Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Lee Davis, a prisoner at HMP Wakefield on 5 November 2018

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 Lee Davis was found dead on 5 November 2018 in his cell at HMP Wakefield of amitriptyline toxicity and cardiomegaly (an enlarged heart). He left letters saying that he had taken his life. Mr Davis was 44 years old. I offer my condolences to Mr Davis' family and friends.

Mr Davis had been in prison since 2013. He had attempted suicide several times during his first two years in prison and was intermittently managed under self-harm and suicide prevention procedures until February 2015. After that, Mr Davis regularly told staff that he had thoughts of suicide and would not leave prison alive. He was not considered to be in crisis, however, and staff did not assess that any risk he posed to himself was imminent.

I am satisfied that staff had no reason to consider that Mr Davis' risk to himself had increased in the weeks before his death and that they could not have foreseen his death.

I am, however, concerned that Mr Davis was not reviewed by mental health services for the last five months of his life because the staff who were treating him were absent. This may mean that a deterioration in his mental state was not picked up.

There were also instances when Mr Davis was assaulted and there is no evidence that this was fully investigated or that Mr Davis was supported appropriately.

I am also concerned that officers did not radio an emergency medical code until four minutes after Mr Davis was seen lying unresponsive on the floor of his cell. Although this did not affect the outcome in Mr Davis' case, as he had been dead for some time, it could make a critical difference in other emergency situations.

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

Sue McAllister, CB
Prisons and Probation Ombudsman **November 2019**

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Summary

Events

1. Mr Lee Davis was remanded into custody in June 2013, charged with serious sexual offences. In September, Mr Davis pleaded guilty. In December, he was sentenced to life imprisonment with a tariff of 12 years 6 months, which was later reduced to eight years on appeal. He was transferred to HMP Wakefield on 17 July 2014.

2. Mr Davis had a long-term degenerative spinal condition which caused him constant pain.

3. He had a history of attempting suicide in the community and in custody. In prison he was twice found hanging by staff, took an overdose, and was found with a plastic bag over his head. He was intermittently subject to Prison Service suicide and self-harm prevention procedures, known as ACCT, in the first two years of his sentence, most recently in February 2015.

4. After this, Mr Davis continued to tell both prison and healthcare staff that he had thoughts of suicide, that he did not think he would be released from prison and that, if he did attempt suicide, it would be an impulsive act and he would not tell anyone in advance. Several different members of staff recorded that they did not assess that Mr Davis was in crisis or at imminent risk and therefore did not open an ACCT.

5. In April 2017, Mr Davis was seriously assaulted by another prisoner. He was subsequently diagnosed with post-traumatic stress disorder (PTSD) as a result of the assault. He was prescribed antidepressants and was regularly reviewed by the mental health team until May 2018, when his mental health nurse, psychiatrist and psychologist had either ceased working at the prison or were away on long-term sick leave. Mr Davis' case was not reallocated to another member of the mental health team until November, only a few days before he died. A nurse did attempt to see him then but was unable to do so because a full lock-down search of the wing was being carried out at the time.

6. Some prisoners said that Mr Davis had told them he was being bullied by other prisoners in the months before his death, and that he had spoken to staff about this. Staff the investigator spoke to said they were unaware of this.

7. On 5 November, at 5.10am, during her routine roll check, an officer observed that Mr Davis was lying on the floor of his cell. She was unsure whether he was sleeping so called another officer for a second opinion. This officer then radioed for a supervising officer to attend. All three officers went into the cell and concluded that Mr Davis had been dead for some time. They therefore did not attempt resuscitation. They called an emergency code, paramedics arrived and pronounced Mr Davis dead at 5.41am.

8. After his death, staff found letters indicating that Mr Davis had intended to take his own life.

9. The post-mortem report concluded that, in the absence of a more compelling explanation, Mr Davis had died from amitriptyline toxicity and cardiomegaly (enlarged heart). The pathologist suggested that the cardiomegaly may have rendered Mr Davis more susceptible to the toxic effects of amitriptyline, a medication he had been prescribed for back pain.

Findings

Assessment of risk

10. Mr Davis was assessed as presenting a risk to himself several times between June 2013 and February 2015 and was made the subject of ACCT monitoring. Although he repeatedly told staff he had thoughts of suicide after this time, they assessed that he was not an imminent risk to himself and therefore decided not to open an ACCT.

11. We have concluded that this was reasonable in the circumstances. Mr Davis' risk was unchanging over a very long period and it would have been oppressive and counter-productive to have monitored him under ACCT procedures for years.

12. We are satisfied that he gave staff no reason to believe he was at imminent risk of suicide in the weeks before his death.

Violence reduction

13. Mr Davis was assaulted by other prisoners twice while at Wakefield: seriously in April 2017 and less seriously in May 2018. We are not satisfied that he was adequately supported following these incidents.

Clinical care

14. The clinical reviewer concluded that while Mr Davis' physical healthcare was equivalent to that which he could have expected to receive in the community, his mental healthcare was not.

15. There was an interruption in his mental health provision from May 2018 onwards because his care was not reallocated to other staff when those treating were unavailable. We cannot say if his mental health deteriorated during this period.

16. The clinical reviewer also recommended that the use of risk assessments by mental health staff be updated and standardised.

Emergency response

17. We are satisfied that it was reasonable in the circumstances for two officers not to enter Mr Davis' cell when they saw him lying unresponsive on the floor.

18. However, we consider that they should have radioed a medical emergency code when they could not get a response from Mr Davis, without waiting for other staff to arrive. Not doing do led to a four-minute delay before healthcare staff were alerted and before an ambulance was called. Although this made no difference in Mr Davis' case, as he had clearly been dead for some time when he was found, such a delay could be critical in other emergency situations.

Recommendations

- The Governor should ensure that all information indicating bullying and intimidation is fully coordinated and investigated in line with national and local policies.

- The Governor and Head of Healthcare should ensure that:
  - the caseloads of healthcare staff are reallocated in a timely manner when staff leave the prison; and
  - healthcare staff use appropriate risk assessments when assessing a prisoner's risk to themselves.

- The Governor should remind staff that, if they are in any doubt about the nature of a medical emergency, they should act with caution and call a medical emergency code.
- The Governor and Head of Healthcare should ensure that any staff named in this report are given the opportunity to read the report at the draft stage in line with paragraph 1.11 of PSI 58/2010.

The Investigation Process

19. The investigator issued notices to staff and prisoners at HMP Wakefield informing them of the investigation and asking anyone with relevant information to contact her. Several prisoners contacted the investigator and she later interviewed them.

20. The investigator visited Wakefield on 7 November. She obtained copies of relevant extracts from Mr Davis' prison and medical records.

21. The investigator interviewed eight members of staff and seven prisoners at Wakefield in November 2018 and January 2019. (She was not able to interview the prison psychiatrist, psychologist and named mental health nurse who treated Mr Davis as the psychiatrist no longer works at the prison and the psychologist and nurse were both on long-term sick leave.)

22. NHS England commissioned a clinical reviewer to review Mr Davis' clinical care at the prison. The clinical reviewer conducted some joint interviews with the investigator.

23. We informed HM Coroner for West Yorkshire of the investigation. He gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.

24. We contacted Mr Davis' wife to explain the investigation and to ask whether she had any matters she wanted the investigation to consider. She did not respond.

25. Mr Davis' wife received a copy of the initial report. She did not make any comments.

26. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.

Background Information

HMP Wakefield

27. HMP Wakefield is a high security prison and holds up to 750 men. There are four main residential wings, a healthcare centre, a segregation unit and a close supervision centre (a small unit aiming to provide a supportive, safe, structured and consistent environment for some of the most challenging offenders). Care UK provides healthcare at Wakefield.

HM Inspectorate of Prisons

28. The most recent inspection of HMP Wakefield was carried out in June 2018. Inspectors reported that the prison was calm, and the inspection was a positive one. The quality of ACCT documents was generally good and quality assurance processes were sound. Staff-prisoner relationships were generally good and enhanced by the keyworker scheme. Overall living conditions and health services were good.

Independent Monitoring Board

29. 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 April 2018, the IMB reported that the prison continued to provide a regime that is just, consistent and inclusive despite the pressures on HMPPS. The IMB reported that levels of violence were relatively low and investigated properly. ACCT documentation was generally good, as were health services.

Previous deaths at HMP Wakefield

30. Since 2016, there have been 20 deaths due to natural causes at Wakefield. Mr Davis' death was the first self-inflicted death during that time. Previous investigations raised no issues that are significant to this investigation.

Assessment, Care in Custody and Teamwork

31. ACCT is the care planning system the Prison Service uses to support prisoners at risk of suicide or self-harm. The purpose of the ACCT is to try to determine the level of risk posed, the steps that staff might take to reduce this and the extent to which staff need to monitor and supervise the prisoner. Checks should be done at irregular intervals to prevent the prisoner anticipating when they will occur. Part of the ACCT process involves assessing immediate needs and drawing up a caremap to identify the prisoner's most urgent issues and how they will be met. Staff should hold regular multidisciplinary reviews and should not close the ACCT plan until all the actions of the caremap are completed.

32. Enhanced case management can be used to support prisoners whose behaviour is so challenging and disruptive that they need additional case management in order that their heightened or exceptional risk of harm to self, others and/or from others is managed. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011, *Management of prisoners at risk of harm to self, to others and from others (Safer Custody)*.

Key Events

June 2013 – July 2014, HMP Doncaster

33. In June 2013, Mr Davis was arrested for serious sexual offences. He was remanded into custody and taken to HMP Doncaster.

34. Mr Davis had a long-term degenerative spinal condition (for which he was prescribed medication) and he was registered disabled. He also had urinary incontinence as a result of his spinal condition.

35. When he arrived at Doncaster, Mr Davis told staff he had had suicidal thoughts in the past but had none at present. Staff started Prison Service suicide and self-harm prevention measures, known as ACCT, which were closed the next day.

36. Mr Davis told a GP that he wanted to continue being prescribed buprenorphine patches (an opioid used to treat chronic pain), as he had been in the community. As an alternative, the GP prescribed tramadol (a painkiller). The GP also prescribed Mr Davis venlafaxine (an antidepressant). Mr Davis' was not permitted to hold this medication in his own possession and it was dispensed daily under the supervision of a nurse.

37. Mr Davis said he would kill himself if he was not prescribed buprenorphine patches. Staff opened an ACCT. Mr Davis said that he had felt suicidal ten years earlier and had taken an overdose 20 years ago. He said he was in constant pain with his back which made him depressed. Healthcare staff told Mr Davis that he had to see whether tramadol was effective before they considered prescribing him buprenorphine (which is widely abused and traded in prisons). The ACCT was closed the following day.

38. In July, staff found Mr Davis with a plastic bag over his head. This was removed and Mr Davis said he would always have thoughts of suicide but that these increased when he was in pain. He said he would not tell anyone if he intended to take his own life. Staff opened an ACCT. Mr Davis later told a doctor that he was still in pain so a GP prescribed dihydrocodeine (a painkiller). On 30 July, Mr Davis declined mental health input saying his issues were related to his back pain. He said he wanted to die and would probably do so in prison.

39. In September, Mr Davis was found hanging in his cell. He remained conscious and was cut down. Mr Davis again said he wanted to die.

40. On 27 September, he appeared at court and pleaded guilty. In October, Mr Davis was prescribed amitriptyline (a painkiller) for his back condition. On 2 December, he was sentenced to life imprisonment with a tariff of twelve years and six months. On 17 December, staff assessed that Mr Davis no longer presented a risk of harm to himself and closed his ACCT.

41. Mr Davis subsequently told his offender supervisor that he felt hopeless about his future. He said he would always be a suicide risk but he had no such thoughts currently and thinking about his son prevented him from considering it at present.

42. In May 2014, staff found Mr Davis in his cell with a ligature attached to his bed and a plastic bag. He had written a message saying, "*Do not resuscitate*". He

told staff that he had taken an overdose the day before but had not told anyone. Mr Davis said that he had attempted suicide due the pain in his stomach and back. Mr Davis' tariff was subsequently reduced to eight years by the Court of Appeal. On 19 May, staff closed his ACCT. Mr Davis said he was planning for the future and no longer had suicidal thoughts.

17 July 2014 onwards, HMP Wakefield

43. On 17 July, Mr Davis transferred to HMP Wakefield. On 4 February 2015, staff found sketches of a person hanging himself. They opened an ACCT. The next day, Mr Davis told staff that he thought about suicide every day. Mr Davis said he believed he would attempt suicide again, nothing could stop him, and he did not want to be released from prison. He told staff he was in constant pain and was upset that he was not getting the correct pain medication. On 11 February, a GP reviewed Mr Davis. He substituted his prescription of tramadol with buprenorphine patches. Mr Davis' ACCT was closed on 13 February.

44. On 24 May 2016, Mr Davis said he was not motivated to complete an offending behaviour course as he did not want to be released from prison because of his back pain. He told staff that he did not think he would benefit from any programmes as he would not reoffend. Mr Davis was employed on the prisoner information desk and as a mentor to older prisoners.

45. At hospital, Mr Davis was given regular MRI scans of his spine to check for any deterioration in his condition. On 30 November, staff noted that there was no worsening but that he still had chronic lower back pain. They continued to regularly review his symptoms and pain management.

46. On 29 January 2017, Mr Davis spoke to his personal officer. (This is an allocated officer who should be a prisoner's first point of contact.) He told him that he did not see the point in doing any offending behaviour programmes as he had received a life sentence. On 27 February, staff held a sentence planning board with Mr Davis who again said he was not ready to complete any offending behaviour programmes. On 22 March, he told staff that he was considering having a 'do not resuscitate' order (or DNACPR), given his health issues. He said he had no thoughts of suicide or self-harm. On 26 April, he discussed the potential DNACPR order with a GP who agreed to liaise with the legal team.

47. On 29 April, another prisoner attempted to strangle Mr Davis with a cord. Mr Davis alerted staff by ringing his cell bell. Mr Davis had lost consciousness and had prominent marks around his neck and associated injuries. The other prisoner was segregated and later pleaded guilty to attempted murder. Mr Davis declined to go to the healthcare unit for observation. He was reviewed by a GP and a nurse over the following days. Mr Davis told staff that he had been attacked because he had refused to give the other prisoner his buprenorphine patch (which can be abused by prisoners as an opiate substitute).

48. The Deputy Regional Manager for Care UK, was Head of Healthcare at the prison at the time. She spoke to Mr Davis shortly after the attack. They discussed the prescription of his patch and re-locating it elsewhere on his body so that other prisoners did not know where it was. Mr Davis agreed to this.

49. An officer told the investigator that Mr Davis was, understandably, more nervous in the months that followed the attack. The officer said that Mr Davis then seemed to recover and appreciated that the assault was not personal but an attempt to acquire his medication. The officer also said that Mr Davis was forthright in identifying problems on the wing while being much more private when it came to his own issues.

50. On 3 May, Mr Davis said it was "too early" in his sentence to be assessed for an offending behaviour programme. On 23 May, he said that he would attempt suicide if he was ever given his medication in his own possession. On 28 June, Mr Davis was given an MRI scan on his brain at hospital. The results were normal. He said he still suffered from back pain which radiated to his legs. The GP referred Mr Davis to the hospital's musculoskeletal service.

51. On 28 July, staff submitted an intelligence report indicating that they believed Mr Davis was in approximately £400 of debt to drug suppliers in the prison. They recorded that Mr Davis had been told by other prisoners that if he handed over one of his buprenorphine patches, it would reduce his debt by £100. Mr Davis had agreed but said he would have to make it look as if it had been stolen from him during an assault. The intelligence report indicates that this is what had occurred on 29 April.

52. On 4 October, Mr Davis asked to see a mental health nurse. A nurse assessed him the next day. Mr Davis said he felt "low" much of the time and found work and socialising increasingly difficult. He said he only slept for around 13 hours each week and had flashbacks to being strangled. Mr Davis said his mood and anxiety had worsened since he had been attacked and he thought nothing would help him. Mr Davis told the nurse that he frequently thought about suicide and had done so since being in prison. The nurse discussed opening an ACCT with Mr Davis but he said that he was not in crisis and needed long-term management instead. He said that he would spend the rest of his time in prison in his cell if he was allowed to. Mr Davis agreed to be assessed by a psychologist.

53. On 8 October, a nurse reviewed Mr Davis. He said he had no plans to harm himself. He told the nurse he would consider talking his own life if his health deteriorated, particularly if he needed a wheelchair. The nurse noted that staff should consider opening an ACCT if Mr Davis' health deteriorated further. On 11 October, a GP noted that he would follow-up Mr Davis' musculoskeletal referral.

54. On 17 October, a psychiatrist assessed Mr Davis. Mr Davis told him that he was having nightmares since being attacked and wanted to remain locked in his cell. Mr Davis said he had thoughts of self-harm. The psychiatrist increased Mr Davis' prescription of amitriptyline. The psychiatrist noted that he should be assessed by a psychologist or nurse regarding his fear.

55. On 31 October, a nurse assessed Mr Davis. Mr Davis said he had thought of two methods of killing himself but did not know when he would act on these thoughts. He said it might be "tomorrow or in two years". He said he did not want to be subject to an ACCT as he was not in crisis. The nurse noted that Mr Davis would remain on her caseload and that she had referred him to a psychologist.

56. On 15 November, Mr Davis was reviewed by the musculoskeletal service at a hospital. Specialists recorded that his back condition had not deteriorated and his neurological examination showed some improvement. Mr Davis did not need a further appointment. He was offered physiotherapy but did not attend.

57. On 22 November, Mr Davis told staff that he wished to be assessed for the Horizon programme (a sex offender treatment programme). On 7 December, staff held a sentence planning review meeting with Mr Davis. This was to consider whether Mr Davis should be referred to the Parole Board for review before his tariff expired. Staff noted that he was not interested in any of the recommendations made or the pathway they had identified to assist his progress in prison. However, they also noted that he wanted to be assessed for the Horizon programme. Mr Davis said that it was too early in his sentence to complete any programmes but he would comply with assessments. Staff noted that Mr Davis was a polite and respectful prisoner who complied with all the rules and enjoyed assisting other prisoners.

2018

58. On 10 January 2018, a psychologist assessed Mr Davis. He told her that he was not sleeping well and had nightmares. She recorded that Mr Davis had PTSD, that he was hopeless, had no interest in life and would “sooner be dead”. He was in constant pain which contributed to his suicidal thoughts. Mr Davis said that he “had things in place already” but did not want to disclose details. Her plan for his treatment was to address his PTSD and increase his motivation to build a life worth living. They met again on 17 January, when she noted that Mr Davis was continuing to struggle.

59. On 18 January 2018, HM Prison and Probation Services (HMPPS) wrote to Mr Davis. The letter indicated that as Mr Davis had not completed any behavioural work, his first Parole Board hearing would be held in April 2021.

60. On 19 January, a mental health nurse assessed Mr Davis. He told her that he had suicidal thoughts but no urges to act on them. (The investigator was unable to interview the nurse because she was on long-term sick leave.) On 25 January, a prison GP reviewed Mr Davis. The prison GP noted that Mr Davis’ mood was “not so good” because of his back pain and lack of hope for the future. He increased Mr Davis’ prescription of venlafaxine and noted that he would review him again in three months. The prison GP left the prison soon after this.

61. On 31 January, a psychologist, reviewed Mr Davis. They discussed his symptoms of PTSD. He told the psychologist that he had no suicidal thoughts. The mental health nurse continued to review Mr Davis monthly.

62. On 7 March, Mr Davis told a psychologist, that he was ambivalent about being alive. The psychologist noted that Mr Davis’ pain management was a priority as it affected his mental well-being. On 12 March, a GP reviewed his back pain. He noted that Mr Davis had no new symptoms and agreed a short-term increase in his buprenorphine prescription.

63. On 11 April, staff submitted an intelligence report saying that Mr Davis had told an officer there was a major problem on B wing with psychoactive substances

(PS) being sprayed onto paper. He did not know who was supplying but he was concerned about the wing's stability.

64. On 4 May, a prison GP reviewed Mr Davis. They discussed his suicidal thoughts caused by his pain. The GP discussed the possibilities of different medication with Mr Davis and increased his prescription of amitriptyline.

65. The same day, staff submitted an intelligence report recording that they had witnessed another prisoner punch Mr Davis. They thought this might be connected with him informing staff about the availability of drugs on the wing.

66. On 23 May, Mr Davis told a mental health nurse that he felt suicidal daily and if he took his own life he would do so on impulse.

67. On 23 June, an officer introduced himself to Mr Davis as his keyworker and explained that he would meet with him every two weeks. (Keyworkers have replaced personal officers as a prisoner's first point of contact. Each key worker is responsible for five or six prisoners and is expected to have a meaningful conversation with each of them at least once every two weeks.)

68. On 25 June, the Reverend from the Chaplaincy spoke with Mr Davis. He told Mr Davis that he had noticed that he seemed low. Mr Davis said he did not have much hope due to his health issues. He also said that he felt scared after 5.00pm so preferred to be locked in his cell by then. Mr Davis said that he had no thoughts of suicide. They spoke about his son and Mr Davis hoped their relationship could be restored in time.

69. On 27 June, staff submitted an intelligence report that during an assessment for the Horizon course, Mr Davis said he had ongoing suicidal thoughts. He said that if he decided he no longer wanted to participate in Horizon, and wanted to take his own life, he would do so without telling anyone. Mr Davis said that he had considered killing himself once he was released so that he would not be a burden to his son. Staff recorded the information in the wing observation book and told the wing supervising officer. Staff recorded that they did not open an ACCT as they did not assess that Mr Davis was an imminent risk to himself as he had been speaking in a general way rather than about any specific plans he had.

70. On the same day, Mr Davis asked the mental health nurse whether a lack of oxygen to his brain at the time of the attack on him in April could have affected his memory as he was having difficulties recalling some words. The nurse referred him for a GP review.

71. On 9 July, an officer spoke to Mr Davis who said he was not interested in doing any programmes as they were "a waste of time" and that he had no interest in the keyworker scheme. The officer said that he would nevertheless continue to see Mr Davis regularly and try to assist his sentence progression.

72. On 19 July, a prison GP assessed Mr Davis' cognition issues. He concluded that they were likely to be caused by Mr Davis' medication and mood. He referred Mr Davis for a CT scan. On 1 August, Mr Davis was assessed as being suitable for the Horizon programme.

73. On 7 September, a nurse spoke to Mr Davis as he had appeared “flat” over the previous week. He said his back was sore, so the nurse referred him for physiotherapy which he later refused. Mr Davis told the nurse that he continued to have flashbacks of being attacked.

74. Prisoners and staff all said that Mr Davis was a very polite and helpful prisoner who would go out of his way to assist others. Over the years, Mr Davis would sometimes lock himself in his cell earlier than was required during the afternoon, particularly at weekends. Prisoners said that they thought Mr Davis did this as he needed some ‘space’, felt physically more comfortable when lying down and felt stressed when he was out of his cell.

75. A prisoner said that Mr Davis told him that he would not finish his sentence and he would “be gone” before that. The prisoner said Mr Davis sometimes felt down due to his offence and what he had subjected his family to. A second prisoner said he had known Mr Davis at Doncaster before they were both transferred to Wakefield. He said that sometimes Mr Davis would feel “on a downer” due to the length of his sentence.

76. A third prisoner said that around mid-September, Mr David told him that he was being bullied by other prisoners, who he named. He told the investigator that he passed this information on to an officer. The officer told the investigator that he was not aware of Mr Davis being bullied and no one had approached him about this before Mr Davis died.

77. Other prisoners said that some prisoners resented Mr Davis being paid more than them and that others pressured him for more food at the servery, or other prisoners’ canteen. They said they did not consider that Mr Davis was a risk to himself.

78. An officer said he was not aware of Mr Davis being pressured at the servery. He said there was always an officer standing there so he did not think there was a problem. No other staff said they were aware of Mr Davis being bullied or pressurised.

79. On 2 October, a prison GP noted a request for a hospital bed to assist with Mr Davis’ pain management. The GP indicated that she would discuss the request with the Head of Healthcare, as well as speaking to a doctor about a referral to the pain clinic. She planned to review Mr Davis once she had this information.

80. On 3 October, Mr Davis was given a warning as he had given the wing cleaners their canteen (shop) orders early. He did not provide an explanation for his behaviour when asked.

81. On 13 October, Mr Davis rang his wife and son, as he did regularly. The investigator listened to a recording of the call. Mr Davis said that the prison was “okay” and quite calm. He said he was trusted by a lot of prisoners and staff and was trying to keep himself busy. Mr Davis asked his wife how his son was doing. They discussed the possibility of their son visiting him in prison and how Mr Davis’ release would affect his son. Mr Davis told his wife that he did not want to put his son “through it” and said that if he took his own life, he believed that his

son and wife would “be free”. They also discussed Mr Davis’ offences at length, and he said he felt most upset for the impact they had had on his family.

82. On 22 October, Mr Davis was discussed at a multidisciplinary meeting and was added to the Improving Access to Psychological Therapies (IAPT) waiting list for individual psychological input with a case worker.

83. On 27 October, an officer met Mr Davis who said he was enjoying his job on the wing, had no issues with other prisoners, was taking his medication, and did not need any assistance with anything. Mr Davis also spoke to his wife and son and gave them no cause for concern.

84. On 30 October, an offender supervisor spoke to Mr Davis about his sentence plan. Mr Davis was awaiting a place on the Horizon course.

85. A prisoner said that, around this time, Mr Davis told him that he was stressed by the volume of another prisoner’s music at night and was finding it difficult to cope. He suggested he spoke to staff but Mr Davis said that he could not be “bothered”. He did not think that Mr Davis was a risk to himself.

86. At the end of October, the head of residence, spoke to Mr Davis and another prisoner. They were using the lift to move boxes of prisoners’ shop purchases (known as ‘canteen’) having been asked not to as the lift was prone to break if loaded with canteen goods. The Head of Residence said he did not give Mr Davis a formal warning, but Mr Davis seemed to understand and did not appear upset. He said he also spoke to staff, who should not have given Mr Davis the lift key.

87. The Head of Residence told the investigator that two days later, Mr Davis spoke to him in front of other staff to confirm that staff were also not allowed to use the lift. He confirmed that they were not and said he would speak to the wing manager about it. He said that Mr Davis’ seemed his usual self when they spoke. He said he had no concerns that Mr Davis was a risk to himself.

88. Several prisoners told the investigator that around this time, Mr Davis had told them he was upset as he had received warnings from staff for using the lift and distributing canteen orders early. Prisoners said that Mr Davis felt aggrieved by this, believing that he always helped staff and had been wrongly accused and singled out. Some prisoners said he was noticeably withdrawn and quieter during this period, although other prisoners and staff the investigator spoke to thought he was his usual self.

89. On 1 November, a nurse from the mental health team tried to assess Mr Davis but was unable to do so as all prisoners were locked in their cells while a full search of the wing was carried out by the drugs team. Staff told the nurse that they had no concerns about Mr Davis, he continued to work well and engaged with staff. The nurse noted that he would book a further session with Mr Davis and indicated that staff should open an ACCT if Mr Davis’ health deteriorated further.

4 and 5 November 2018

90. On 4 November, a prisoner told the investigator that Mr Davis seemed withdrawn and upset when he saw him in the morning. Other prisoners said that Mr Davis seemed his usual self that day and played cards with them. These prisoners who said that Mr Davis had seemed happy and not like he had appeared in the past when a prisoner had considered he posed a risk to himself.

91. At 4.53pm (according to CCTV), an officer locked Mr Davis' cell. Mr Davis was already inside. It is not known when Mr Davis last went into his cell since this CCTV footage was erased before the investigator was able to view it. At 4.56pm, an officer briefly looked into Mr Davis' cell to complete his roll check.

92. An officer was working overnight on 4 November. She checked all the prisoners on B wing, including Mr Davis at 7.26pm. The officer told the investigator that she could not specifically remember checking Mr Davis, but that she must have had no concerns at that point as she took no further action.

93. On 5 November, at 5.10am, the officer checked Mr Davis as part of her roll check of all prisoners. Mr Davis was lying face-down on the floor. She said that prisoners sometimes slept on the floor or fell out of bed so this was not unusual. She tried to get a response from Mr Davis by kicking his door and shouting his name. She turned the light on in the cell as a second officer came onto the wing.

94. The officer asked the second officer to look into Mr Davis' cell, which she did. This was less than a minute after the officer had reached the cell. The second officer told the investigator that "it was clear that Lee was in a bit of a predicament". She could not get a response from Mr Davis or see any signs of life. The officer radioed a Supervising Officer (SO), asking him to come to Mr Davis' cell.

95. When the SO reached Mr Davis' cell at 5.14am, both officers were standing outside. The SO looked through the observation panel, called Mr Davis' name and kicked the door. He got no response. The SO unlocked the cell and all three members of staff went inside. This was less than four minutes after the first officer had first looked in. They tried to get a response from Mr Davis. The SO checked for signs of life. He noted that Mr Davis was cold to the touch. The second officer said that Mr Davis was stiff with rigor mortis, there was vomit around his mouth and on the floor, his skin was "mottled" and it was clear that he had died. For this reason, the second officer told the investigator, they did not attempt to resuscitate Mr Davis.

96. The SO radioed a code blue (indicating that a prisoner is not breathing or is having difficulty breathing) at 5.14am. Staff in the control room telephoned an ambulance immediately. The SO continued to assess Mr Davis and tried to get a response. He recorded that there was a brown substance on the top of his head and bruising above his left eye. The SO decided not to turn Mr Davis over.

97. A nurse responded to the emergency code. As he did not have keys, he was collected by a manager from the healthcare centre and taken to B wing. The nurse reached Mr Davis' cell at 5.21am. He told the investigator it was clear that

Mr Davis had been dead for at least two hours as rigor mortis had set in. Staff left the cell and waited for paramedics to arrive.

98. Paramedics arrived and, at 5.41am, pronounced Mr Davis dead. (This was the official time recorded by paramedics. All other timings are taken from CCTV which was about seven minutes fast.) Paramedics noted that Mr Davis had rigor mortis in his hands and blood pooling in body.

99. Staff found signs around the cell saying, "*Do not resuscitate.*" Also written on the board in his cell was, *"What's the point in living if you don't feel alive? Death is a release not a punishment. In the midst of life, we are death. Death is only the beginning."*

100. Staff also found letters to several people which indicated Mr Davis' intention to take his life because he could not imagine a future for himself. He also provided instructions for his funeral.

101. Mr Davis had also addressed a letter to the prison saying that the availability of drugs was not being tackled effectively. He wrote, "I have never used drugs before but this is an easy way to go." He said that prisoners were too scared to come out of their cells and officers had bullied him and written false information in his record indicating that he had done things after he had been told no action would be taken. He wrote that the Head of Residence, was "more interested in the lift on B wing than stopping drugs and bullying".

102. A prisoner told the investigator that he found out after Mr Davis died that he had given some of his belongings and biscuits to another prisoner on the evening of 4 November.

Contact with Mr Davis' family

103. An officer was appointed as family liaison officer (FLO) at 6.45am on 5 November. Having checked Mr Davis' wife's address with police, she left the prison at 10.15am and arrived at the address at 11.00am. There was no one there. The FLO returned to the address at 12.15pm but there was still no answer. The FLO contacted the prison and the Head of Safer Custody, told her that they had found address details for Mr Davis' mother and father-in-law. At 1.10pm, the FLO arrived at Mr Davis' father-in-law's house and broke the news of Mr Davis' death. He was concerned for Mr Davis' son who he said had attempted suicide two weeks earlier.

104. Mr Davis' father-in-law telephoned Mr Davis' wife and asked her to come to his house. Staff then broke the news to her there. The FLO remained in contact with Mr Davis' wife over the following weeks. She returned Mr Davis' property to her and offered a contribution to funeral expenses in line with Prison Service policy.

105. With regard to Mr Davis' son's attempted suicide, the FLO told the investigator that Mr Davis' wife said that although Mr Davis knew something had happened with his son, she had not gone into "great detail" about it.

Support for prisoners and staff

106. After Mr Davis' death, a Custodial Manager (CM), debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support. Once the Head of Safer Custody arrived at the prison, she also debriefed those staff still on duty, and telephoned those who had already left, to offer her support.

107. Staff said that they had felt well supported after Mr Davis' death, apart from a nurse who told the investigator that no one had checked how he was until he raised this omission with a manager.

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

Post-mortem report

109. The toxicology report found that amitriptyline (a medication Mr Davis was prescribed) was present in Mr Davis' blood above therapeutic levels and at a concentration sufficient to cause death, although not indicative of a significant overdose.

110. The toxicology tests found no evidence that Mr Davis had used psychoactive substances (PS) before his death. However, the pathologist said that these substances are difficult to detect and it is difficult to entirely exclude the possibility that Mr Davis had used them before his death.

111. The post-mortem report concluded that Mr Davis' cause of death was amitriptyline toxicity and mild cardiomegaly (an abnormal enlargement of the heart). The pathologist concluded that the cardiomegaly may have made Mr Davis more susceptible to the toxic effects of amitriptyline.

Findings

Assessment of risk

112. Staff assessed Mr Davis as posing a risk to himself intermittently between his arrival in prison in June 2013 and February 2015 when his last ACCT was closed. During this time, he admitted to taking an overdose, was found with a plastic bag over his head and was found hanging twice.

113. Some of the risk Mr Davis presented related to his back pain and there are numerous clinical entries about how this affected his mood and risk. The clinical reviewer is satisfied that Mr Davis' back pain was managed appropriately by healthcare staff.

114. After February 2015, Mr Davis was not managed under an ACCT. Throughout this period –more than three and a half years – Mr Davis continued to experience pain with his back and told staff that he often thought of suicide, believed he would die in prison, would not tell anyone if he intended to take his own life and would act impulsively. He also said he felt hopeless about the future. He said on numerous occasions that he did not want to be subject to ACCT monitoring as he was not in crisis but that he did need long-term support.

115. We recognise that it is very difficult to manage the risk posed by a prisoner who expresses suicidal thoughts virtually continuously over a long period. ACCT procedures are designed for managing relatively short-term risk, and not for someone like Mr Davis whose risk was static and inherent. We do not, therefore, consider that it would have been appropriate or effective to have managed Mr Davis under ACCT for years. Indeed, to have done so would have been oppressive and would have been more likely to have had an adverse effect on his mood.

116. We are satisfied that in the months before he took his life, staff had no reason to consider that Mr Davis was at increased risk of suicide or self-harm. Mr Davis' key worker saw him roughly every two weeks, including eight days before his death, but Mr Davis made it clear that he did not see any value in the key worker role and chose not to engage with an officer in a meaningful way.

117. Some prisoners said that Mr Davis was being intimidated and pressurised by other prisoners in the weeks before he died, but all the staff the investigator spoke to said they were unaware of this. The investigator discussed the note that Mr Davis had left addressed to the prison with the Head of Residence, who was named in the note. The Head of Residence said that he was not aware that Mr Davis was being bullied or having any difficulties with staff or prisoners. He acknowledged how Mr Davis might have felt because he had spoken to him about the lift but said that he had not seemed upset at the time. Mr Davis had also denied having any issues with other prisoners, when asked directly by his keyworker a few days before he died.

118. After Mr Davis' death, the prison became aware that Mr Davis' son had attempted to take his own life two weeks earlier. It is not clear exactly what Mr Davis knew about this incident or what impact it had on his state of mind, but staff knew nothing about it at the time.

119. We are satisfied that Mr Davis gave staff no reason to believe that he was at increased risk of suicide in the weeks before his death. It follows that we do not consider that staff could have been expected to foresee or prevent Mr Davis' death.

120. We do, however, have two concerns: that Mr Davis did not always receive appropriate support when he was assaulted by other prisoners, and that the absence of mental health support in the last five months of his life meant that any deterioration in his mental health may have gone unnoticed. These issues are discussed below.

Violence reduction

121. Wakefield's violence reduction policy sets out measures to understand and tackle the underlying causes and triggers for violence, to reduce violence and improve the response to violent incidents. It says that sanctions should be used in a proportionate and reasonable manner and that victims should be provided with support in a consistent manner. Victims should be offered support through an individualised plan. This is not mandatory and if they refuse, this should be documented in their record.

122. During his time at Wakefield, records show that Mr Davis was assaulted by other prisoners on two occasions: he was seriously assaulted in April 2017 (which resulted in another prisoner being charged with attempted murder) and he was punched in the face in May 2018.

123. After the assault in April 2017, Mr Davis received appropriate support both from prison staff and mental health staff However, when it was subsequently suggested that the assault may have been related to a significant drug debt, we have not seen any evidence that this was raised with Mr Davis or that he was offered any support by the prison's drug misuse services.

124. We have not seen any evidence that Mr Davis was offered appropriate support after the assault in May 2018 which was thought to have taken place after he told staff about the presence of drugs on the wing.

125. We therefore make the following recommendation:

The Governor should ensure that all information indicating bullying and intimidation is fully coordinated and investigated in line with national and local policies.

Clinical care

Mental healthcare

126. The clinical reviewer concluded that Mr Davis' mental healthcare was not equivalent to that he could have expected to receive in the community.

127. Mr Davis had a history of depression, suicidal thoughts and attempted suicide. There is some good evidence that his mental state was regularly reviewed initially through his involvement with a psychologist, and a mental health nurse. Mr Davis' care was not reallocated in their absence. This oversight was rectified

when a nurse tried to review Mr Davis at the beginning of November, but the nurse was unable to see Mr Davis before he died. The Deputy Regional Manager, Care UK said that there is now a system in place to avoid this reoccurring.

128. In addition, Mr Davis was not seen by a psychiatrist after a prison GP left in January 2018 and was not replaced.

129. The Deputy Regional Manager, Care UK suggested to us that, if Mr Davis had been reviewed by mental health staff in the months before he died, the decision would probably have been taken to discharge him from mental healthcare. However, we share the clinical reviewer's view that it is difficult to come to this conclusion in the absence of any assessment of Mr Davis' mental state during this period. We are concerned that in the absence of regular contact with mental health staff in the five months before he died, it is simply not possible to say if Mr Davis' mental health deteriorated during this time.

130. The clinical reviewer also commented that there is nothing to suggest that evidence-based treatment such as Eye Movement Desensitisation Reprocessing (EMDR) was considered for Mr Davis' PTSD. As a psychologist was not available for interview at the time of the investigation, it has not been possible to confirm the clinical decision making about Mr Davis' psychological treatment.

131. The clinical reviewer also concluded that more focused risk assessments and management may have been beneficial to support and treat Mr Davis' risk to himself appropriately.

132. We make the following recommendation:

The Governor and Head of Healthcare should ensure that:

- **the caseloads of healthcare staff are reallocated in a timely manner when staff leave the prison; and**
- **healthcare staff use appropriate risk assessments when assessing a prisoner's risk to themselves.**

Physical healthcare

133. The clinical reviewer concluded that Mr Davis' physical healthcare was equivalent to that which he could have expected to receive in the community. His back pain was managed appropriately, in terms of both the medication prescribed and referral to hospital. Mr Davis declined the offer of physiotherapy.

134. The post-mortem indicated that Mr Davis' cause of death was related to mild cardiomegaly. The clinical reviewer concluded that there was no evidence of symptoms related to this condition in his medical record and that staff could not have been expected to suspect that Mr Davis' heart was enlarged.

Substance misuse

135. Post-mortem toxicology tests found amitriptyline (a medication he was prescribed) in Mr Davis' blood above therapeutic levels and at a concentration sufficient to cause death, although not indicative of a significant overdose.

136. It is unclear how Mr Davis was able to acquire an overdose of this medication. Given Mr Davis's potential risk to himself, he did not hold his medication in his possession but took it orally under the direct supervision of a nurse. Healthcare staff said that there was no evidence to suggest that he had been stockpiling his amitriptyline. There is also no evidence that Mr Davis had been obtaining drugs from other prisoners, although there was an intelligence report in July 2017 suggesting that Mr Davis had a significant drug debt.

137. We cannot, therefore, say where Mr Davis obtained the amitriptyline from, but we do not consider that it would have been impossible for him to have stockpiled it or to have obtained it from other prisoners.

138. We note that the pathologist could not rule out the possibility that Mr Davis had also used PS before his death. Mr Davis left a note saying that he had never used drugs "before", which suggests that he may have used illicit drugs before his death.

Emergency response

Entering Mr Davis' cell

139. An officer saw Mr Davis lying on the floor of his cell when she carried out her early morning roll check. She tried to get a response from him and called a second officer who reached the cell less than a minute after the officer. Neither officer usually worked on B wing and had no prior knowledge of Mr Davis. They were unsure whether he was sleeping, genuinely unwell or trying to entice them into his cell by pretending to be unwell. They risk-assessed the situation and decided that it was not safe to enter the cell without the presence of a third officer.

140. Mr Davis was a category B prisoner and we accept that this was reasonable in the circumstances. Both officers said they would enter a cell on their own in a life-threatening situation.

Calling a medical emergency code

141. Prison Service Instruction (PSI) 03/2013, *Medical Emergency Response Codes*, says that prisons must have a local protocol in place to ensure a prompt and effective response to medical emergencies. This should include calling a 'code red' for bleeding and burns and a 'code blue' for breathing problems and collapses. The PSI says that the local protocol should:

> '*Inform staff that if they are in any doubt about the nature of the injury, they must call an ambulance.* It is better to act with caution and request an ambulance that can be cancelled if it is later assessed as not required.'

142. In Mr Davis' case, when both officers saw Mr Davis unresponsive on the floor of his cell, they radioed a SO, who they knew to be nearby. When he arrived, all three went into Mr Davis' cell and, after checking Mr Davis, the SO radioed a code blue medical emergency. This meant there was a delay of around four minutes between the officer seeing Mr Davis unresponsive on the floor and the SO calling a code blue.

143. We consider that the officers should have radioed a code blue when they could not get a response from Mr Davis, without waiting for the SO. This would have summoned healthcare staff and an ambulance without delay. As the PSI says, it is better to act with caution and cancel the ambulance if it is not needed. The delay made no difference to the outcome for Mr Davis who had been dead for some time when he was found but could be critical in other emergencies.

144. We recommend:

The Governor should remind staff that, if they are in any doubt about the nature of a medical emergency, they should act with caution and call a medical emergency code.

Resuscitation

145. Staff did not attempt to resuscitate Mr Davis as he appeared to have been dead for some time when he was found. The clinical reviewer concluded that this was appropriate.

Sharing PPO findings

146. We consider it important that the findings of our investigations are shared with the staff involved. We, therefore, recommend:

The Governor and Head of Healthcare should ensure that any staff named in this report are given the opportunity to read the report at the draft stage in line with paragraph 1.11 of PSI 58/2010.

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