involved in the ACCT process. The manager updated the caremap and noted that the safer custody team would contact his family on 3 July. She noted that Mr Dunnings' risk remained unchanged but lowered his observations to one an hour and scheduled a review for 3 July.

123. At 4.56pm, the custodial manager emailed colleagues to note her contact with Mr Dunnings during the ACCT review and to ask the safer custody team to contact her on 3 July to discuss the process of contacting family members. (There is no evidence that Coldingley contacted Mr Dunnings' adoptive parents.)

124. On the morning of 2 July, Mr Dunnings told a nurse that he did not want to take his sertraline as he was making suicide plans and the medication worsened his mood. She noted that throughout her contact with Mr Dunnings, he was laughing, joking and made good eye contact. She planned for the GP to review his medication the next morning.

125. At lunch time, Mr Dunnings spoke to his biological mother and they discussed which day she should visit. Mr Dunnings told his biological mother that the prison was trying to take his Category C status from him but he would fight it.

126. On 3 July, a prison GP noted Mr Dunnings' plans to kill himself but not until after his biological mother's visit on 7 July. He noted that Mr Dunnings had again asked for pregabalin. The GP concluded that Mr Dunnings was fit to remain in the segregation unit and that he would tell the mental health inreach team about his contact. He asked the mental health nurse to review Mr Dunnings' mental health and suicide risk.

127. That morning, Mr Dunnings told an officer that he had an appointment with the mental health team that day. The officer noted that Mr Dunnings had calmly told him that he would kill himself after his biological mother and daughter visited. Mr Dunnings asked the officer what would happen to any letters addressed to his family and his solicitor, left on his bed after his death. He told Mr Dunnings that the letters would be evidence. The officer told the investigator that Mr Dunnings would repeat that his "…sentence had done me in", how he "… couldn't do it anymore," and that there was "… no light at the end of the tunnel".

128. The mental health nurse responded to the GP's earlier request to assess Mr Dunnings. The nurse noted that Mr Dunnings' anxiety levels had increased and told him that the psychiatrist would see him on his next visit. Mr Dunnings said that it would be too late. The nurse noted that he did not see any sign of serious suicidal thoughts. The nurse later noted in Mr Dunnings' medical record that he was compliant, felt anxious and that he was not being supported or listened to, and that pregabalin was the only medication that worked for his anxiety. The nurse told Mr Dunnings that it was unlikely he would be given pregabalin. The nurse noted no physical signs of anxiety and concluded that there was no need to change his management plan. The nurse told the GP that staff were aware of Mr Dunnings' threats and were managing him well. He told him that the psychiatrist would review Mr Dunnings at his next clinic but that he might have transferred to another prison by then. The GP responded to say that he agreed with the nurse's review.

129. At 11.45am, an officer noted that Mr Dunnings was presenting as anxious and disturbed, was angry with the "system" and would take his own life. At 12.40pm, an officer noted that Mr Dunnings had threatened to block his observation panel and had threatened to take officers' keys if they went into his cell.

130. At 2.00pm, a custodial manager chaired Mr Dunnings' twelfth ACCT review. A nurse attended. Mr Dunnings said that there had been no change in his feelings and he was resolute that he would end his life after he had had a visit from his biological mother that Friday and from his daughter the following Tuesday. Mr Dunnings said that he had been failed by the "system" and confirmed that he wanted family involvement in his ACCT reviews. It was assessed that Mr

Dunnings' level of risk remained unchanged and that hourly observations should continue. The next review was scheduled for 7 July.

131. On 4 July, Mr Dunnings was told that his appeal against the charge of barricading the cell had been successful and that the finding of guilt had been quashed. An officer noted that Mr Dunnings appeared in a better frame of mind, and had asked not to be segregated. During a segregation round, a nurse noted that Mr Dunnings was fit for continued segregation.

132. That day, Mr Dunnings was discussed at a substance misuse multidisciplinary team meeting which the mental health inreach team attended. A substance misuse worker noted that the nurse had said that Mr Dunnings presented differently to different people, at times seemed suicidal and at other times, was smiling and joking. She said that his contact with the substance misuse team had been suspended as he did not want to engage.

133. At 2.00pm, a custodial manager noted in Mr Dunnings' segregation records that he had been reclassified as a Category B prisoner after a number of incidents, including an unprovoked attack on another prisoner, and that he was waiting to be transferred to a Category B prison. He noted that because Mr Dunnings was no longer serving a punishment of cellular confinement, he was now being held in the segregation unit under Rule 45. There was no segregation review.

134. On 5 July, Mr Dunnings refused to speak with a nurse or take his medication. The mental health nurse noted that his mood and mental state were stable, and that there was no need for his management plan to be changed. The nurse noted that he was fit to remain in the segregation unit. An officer noted that Mr Dunnings had refused to talk or engage with any of them. He told the investigator that in the days leading to his death, Mr Dunnings presented as calm and not sad or upset.

135. Later that morning, Mr Dunnings told his biological mother by telephone that he had arranged for her to visit on 7 July. They also talked about other family members. Mr Dunnings said that the charge of barricading the cell had been quashed on appeal, that the prison had no right to hold him in the segregation unit and that he would speak to his solicitor about it.

136. In the afternoon, a prison GP noted that Mr Dunnings was fit to be segregated. The substance misuse support worker also saw Mr Dunnings, who told her that he did not want to read his RESOLVE report and was happy for her to pass it to probation. She noted that Mr Dunnings told her that he felt fine.

137. HMP Swaleside confirmed that they would accept Mr Dunnings on transfer and that this would take place on 10 July. (There is no evidence to indicate that Mr Dunnings was told about the transfer.)

138. On 6 July, a nurse saw Mr Dunnings and noted that he had no thoughts of suicide or self-harm. Staff noted that Mr Dunnings took exercise in the open air and that a message had been passed to him from his biological mother, thanking him for his letters and that she was looking forward to seeing him the next day.

139. On 7 July, the mental health nurse saw Mr Dunnings and noted that he presented as compliant, that his mood and mental state were stable. A prison GP saw Mr Dunnings during her segregation round but noted no concerns.

140. That afternoon, an officer took Mr Dunnings for his visit from his biological mother. He said that Mr Dunnings seemed okay. He said that when he went to collect Mr Dunnings, he asked the officer why he was now a Category B prisoner. He said that Mr Dunnings was angry about his categorisation, and said it was a joke. (There is no evidence to indicate who told Mr Dunnings about his re-categorisation or if he simply assumed that he would be re-categorised.)

141. At around 3.00pm, Mr Dunnings asked an officer if he could speak to someone about why he was no longer a Category C prisoner. The officer told Mr Dunnings that a review would hopefully confirm this.

142. At 4.05pm, a custodial manager chaired Mr Dunnings' thirteenth ACCT review. A nurse and an officer joined the review after it had started. The manager noted that Mr Dunnings was extremely agitated when he arrived. The officer said that the manager asked Mr Dunnings if he was still going to take his life after his visit from his daughter. Mr Dunnings said that he would once he had said goodbye to her on Tuesday 11 July, and that staff would have to explain to the Coroner why he had killed himself. The officer said the manager told Mr Dunnings that staff would try and stop him and he was reminded of the support available to him. Mr Dunnings shrugged his shoulders and said it did not matter.

143. The officer said that Mr Dunnings kept raising the issue of his re-categorisation, asked why he was a Category B prisoner, why he had not received any paperwork and why no one had told him about it. He said the manager told Mr Dunnings that he did not know why but asked the officer to check Mr Dunnings' records. The officer said that Mr Dunnings said that staff were "fucking with his life" and that "stuff like this was killing people on IPP sentences". He said that he found segregation paperwork which confirmed Mr Dunnings had been made a Category B prisoner. The officer said that Mr Dunnings was visibly upset and angry. Mr Dunnings slammed his fist on the table angrily and stormed out of the office, swearing. The manager concluded that Mr Dunnings' level of risk had risen and he was to continue to be checked hourly. He scheduled the next review for 11 July, the day that Mr Dunnings' daughter was due to visit.

144. The officer said that when he left the room, Mr Dunnings kicked a sign and a threw a fan down the corridor before returning to his cell. He followed Mr Dunnings, who was sitting on his bed, holding his head in his hands. He offered to talk to him. He said that he told the manager that he thought that the situation could have been handled better and that he thought Mr Dunnings really was going to take his life. He said the manager said that Mr Dunnings had been saying that for weeks and that he would not do anything until after his daughter's visit.

145. The custodial manager noted that the officer had managed to calm Mr Dunnings down, that his risk remained raised and that he was to remain on hourly checks. He said that Mr Dunnings' outburst appeared to have been through frustration.

146. At 4.45pm, the custodial manager emailed colleagues, noted his contact with Mr Dunnings, explained that he had been very agitated and had said he would end his life after his visit on 11 July. He noted that Mr Dunnings said that the prison would have to explain his actions to the Coroner.

147. That evening, Mr Dunnings ate his evening meal and at 8.00pm, he asked Officer A for a toilet roll, which the officer gave him. At 9.00pm, the officer noted that Mr Dunnings was standing in his cell, and during checks at 10.00pm and 11.00pm, the officer noted that Mr Dunnings was sitting on his bed.

148. At midnight, Officer A saw Mr Dunnings standing in his cell. He carried out a further check at 1.04am on 8 July. He said that he could not see Mr Dunnings through the observation panel. He then checked on the three remaining prisoners in the segregation unit before returning to Mr Dunnings cell at 1.05am, where he shone his torch through the observation panel. The officer said that he could not see Mr Dunnings, but then saw his feet and what appeared to be his body leaning against the cell door.

149. Officer A said that he radioed for the prison's night managers to come to the segregation unit immediately. The night custodial manager was in the segregation unit's office when the officer came to him and told him that he could not see or get a response from Mr Dunnings.

150. At 1.06am, the night custodial manager and Officer A arrived at Mr Dunning's cell. The manager shone his torch through the door for about 20 seconds and saw that Mr Dunnings appeared to be sitting by the door. He turned the cell light on and saw that Mr Dunnings had hanged himself. He unlocked the cell door and went in, followed by two officers, who had responded to the earlier call for assistance. The manager held Mr Dunnings while both officers cut the ligature. The ligature, made of bedding, was tied around the hinge of the cell door and Mr Dunnings had also tied it around his ankles. The officers found no signs of life. Officer B said Mr Dunnings was cold but that rigor mortis had not set in.

151. The officers started cardiopulmonary resuscitation. Officer A started chest compressions while Officer B gave breaths. At about 1.11am, the night custodial manager called a medical emergency code blue, indicating that a prisoner is unconscious or having difficulties breathing, and asked for an ambulance. Two operational support grades immediately called an ambulance. The manager left the cell to provide information to the ambulance service. As he was speaking to the emergency services, other officers arrived at the segregation unit and the defibrillator was taken to the cell.

152. Returning to the cell a little later, the night custodial manager asked an officer to take over chest compressions from Officer A and later asked another officer to help. Officer B continued giving breaths throughout the resuscitation efforts. An officer attached the defibrillator but it found no shockable heart rhythm. (A defibrillator is a life-saving device that gives the heart an electric shock in some cases of cardiac arrest.)

153. At about 1.30am, paramedics arrived and continued unsuccessfully to resuscitate Mr Dunnings. At 2.12am, paramedics noted that Mr Dunnings had died.

154. Mr Dunnings left several notes of intent in his cell, addressed to family members, in which he said that his sentence had "crippled" him, that he had given up and could no longer cope. Mr Dunnings also said that a prison GP had lied to him and refused to help him.

155. On the wall of the cell, Mr Dunnings had written of his dissatisfaction with members of Coldingley's mental health and healthcare teams.

After the incident

156. One of the prisoners involved in the barricade incident told the investigator that Mr Dunnings was concerned about his IPP sentence and possible re-categorisation, had mental health issues and believed that healthcare staff had taken his medication. He said that Mr Dunnings had been telling him for days that he was going to kill himself and that staff knew about this. He said Mr Dunnings had bought cards to send to his family.

157. Another prisoner said that on the morning of 7 July, Mr Dunnings had told him that he wanted to write to his family and say goodbye. He said that Mr Dunnings had not bought tobacco, as he would normally have done. He said that he told Mr Dunnings to ask him for tobacco if he needed it. He said staff did not take notice of the threats Mr Dunnings made about taking his life. He said that Mr Dunnings often talked about taking his life but that he did not think that he would go through with it because of his family.

158. A further prisoner said that Mr Dunnings would say he could "no longer do it", referring to his IPP sentence. He said that Mr Dunnings' pregabalin had been stopped, and he was not receiving medical help.

Family contact

159. Two staff were appointed as family liaison officers. At 7.00am, they broke the news of Mr Dunnings' death to his biological mother at her home. The prison offered to contribute to the cost of Mr Dunnings' funeral in line with national policy. Subsequent contact was made with other members of Mr Dunnings' family. Memorial services were later held at the prison.

Support for prisoners and staff

160. A governor individually debriefed the night staff involved in the emergency response and offered support. Staff notified prisoners of Mr Dunnings' death, and offered them support. Officers reviewed prisoners assessed as at risk of suicide and self-harm in case the news of Mr Dunnings' death had affected them.

Cause of death

161. A post mortem examination concluded that the cause of Mr Dunnings' death was hanging. A toxicology examination found pregabalin and a low concentration of sertraline in Mr Dunnings' bloodstream when he died, both of which were consistent with a therapeutic dosage.

Findings

Management of risk of suicide and self-harm

Location in segregation unit

162. We published a Learning Lessons Bulletin in June 2015 about the self-inflicted deaths of prisoners in segregation. It concluded that, all too often, prisoners at risk of suicide and self-harm were segregated without sufficient evidence that staff had considered other options or identified exceptional circumstances. We noted that segregation reduces some protective factors against suicide and should only be used in exceptional circumstances for those at risk of taking their own life.

163. Prison Service Instruction (PSI) 64/2011 on safer custody says that prisoners subject to ACCT monitoring should only be segregated in exceptional circumstances as it heightens their vulnerability, and the reasons and options considered must be clearly documented in the ACCT plan.

164. No senior manager formally considered whether there were exceptional reasons for holding Mr Dunnings in the segregation unit and no one considered alternative locations. This is not in line with the requirements of Prison Service Order (PSO) 1700 on segregation and Coldingley's safer custody policy dated December 2016 which requires segregation of a prisoner subject to ACCT procedures to be authorised by a senior manager of governor grade.

165. We consider that the initial decision to segregate Mr Dunnings, while he was subject to ACCT procedures, was not unreasonable as he had been involved in two serious incidents on 14 June. After he had been re-categorised to Category B on 21 June, his Category B status meant that he could no longer be held on a normal wing at Coldingley (because Category B prisoners cannot be held in a Category C prison).

166. However, although we accept that it would not have been possible for Mr Dunnings to return to a standard wing at Coldingley, a senior manager should have considered whether there were exceptional reasons for him to remain in Coldingley's segregation unit, and there is no evidence that anyone considered alternative locations that might have been more suitable for him while he was subject to ACCT monitoring.

ACCT reviews

167. PSI 64/2011 requires that case reviews are multidisciplinary, where possible. There were no healthcare staff at Mr Dunnings' first case review. Although a healthcare representative attended subsequent reviews, the mental health team only attended a couple of reviews and did not contribute, despite Mr Dunnings' clear mental health issues. Contrary to Coldingley's safer custody policy of December 2016, the duty governor did not attend Mr Dunnings' first case review and the IMB was not invited.

168. Mr Dunnings had a good relationship with some of the officers who worked in the segregation unit. We are concerned that officers who knew him, such as a particular officer, his offender supervisor and a senior member of OMU, were not invited to attend his ACCT reviews despite Mr Dunnings' concerns about his IPP sentence, parole hearings, re-categorisation and possible transfer.

169. Many of Mr Dunnings' ACCT reviews were procedural and lacked meaningful discussion of issues that might affect his level of risk such as his re-categorisation, IPP status, deferred parole hearing, ongoing investigations by police and elevated levels of anxiety. As a result, many of the case reviews failed to address his concerns and assess his level of risk effectively. Reviews also failed to address the impact of Mr Dunnings' limited access to activities during his time in the segregation unit and on 25 June, his observations were reduced without an ACCT review.

Caremaps

170. PSI 64/2011 requires caremaps to reflect the prisoner's needs, level of risk and the triggers of their distress. They should aim to address issues identified in the ACCT assessment.

171. Although some of the caremap objectives for Mr Dunnings such as his continuing contact with the prison psychiatrist, budgeting for tobacco, and keeping contact with family were useful, they were not aimed at reducing his risk or addressing recurrent concerns about being transferred, re-categorisation and his medical issues. Staff failed to recognise how important it was for Mr Dunnings to be near his family, that he did not understand why he remained in segregation and that he did not know whether he was being re-categorised and how it would affect him as an IPP prisoner.

172. While there is evidence that some staff had a caring approach – for example, they tried to establish what was happening about his re-categorisation, and intervened to help him with his healthcare concerns - for the most part, staff failed to set and record clear and effective actions in Mr Dunnings' caremap, which might have reduced his risk. When Mr Dunnings did not attend ACCT reviews, staff did not review his caremap as they should have done.

Observations

173. Despite Mr Dunnings' demeanour and actions during and after his final ACCT review on 7 July, his repeated statements that he intended to take his life and staff's consideration that his risk was raised, we are concerned that his observations remained unchanged at one an hour throughout the day and night. We consider that this was too low and did not reflect his risk. Although it is unlikely that Mr Dunnings would have met the criteria for being placed under constant watch as he had not self-harmed since he was subject to ACCT monitoring, there is no evidence that anyone considered raising the level of his observations.

174. Coldingley's local practice is to check all prisoners in the segregation unit hourly. This was the same frequency that Mr Dunnings was being checked at the time of his death and at certain points during his time in segregation. We are concerned

that Mr Dunnings was not checked more frequently as he was subject to ACCT monitoring and required closer monitoring than provided for in the routine regime. We accept that there might be times when a prisoner subject to ACCT monitoring in the segregation unit might only need to be assessed once an hour. However, even in such cases, these checks should be in addition to the routine segregation checks.

175. Many of the checks on Mr Dunnings were carried out at regular intervals, contrary to PSI 64/2011 which requires ACCT observations are conducted at unpredictable intervals. This would have allowed Mr Dunnings to predict when the next check would be. The frequency of checks did not consistently reflect the number of checks required.

Family involvement in ACCT

176. PSI 64/2011 requires staff to encourage prisoners subject to ACCT procedures to communicate with their families and to consider involving the family in the ACCT process, including inviting the prisoner's family to case reviews. It was suggested to Mr Dunnings at an ACCT review on 21 June that he might want to involve his family in the ACCT process. On 1 July, Mr Dunnings gave his consent to do so but despite an internal email about this, there is no evidence that anyone took steps to involve Mr Dunnings' family in the ACCT process, particularly during the week before his death.

177. We accept that it will not always be easy for prisons to facilitate family involvement but Mr Dunnings had regular contact with his family and received frequent visits from them and friends. Their knowledge of Mr Dunnings might have helped staff make better informed decisions about him.

General conclusions about ACCT procedures

178. Staff judgement is fundamental in operating ACCT procedures. The system relies on staff using their experience and skills, as well as local and national assessment tools to determine risk. While a prisoner's presentation is important and reveals something of their level of risk, it is only a reflection of their state of mind at the time and should be considered as a single piece of evidence when judging risk. Staff should consider all risk factors to ensure that a prisoner's level of risk is judged holistically. We consider that staff did not interact effectively to identify Mr Dunnings' issues, needs and risk which would have provided him with relevant support in the weeks leading to his death. We cannot know whether better ACCT procedures and more effective interventions would have prevented Mr Dunnings' actions but more should have been done to ensure that he received appropriate support. We make the following recommendation:

The Governor should ensure that staff manage prisoners at risk of suicide or self-harm in line with national guidelines. In particular, that:

- **Prisoners assessed as at risk of suicide or self-harm are not held in the segregation unit unless all other options have been considered and excluded. A senior manager of a governor grade should record the exceptional circumstances for segregation.**

- **Case reviews are multidisciplinary and include all relevant people involved in a prisoner's care, including mental health staff, where appropriate, and healthcare staff attend all first case reviews.**

- **Staff read the ACCT document and familiarise themselves with all relevant issues and known risk factors before holding reviews, and ACCT case reviews should assess and record the level of risk, considering all risk factors.**

- **Caremap actions, are specific, meaningful and time-bound, aimed at reducing prisoners' risks and review them at each case review.**

- **The frequency of observations should reflect the prisoner's risk and be adjusted when that risk changes. Staff should check on prisoners, who are subject to ACCT procedures, at unpredictable intervals and record their observations.**

- **The Governor should ensure that ACCT case managers consider involving the prisoner's family in the ACCT process and understand the procedures to do so.**

- **The Governor should ensure that there are procedures in place to check the quality of ACCT procedures, identify bad practice, learn lessons, and where appropriate, provide staff refresher training on ACCT procedures.**

Re-categorisation issues

179. Mr Dunnings' security category status was reassessed because of the incidents in which he was involved on 14 June. On 21 June, he was re-categorised as a Category B prisoner. We have identified a number of significant failings in the way that Coldingley managed Mr Dunnings' re-categorisation.

180. PSI 40/2011 on categorisation and re-categorisation requires staff and other professionals who know a prisoner best to contribute to the categorisation assessment. This might include reports from the personal officer, offender supervisor and healthcare team.

181. PSO 4700 on indeterminate sentences says that if staff are considering whether to raise a prisoner's security category, there should usually be a review of probation records, and where time allows, a review board should be held, with reports submitted from the offender supervisor and security department to highlight any concerns and reasons for considering a higher security category. The PSO states that in the case of IPP prisoners, the offender manager should chair the review board or at least be consulted about the decision.

182. The Deputy Governor of Coldingley and a custodial manager's accounts of the management meeting of 16 June differ: The Deputy Governor told the investigator that he had asked the manager to review Mr Dunnings' categorisation. The manager said that it had been agreed in the management meeting that Mr Dunning would be re-categorised to Category B and that he had

been tasked with completing the paperwork, which he did on 20 June, and sent to the Deputy Governor for approval. The Deputy Governor in turn forwarded it to another manager, with a covering email which said, "I feel Mr Dunnings would be more suitable in a more secure environment…" Although the wording of the email could be interpreted as a request for Mr Dunnings to be re-categorised, the Deputy Governor told us that his understanding was that the recommendation for re-categorisation would be assessed at a review board. The manager signed the paperwork, drafted by the custodial manager, and forwarded it to her manager, who authorised Mr Dunnings' re-categorisation.

183. We are very concerned that contrary to national requirements, no-one sought reports about Mr Dunnings' re-categorisation from relevant parties, including his offender supervisor. Coldingley did not hold a review board to consider his re-categorisation, as they should have. We note that although Mr Dunnings' disciplinary charge for barricading his cell was quashed, no further review of his security re-categorisation was considered, even though the barricade incident was one of the main reasons for his re-categorisation.

184. PSI 40/2011 requires categorisation assessments to be made using the appropriate forms. Although the custodial manager completed the correct form, the information was transferred to an old re-categorisation form. The other manager signed the re-categorisation paperwork although she had no input into re-categorising Mr Dunnings. While these actions had no significant impact, they indicate the confusion about the re-categorisation process.

185. PSI 40/2011 states that the re-categorisation process should be open and that prisoners must be able to understand why they have been re-categorised. PSO 4700 states that prisoners must be told in writing the reasons and evidence for raising their security category, as must the offender manager. The PSO also states that IPP prisoners must be given written notification of their right to make representations about the decision to raise their security category.

186. At his ACCT review on 28 June, Mr Dunnings was told that he was being considered for re-categorisation. This was not correct as he had been re-categorised seven days earlier, and should have been told then. It was only on 7 July, the day before his death, that Mr Dunnings was told that he had been re-categorised. Staff did not consider the impact of this news on him during his ACCT review even though re-categorisation was likely to have a negative effect on Mr Dunnings' chances of parole.

187. In the weeks leading to his death, Mr Dunnings told staff many times about his concerns about being transferred from Coldingley, his IPP sentence, re-categorisation and how his actions might impact on his parole. Despite repeatedly seeking clarification about all these issues, staff, including managers, failed to be open and transparent with Mr Dunnings about his change in circumstances and to provide him with an honest answer to his questions and concerns. It appears that this added to Mr Dunnings' uncertainty about his future and his feeling that staff were not telling him the truth.

188. It is of great concern that Mr Dunnings was never formally told in writing or verbally that he had been re-categorised to Category B or told of the appeal process. Prisoners subject to IPP sentences are particularly vulnerable to

experiencing stress and uncertainty. It is of the utmost importance that prisoners are provided with accurate and up to date information about decisions taken about them.

189. We are very concerned that Coldingley did not implement the required procedures when considering Mr Dunnings' re-categorisation. We make the following recommendation:

The Governor should ensure that staff understand and follow the procedures for the re-categorisation of prisoners, inform them of decisions and reasons for re-categorisation and provide them with information about the appeal process.

Segregation Issues

190. PSO 1700 on segregation requires that Mr Dunnings should have had a mental health assessment within 24 hours of ACCT monitoring starting. This did not happen. The first contact Mr Dunnings had with the mental health nurse was on the morning of 16 June during what appears to have been a routine visit.

191. Coldingley's safer custody policy dated December 2016 states that before a prisoner is located in the segregation unit, a senior manager of governor grade and a member of healthcare must sign the algorithm to confirm that a prisoner is fit to be located there. Although a nurse had signed a segregation algorithm when Mr Dunnings was segregated on 14 June and before he was subject to ACCT procedures, no algorithm was considered again or completed after ACCT procedures started. It was not until 16 June that the segregation unit algorithm was completed.

192. PSO 1700 requires that an initial segregation review board is 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 among others, consist of a chairperson, segregation officer and, where relevant, the ACCT case manager. It is a requirement for a healthcare representative to attend. PSO 1700 says that the review board should ensure that there are exceptional circumstances why a prisoner managed under ACCT procedures is segregated, and that particular care should be taken when authorising the continued segregation of a prisoner subject to ACCT monitoring.

193. Mr Dunnings' first segregation review of 16 June did not consider whether there were health reasons why Mr Dunnings should not be segregated, although he was being managed under ACCT procedures. There is no evidence that a custodial manager who chaired the review considered or recorded whether there were continuing exceptional circumstances to justify his segregation. There is no evidence that concerns about Mr Dunnings' mental health or risk of suicide and self-harm were considered and the ACCT case manager was not present at the review board.

194. Following Mr Dunnings' 72-hour segregation review, a further review was scheduled for 29 June. We consider that this was too long a period, bearing in mind that Mr Dunnings was subject to ACCT procedures and to prison

disciplinary procedures. It would have been good practice for further segregation reviews to have taken place when Mr Dunnings was re-categorised on 21 June and when his adjudication was quashed on 4 July. We are concerned that a 72-hour review was not held, as required, after Mr Dunnings' reason for segregation changed on 4 July.

195. We are concerned that important safeguards for segregated prisoners at risk of suicide and self-harm were not implemented. In our Learning Lessons Bulletin about segregation, we found that, when there are exceptional reasons to justify the segregation of a prisoner at risk of suicide and self-harm, the additional mandatory safeguards of PSO 1700 should be followed, including holding a mental health assessment within 24 hours. Staff should consider a prisoner's fitness for segregation at segregation review boards and base their decisions on the prisoner's full mental health history and other relevant factors that might compromise their ability to cope. Segregation review boards should be held more frequently than the minimum requirement for prisoners subject to ACCT monitoring. We make the following recommendation:

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

- **A mental health assessment is carried out within 24 hours whenever ACCT procedures are started for a prisoner in the segregation unit.**
- **Segregation algorithms are completed when prisoners in segregation become subject to ACCT procedures.**
- **Segregation review boards include the ACCT case manager when a prisoner is identified as at risk of suicide and self-harm. The review chair should consider and record whether there are exceptional reasons to authorise continuing segregation.**
- **All attendees at segregation reviews understand the purpose of the review and be confident about challenging continued segregation when they have concerns about a prisoner's vulnerability.**
- **Healthcare representatives at segregation reviews are fully briefed about relevant aspects of the prisoner's health needs and where possible, should be the person responsible for the individual's care.**
- **Segregation review boards are held more frequently than the minimum requirement for prisoners subject to ACCT procedures.**
- **Authorisation for segregation is completed promptly and accurately, and set out in full the reasons for the decision.**

Healthcare Issues

196. The clinical reviewer highlighted numerous failings in Mr Dunnings' clinical management at Coldingley, including the management of Mr Dunnings' diagnosis, prescription of medications, mental healthcare and the organisation and communication between healthcare disciplines. He concluded that the care Mr

Dunnings received was not equivalent to that which he could have expected to receive in the community. The Head of Healthcare will need to address the clinical reviewer's numerous recommendations.

Diagnosis and treatment plans

197. The clinical reviewer noted that although Mr Dunnings' mental health was reviewed in December 2016, he was not diagnosed with anxiety and personality disorder until May 2017 when plans were made to address his needs. He reported that when a plan was eventually made for Mr Dunnings, few of the recommendations were subsequently taken forward. The clinical reviewer concluded that the many months it took to diagnose and develop a care plan could have been shortened, allowing Mr Dunnings to access appropriate care sooner.

The Head of Healthcare and the Mental Health Team should ensure that all patients with mental health problems are assessed promptly in line with National Institute for Health and Care Excellence (NICE) guidance and a written care management plan is developed and actioned.

Medication

198. Mr Dunnings had tried numerous antidepressants at Coldingley and experienced differing levels of side effects. The healthcare team regularly offered him alternative medications, and sometimes re-prescribed the same medication. However, the clinical reviewer noted that Mr Dunnings did not tolerate any of the prescribed medication well, and he was not prepared to take them for long enough to experience any therapeutic benefit. He noted that his non-compliance was often not properly assessed, and was not, for example, reviewed by a GP, as it should have been.

199. The clinical reviewer noted that all the medications prescribed to Mr Dunnings were appropriate to manage his anxiety and depression. However, given the number of medications that Mr Dunnings was prescribed (which were either not tolerated or ineffective), we are concerned that this was not always brought to the attention of his supervising clinicians and when it was, medical reviews did not always follow. The clinical reviewer concluded that it might have been better for staff to have focussed on psychological interventions.

200. While the clinical reviewer recognises concerns about the illicit use and trading of pregabalin in prisons, he also refers to the NICE guidance of 2011 which acknowledges that pregabalin might be appropriate to prescribe when other antidepressants cannot be tolerated.

201. Mr Dunnings was prescribed pregabalin for four weeks so that he could complete his RESOLVE course. The clinical reviewer noted that pregabalin might have been of some benefit to him but his prescription was never reviewed.

202. The clinical reviewer noted that Mr Dunnings needed tailored mental health support which he never received. He reported that healthcare staff relied on conversations between different healthcare teams, and there is no evidence to indicate that mental health referrals were made or followed up and that care

management plans were monitored. Although he noted a good working relationship between GPs, healthcare and mental healthcare services, the arrangements were informal and there were few structured multidisciplinary team meetings. He noted that prison GPs never met to review care and learn lessons. He concluded that informal conversations should be supplemented with clinical notes which would clarify what progress had been made against management plans. We make the following recommendation:

The Head of Healthcare should ensure that:

- **GPs review prisoners' prescriptions when appropriate to ensure that their medication needs are addressed; and**
- **Healthcare staff regularly meet to review patient care, including holding multidisciplinary meetings, where appropriate.**

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