Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Gavin Caddick a prisoner at HMP Haverigg on 13 December 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*

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 I oversee can improve their work in the future.

Mr Gavin Caddick died on 13 December 2017. He was found hanged in his cell at HMP Haverigg. Mr Caddick was 33 years old. I offer my condolences to Mr Caddick's family and friends.

Mr Caddick had a history of drug use and associated mental health issues, including drug-induced psychosis. He had no physical healthcare issues and he received adequate mental health care while in prison. However, I am concerned that Mr Caddick's apparently prolific use of psychoactive substances was not effectively identified, challenged, treated and recorded. This is particularly disappointing since I have previously made recommendations to Haverigg on this subject.

I am concerned that several factors which are known to be linked to an increased risk of suicide were not explicitly considered during Mr Caddick's time in prison. I am also concerned that staff did not enter Mr Caddick's cell for around four minutes after they could not get a response from him. Again, this is something that we have raised in a previous investigation into a death at Haverigg.

I believe the liaison and support which Mr Caddick's family received after his death could have been better.

I draw the attention of the Prison Group Director, Cumbria and Lancashire Group, to the fact that I am repeating recommendations from previous investigations. He will wish to assure himself that, this time, effective action is taken to implement them.

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
Deputy Prisons and Probation Ombudsman **November 2017**

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Summary

Events

1. Mr Gavin Caddick spent most of his adult life in prison, serving 11 terms of imprisonment. In December 2015, he was remanded into custody and on 18 July 2016, was sentenced to 32 months imprisonment. He was taken to HMP Moorland. He had a history of depression and paranoia related to alcohol and drug use. Staff started Prison Service suicide and self-harm prevention measures, also known as ACCT, as Mr Caddick was distressed by the length of his sentence and said he deserved to die. The ACCT was closed the next day when Mr Caddick was no longer considered to be a risk to himself. In April 2017, he was released on licence.

2. In August, Mr Caddick was arrested for further offences and remanded into custody. He was taken to HMP Preston and was also subsequently recalled for breaching his licence. Court staff were concerned he presented a risk to himself but on his arrival at Preston, staff did not believe it was necessary to open an ACCT. He was assessed by a psychiatrist and mental health nurse and diagnosed with possible drug-induced psychosis. He was prescribed antipsychotic medication. Mr Caddick's symptoms and behaviour gradually stabilised and he was regularly reviewed by the mental health team.

3. On 8 November, staff suspected that Mr Caddick had taken psychoactive substances (PS), something he admitted doing in the past. On 14 November, he was sentenced to 27 months imprisonment and three days later was taken to HMP Haverigg. As records indicated he had attempted suicide in 2015, his mental health was assessed. He was referred to the mental health team.

4. Prisoners said that Mr Caddick regularly smoked PS at Haverigg. Some said he became more withdrawn and quieter as a result, and was in debt to other prisoners. However, when on 2 December, Mr Caddick was made to do a sobriety test because he was suspected of using PS, he passed. On 5 December, healthcare staff noted that unit staff had said Mr Caddick was a "prolific" PS user. It is not clear where this information came from. It is not documented elsewhere.

5. On 7 December, a mental health nurse assessed Mr Caddick. The nurse noted that his mental health was currently stable. He planned to review him again three weeks later and refer him to the psychiatrist. Around 10 December, three prisoners saw what they suspected was a noose around the shower rail in Mr Caddick's cell. Mr Caddick claimed it was for exercise but the prisoners were not convinced and took it away. They did not tell staff.

6. On 13 December, during a morning roll check, officers were unable to get a response from Mr Caddick. A prisoner told them about the noose. The officers nevertheless went to check whether Mr Caddick was supposed to be in his cell. When the cell was finally unlocked, over four minutes after the roll check, Mr Caddick's was found hanged from his shower rail. Staff attempted to resuscitate him and paramedics attended. Mr Caddick was pronounced dead at 8.52am.

Findings

Assessment of risk

7. Mr Caddick had several factors which increased his risk to himself. There is no evidence that these risk factors were explicitly considered when he arrived at Preston or Haverigg.

Drug management

8. There is evidence that Mr Caddick was using PS while at Haverigg. This was not dealt with robustly, or in line with Haverigg's local policy for tackling PS use.

Entering Mr Caddick's cell

9. It took staff four minutes to unlock Mr Caddick's cell after they were unable to get a response from him. The two officers who first arrived said they would never go into a cell without their manager's permission, or without three officers present.

Family Liaison

10. Mr Caddick's mother was told of his death promptly. However, we found that the family liaison and support offered after this could have been more proactive. The prison also gave Mr Caddick's mother incorrect information which increased her distress.

Recommendations

- The Governors of Haverigg and Preston should ensure that staff consider and record all known risk factors when determining a prisoner's risk of suicide and self-harm.

- The Governor and Head of Healthcare at Haverigg should ensure that there are effective supply and demand reduction strategies to help eradicate the availability of PS and that staff are vigilant to signs of its use and take appropriate action. In particular, staff should ensure that signs of drug use are recorded in prisoners' records and all staff should submit intelligence reports when they are aware of suspected drug use.

- The Governor should ensure that staff open cells as soon as possible when there is an immediate danger to life.

- The Governor should ensure that prison staff offer appropriate support and information to a prisoner's next of kin and ensuring the information they communicate is accurate.

- The Prison Group Director, Cumbria and Lancashire Group, should assure himself that meaningful, effective and sustained action is taken to implement recommendations from PPO investigations at HMP Haverigg.

The Investigation Process

11. The investigator issued notices to staff and prisoners at HMP Haverigg, informing them of the investigation and asking anyone with relevant information to contact her. No one responded. The investigator obtained copies of relevant extracts from Mr Caddick's prison and medical records.

12. The investigator interviewed 12 members of staff and 4 prisoners at Haverigg in January 2018.

13. NHS England commissioned a clinical reviewer to review Mr Caddick's clinical care at the prison. The clinical reviewer also attended the interviews with the clinical staff.

14. We informed HM Coroner for North and West Cumbria of the investigation. He provided us with the results of a preliminary post-mortem examination and toxicology results. We have sent the coroner a copy of this report.

15. One of the Ombudsman's family liaison officers, contacted Mr Caddick's partner and mother, to explain the investigation and to ask whether they had any matters they wanted the investigation to consider. Mr Caddick's partner asked whether the prison had access to the mental health report prepared when Mr Caddick was sentenced. She also wanted to know whether Mr Caddick was prescribed any medication.

16. Mr Caddick's mother wanted to know what her son had used to hang himself and whether he had left a suicide note. She also said that she was upset by the level of support offered to her by the prison following her son's death. She said that she had had to initiate most contact and she had left messages with the Governor and his secretary which had not been returned. She did not think she had been given any direct contact details for her family liaison officer and said that Mr Caddick's belongings had been posted to her. She also said that prison staff had told her that her son had no post in his belongings. This had upset her as she had written to him. She later found out from the police that they had taken this post from Mr Caddick's cell as evidence. After Mr Caddick's funeral, his mother had to contact the prison to ask them to pay the funeral expenses it had offered. She did not think this was satisfactory.

17. Mr Caddick's mother received a copy of the initial report. Her legal representative made a number of comments which do not impact on the factual accuracy of this report and have been addressed through separate correspondence.

18. HM Prison and Probation Service (HMPPS) also received a copy of the report. They raised a number of concerns, most of which have been addressed through separate correspondence. However, we have slightly amended our findings and recommendation about family liaison. HMPPS accepted all the recommendations.

Background Information

HMP Haverigg

19. HMP Haverigg holds 286 sentenced men. Cumbria Partnership Trust provides physical health services. A GP works at the prison full-time and an out of hours service is provided by a local practice. Greater Manchester Mental Health Trust provides mental health and substance misuse services with two psychiatrists subcontracted to do one day a week each at the prison.

HM Inspectorate of Prisons

20. The most recent inspection of HMP Haverigg was conducted in April 2017. Inspectors reported that prisoners at risk of suicide or self-harm were well cared for. ACCT documentation showed good multidisciplinary care and prisoners were positive about the support they had received from staff. They found that levels of violence were too high and more needed to be done to manage the perpetrators of violence and support victims. There was a good range of education and work placements, and a focus on making sure prisoners spent time out of their cells. Inspectors found that health services were reasonably good. They also found that night staff were not always clear about their responsibility to enter a cell when a prisoner had self-harmed.

21. Inspectors found that the mental health team provided reasonably good care with excellent joint working between Unity, the substance misuse service, and the mental health team, with the establishment of a formal dual diagnosis pathway. They also found that the quality of relationships between staff and prisoners was good.

Independent Monitoring Board

22. 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 November 2017, the IMB reported that it was concerned about the widespread use of Psychoactive Substances (PS) and the impact of this on the health of staff and prisoners. They also noted its contribution to violence, debt and bullying, and that a violence reduction strategy had been developed to deal with these issues. The board noted that the geographical situation of the prison, and its large perimeter fence meant it was difficult to prevent illicit items getting into the establishment. The board concluded that the use of ACCT procedures to support prisoners at risk was good and the standard of care was high.

Previous deaths at HMP Haverigg

23. Since 2013, there have been seven deaths at Haverigg, including Mr Caddick. Of these, two were self-inflicted. There has been one further self-inflicted death since Mr Caddick died. Previous investigations raised issues about recording information about the risks prisoners posed to themselves, the management of PS use and the immediate unlocking of cells in a life-threatening situation. It is disappointing and concerning to be repeating recommendations on these issues.

Assessment, Care in Custody and Teamwork

24. ACCT is the care planning system the Prison Service uses to support prisoners at risk of suicide or self-harm. The purpose of ACCT is to try to determine the level of risk posed, the steps that staff might take to reduce this and the extent to which staff need to monitor and supervise the prisoner. Checks should be made 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. 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)*.

Incentives and Earned Privileges (IEP) Scheme

25. Each prison has an Incentives and Earned Privileges (IEP) scheme, which aims to encourage and reward responsible behaviour, encourage sentenced prisoners to engage in activities designed to reduce the risk of re-offending and to help create a disciplined and safer environment for prisoners and staff. Under the scheme, prisoners can earn additional privileges such as extra visits, more time out of cell, the ability to earn more money in prison jobs and to wear their own clothes. There are four levels, entry, basic, standard and enhanced.

Psychoactive Substances (PS)

26. Psychoactive substances (formerly known as 'new psychoactive substances or 'legal highs') are a serious problem across the prison estate. They are difficult to detect and can affect people in a number of ways including increasing heart rate, raising blood pressure, reducing blood supply to the heart and vomiting. Prisoners under the influence of PS can present with marked levels of disinhibition, heightened energy levels, a high tolerance of pain and a potential for violence. Besides emerging evidence of such dangers to physical health, there is potential for precipitating or exacerbating the deterioration of mental health with links to suicide or self-harm.

27. In July 2015, we published a Learning Lessons Bulletin about the use of PS (still at the time NPS) and its dangers, including its close association with debt, bullying and violence. The bulletin identified the need for better awareness among staff and prisoners of the dangers of PS; the need for more effective drug supply reduction strategies; better monitoring by drug treatment services; and effective violence reduction strategies.

28. HM Prison and Probation Service (HMPPS) now has in place provisions that enable prisoners to be tested for specified non-controlled psychoactive substances as part of established mandatory drugs testing arrangements.

Key Events

HMP Doncaster and HMP Moorland, December 2015 – April 2017

29. Mr Gavin Caddick was charged with driving offences, battery, theft and criminal damage and remanded into custody on 19 December 2015. He was taken to HMP Doncaster. He had been misusing drugs in the community and was diagnosed with drug-induced psychosis by mental health staff. On 18 July 2016, he was sentenced to 32 months custody and taken to HMP Moorland. He was subject to Prison Service suicide and self-harm monitoring, known as ACCT, for one day. He said he was distressed by the length of his sentence and deserved to die. The next day, he said he felt better and the ACCT was closed. In April 2017, he was released from Moorland on licence. One of the conditions was not to re-offend.

HMP Preston, August 2017 – 17 November 2017

30. On 12 August, Mr Caddick was arrested and charged with further offences. He remained in police custody for several days and was referred to the mental health crisis team due to his behaviour. He had been under the influence of alcohol and cocaine when committing the offences and demonstrated symptoms of a drug-induced psychosis. On 17 August, Mr Caddick appeared at court and was remanded into custody. He was taken to HMP Preston. Staff at court were concerned that he might present a risk to himself and completed a suicide and self-harm warning form which accompanied him to the prison. This indicated that he was distressed and had previously attempted to commit suicide in 2015.

31. A nurse assessed Mr Caddick when he arrived at Preston. She noted the information from the suicide and self-harm warning form but did not consider that Mr Caddick presented a risk to himself and therefore did not open an ACCT. She recorded that Mr Caddick displayed “odd, unsettled behaviour” and that he had been diagnosed with drug-induced psychosis several years earlier. She noted that Mr Caddick made some bizarre statements and had some paranoid beliefs that people wanted to kill him. She referred him to the mental health team.

32. Mr Caddick had been charged with further offences and was therefore potentially in breach of his licence. His offender manager recommended his recall to custody. Information in this paperwork indicated that Mr Caddick had attempted to hang himself in 2015 and had been admitted to a psychiatric ward for two weeks as a result. She noted that any deterioration in Mr Caddick’s mental health or substance misuse in the past had been linked to an increase in his risk to himself or others.

33. On 22 August, staff issued Mr Caddick’s recall paperwork to him. On 25 August, he was verbally threatening and aggressive to his cellmate. Staff reviewed Mr Caddick’s cell sharing risk assessment. They noted he displayed severe, agitated and paranoid behaviour, and assessed him as high risk and not suitable to share a cell. Mr Caddick’s cellmate moved cells. Staff contacted the mental health team who said they would assess him as soon as possible.

34. On 4 September, a psychiatrist, and a mental health nurse assessed Mr Caddick. The psychiatrist noted that Mr Caddick was irritable, chaotic, disorganised and

difficult to follow. Mr Caddick said he had previously used amphetamines and cannabis, and felt he had had a "bit of a breakdown" around the time of his arrest. The doctor diagnosed Mr Caddick with a suspected drug-induced psychosis. He prescribed him olanzapine (an antipsychotic). The doctor noted that staff should monitor Mr Caddick and consider transferring him to the healthcare wing for assessment if it was appropriate.

35. On 13 September, a nurse reviewed Mr Caddick. The nurse noted that Mr Caddick seemed more relaxed than the last time he had seen him but his thoughts and conversation were still rapid and pressured. Mr Caddick said he had found the medication helpful. The nurse contacted wing staff and asked them to let him know if Mr Caddick's behaviour deteriorated. On 18 September, the psychiatrist reviewed Mr Caddick and also noted an improvement in his presentation. He noted that he would review Mr Caddick in two to three weeks.

36. On 20 September, wing officers spoke to a nurse about Mr Caddick. They said they had some concerns about his mental health, they had seen him mumbling to himself, exhibiting bizarre behaviour, isolating himself and not associating with other prisoners. They were concerned that there seemed "an edge" to him and felt "he could lose it any time". The nurse met Mr Caddick. They had a lengthy discussion about his current circumstances and substance misuse. Mr Caddick said he had recently smoked PS in prison. The nurse did not submit an intelligence report or refer Mr Caddick to substance misuse services. Mr Caddick made some bizarre and paranoid statements. He said he had no thoughts of self-harm, and that his partner and children were his motivation not to behave in this way.

37. On 21 September, Mr Caddick asked to see a nurse. The nurse assessed that he was still suffering from psychosis and had paranoid delusions. He noted that Mr Caddick was on the waiting list to move to the healthcare wing. On 22 September, a nurse assessed Mr Caddick. He asked for his prescription of olanzapine to be increased as he had started to feel worse. Mr Caddick transferred to the healthcare wing. Healthcare staff continued to monitor Mr Caddick's mood and presentation over the following few days. The psychiatrist reviewed Mr Caddick on 27 September, increased his medication and planned to review him again two weeks later.

38. A nurse assessed Mr Caddick on 2 October. He had no paranoid thoughts and was moved back to a standard wing the following day. The nurse continued to review Mr Caddick regularly. On 7 November, the nurse recorded that Mr Caddick had been compliant with his medication, was working as a cleaner, was attending the gym and had put on weight.

39. On 8 November, Mr Caddick pleaded guilty to nine charges at Preston Crown Court and his case was adjourned until 14 November for sentencing. At 6.10pm, an officer found Mr Caddick in his cell under the influence of PS. He requested healthcare staff, who responded and said that prison staff should continue to observe Mr Caddick and to contact healthcare staff again if his condition deteriorated. The officer submitted an intelligence report with this information and logged it on Mr Caddick's record. As a result, Mr Caddick's IEP level was reduced to basic, he lost his job and received four days cellular confinement as a

punishment following a disciplinary hearing. He was moved to the Care and Separation Unit on 10 November. While there, mental health nurses assessed him daily and noted no concerns. On 13 November, he moved back to a standard wing.

40. On 14 November, Mr Caddick was sentenced to 27 months imprisonment at Preston Crown Court. Mr Caddick's partner told the investigator that there was a psychiatric report prepared for the court to assist with sentencing. There is no evidence that this was sent to the prison, and the investigator did not have access to this report.

HMP Haverigg, 17 November – 12 December 2017

41. On 17 November, Mr Caddick was transferred to HMP Haverigg. The Person Escort Record noted that he had attempted suicide by hanging in 2015 and had been diagnosed with a drug-induced psychosis. His cell sharing risk assessment indicated that he was not suitable to share a cell.

42. All new prisoners at Haverigg are assessed by the mental health team. The Head of Mental Health and Substance Misuse Services, said that he was aware that Mr Caddick would be coming to Haverigg that morning and he had reviewed his medical record in preparation. He assessed Mr Caddick in reception. Mr Caddick said he was happy to be at Haverigg although he wanted to transfer to a prison nearer his partner and children. They discussed Mr Caddick's history of substance misuse, although he did not disclose his recent PS use, and his suicide attempt in 2015. Mr Caddick said he had no current thoughts of suicide or self-harm. He said that Mr Caddick seemed to be focused on his family and he had no concerns that he was at risk of suicide. He referred him to the mental health team.

43. A nurse also assessed Mr Caddick when he arrived. Mr Caddick said that recently he had used amphetamines, cannabis and cocaine on occasion but did not mention his PS use. His drug test was negative. The nurse referred him to the GP to review his medication. The GP reviewed Mr Caddick's medical record, noted that he had been diagnosed with a possible drug-induced psychosis and continued his prescription of olanzapine. He referred Mr Caddick for blood tests and an electrocardiogram (or ECG – to test the heart's rhythm and electrical activity) to review the effect the medication was having on his physical health. He noted he would review Mr Caddick soon.

44. On 20 November, a healthcare assistant in the substance misuse team, assessed Mr Caddick. He told her that he had been abstinent from drugs for the last four years and declined any support in this area. She gave him an information pack.

45. On 24 November, Mr Caddick applied to join the Challenge to Change Programme, an offending behaviour programme which takes six months to complete. Prisoners on this programme all live in Residential Unit 5 of the prison so Mr Caddick moved there from the first night centre where he had been since he arrived. Staff noted that he had a positive attitude and was keen to engage with the programme. A custodial manager, said that Mr Caddick would have

been aware that participation on the programme meant he had to stay at Haverigg for six months.

46. Mr Caddick's personal officer, introduced herself to Mr Caddick shortly after his arrival on the unit. She explained to him that as his personal officer she was his first point of contact if he needed or wanted to discuss anything. She said that Mr Caddick never came to her with any concerns and that he was a quiet prisoner.

47. The investigator spoke to four prisoners who were friends with Mr Caddick on the unit. They said that Mr Caddick was generally a quiet prisoner who spoke to them about having no contact with his children, and that he wanted to be in a prison nearer his family. A prisoner said that when Mr Caddick arrived on the unit he seemed fine and already knew some of the prisoners from HMP Preston. He said that after a couple of weeks, he started socialising less with other prisoners, became depressed and much quieter. He believed this was due to Mr Caddick's use of PS.

48. On 27 November, Mr Caddick began working in the kitchen. On 2 December, an officer suspected that Mr Caddick was under the influence of PS. He said that Mr Caddick had blood shot eyes and his reactions were slower than normal. He asked Mr Caddick to complete a sobriety test which involved recalling information and physical tasks, such as standing on one leg. Mr Caddick passed this test but the officer submitted a request for a mandatory drug test to the security department. This was never actioned as there were insufficient staff available over the next 48 hours. He also noted the information on Mr Caddick's record but did not submit an intelligence report. The officer said that he never had any concerns after this that Mr Caddick used PS but he did continue to associate with people on the unit who were known to be involved in its use or supply. Mr Caddick failed to attend work that afternoon. He also failed to attend on the afternoon of 3 December.

49. On 4 December, a GP assessed Mr Caddick. He said that he felt better since he had started taking olanzapine. The GP noted that he would continue its prescription until Mr Caddick had been reviewed by a psychiatrist. The doctor noted that Mr Caddick still needed blood tests and an ECG.

50. Mr Caddick made several telephone calls to his mother and partner while at Haverigg. The investigator listened to these calls, the last of which was made on 4 December. He asked his partner to send him money, clothes or trainers. During these calls, he seemed focused on the future and never expressed any intention to harm himself.

51. On 5 December, a recovery worker recorded in Mr Caddick's medical record that unit staff had indicated that he was a "prolific PS user." On 7 December, a mental health nurse assessed Mr Caddick. They discussed Mr Caddick's background, offending history and substance misuse. He told the nurse that he had attempted suicide around three years earlier by hanging himself but the ligature had snapped. Mr Caddick said he was happy to be alive. The nurse noted that Mr Caddick seemed keen to address his substance misuse and offending behaviour. They discussed his recent mental health history and prescription of olanzapine. The nurse also ensured that Mr Caddick understood

that if he continued to use drugs, he risked having another drug-induced psychosis. Mr Caddick said he understood this.

52. The nurse noted that Mr Caddick's presentation was "flat" but he said he had no current thoughts of suicide or self-harm. Mr Caddick said his main concern was being located so far from his family and hoped to be transferred nearer to them. The nurse noted that Mr Caddick was currently stable and taking olanzapine. The nurse told the investigator that Mr Caddick appeared to be making plans and he had no concerns that he was a risk to himself. He planned to add Mr Caddick to his caseload and monitor any changes in his presentation. The nurse told the investigator that he would probably have reviewed Mr Caddick about three weeks later. After this, once he had more of an idea of how stable Mr Caddick was, he would have referred him to the psychiatrist to review his medication.

53. Prisoners said that Mr Caddick told them he had stolen hot chocolate from the kitchen and other prisoners at work had started being "off" with him as a result, so he started missing work in the kitchens. A catering manager, said that Mr Caddick was a quiet prisoner who did not integrate much with the others. He never noticed Mr Caddick missing work without having a good reason, or noticed any animosity from other prisoners, nor was he aware of Mr Caddick stealing anything. He said he never seemed under the influence of PS at work.

54. A prisoner, said that he smoked PS daily with Mr Caddick. He said that Mr Caddick had told him that "coming down" from PS was the worst point; that he would be awake at 3.00am, shivering, sweating and feeling very cold. He said he had attempted suicide when withdrawing from PS, four days before Mr Caddick.

55. Prisoners said that Mr Caddick had sold his trainers and clothes to prisoners to fund his drug use. Once he had nothing left to fund his habit, prisoners said he got himself into debt. Two prisoners said he owed £25, which they did not consider a large amount and Mr Caddick did not seem overly worried about this. They also commented that due to Mr Caddick's height, stature and friends, he would be able to defend himself if any prisoners resorted to violence, as was sometimes the case. They tried to advise him what to do about the debt. He also asked them to get him some trainers. Two prisoners said that Mr Caddick had used another prisoner's illegal mobile telephone to try to persuade someone in the community to repay his drug debt. (Mobile phones are not allowed in prisons.)

56. Staff said there was a significant problem with PS on the unit at the time. The unit observation book for the first two weeks of December has several references to PS use on the wing with prisoners being found seemingly under the influence. Staff were also vulnerable to inhaling the drug second-hand. However, officers the investigator spoke to seemed largely unaware that Mr Caddick used PS or that he was in debt to other prisoners. An officer said he suspected Mr Caddick used PS as he associated with prisoners who did. However, he never actually saw him using PS or being under the influence.

57. Around 10 December, three prisoners, were in Mr Caddick's cell when they noticed that he had what looked like a noose made from bedsheets, tied onto the shower frame. The prisoners asked him about it and Mr Caddick claimed it was

to help him exercise, to do "pull ups". The other prisoners questioned him about this. Mr Caddick took his top off to prove that he had no marks on him from self-harm or attempting suicide. The prisoners remained doubtful and took the noose with them. One of the prisoners said that sometimes Mr Caddick would ask how long it would take someone to kill himself and what it would be like. The prisoner said he had heard other prisoners say this in the past so did not believe Mr Caddick was being serious.

58. Mr Caddick's mother said that she spoke to Mr Caddick on 10 or 11 December and he seemed his usual self. She had no concerns about him. Mr Caddick's partner also said she spoke to him on 10 December and he seemed to be looking forward to the future. Since these calls are not registered on his prison telephone record, it seems likely that Mr Caddick did indeed have access to an illegal mobile telephone.

59. Mr Caddick did not attend work in the kitchens on 12 December. Officer A said he saw Mr Caddick on the unit and he said he was unwell. The officer had no concerns about him, however, as Mr Caddick seemed to be associating with prisoners as usual that morning. A prisoner said that he saw Mr Caddick during the day and he had been asking him to get him some trainers.

60. Three prisoners said that Mr Caddick had asked them during association, between 6.00pm and 7.00pm that evening, whether they had any PS. None of them did, and they did not think that there was any available on the unit that evening. They did not think that Mr Caddick acquired any PS before he was locked up. A prisoner had been in Mr Caddick's cell immediately before they were locked up for the evening. This is confirmed by CCTV.

61. An officer locked Mr Caddick in his cell around 7.00pm. The officer said he had seen him that evening and he had no concerns about him. When he locked him in his cell, he told him he would see him in the morning, to which Mr Caddick replied, "Yes alright." An officer support grade (OSG), completed the evening roll check that night around 9.00pm. He said that when completing a roll check, he always ensures that a prisoner is in his cell and is well. He said that he could not specifically remember checking Mr Caddick but knew that there must have been nothing out of the ordinary during his roll check or he would have reported it. He said that Mr Caddick had never come to his attention previously, so he had no reason to remember who he was.

Events of 13 December

62. On 13 December, at 6am, the OSG completed a further roll check. Again, he could not specifically remember checking Mr Caddick's cell but said that this meant that there must have been nothing out of the ordinary, and he must have seen Mr Caddick in his cell. Unfortunately, the investigator was only able to watch CCTV footage from around 7.45am as the prison had technical difficulties downloading the CCTV that recorded events before this time.

63. CCTV shows Officer A completing the next roll check by looking into each prisoner's cell through the observation panel using a torch. When he reached Mr Caddick's cell, he continued to look through the observation panel for 49 seconds. (The CCTV footage does not record the actual time, only the time lapsed but it

was about 7.45am.) The officer told the investigator that he could not see Mr Caddick, he was not in his bed and he could see that his bathroom door was shut. The officer said that he knocked on the cell door several times and shouted Mr Caddick's name but got no response. Initially, he thought that Mr Caddick was in the shower but he could not hear any water running. The officer then walked away from Mr Caddick's cell to find another officer.

64. Officer B was also working on the unit that morning. She said that after she had finished her roll count, Officer A told her that he could not get a response from Mr Caddick's cell. She reached Mr Caddick's cell about one minute after Officer A had left it and looked through the observation panel. She knocked on the door and called Mr Caddick's name but received no response. Officer A also returned to Mr Caddick's cell thirty seconds after Officer B.

65. Twenty seconds after this, CCTV shows Officer A going to a prisoner's cell, virtually opposite Mr Caddick's cell. Officer A said to the prisoner told him that Mr Caddick "might be hanging" as he had "taken a noose from him the day before and he seemed very depressed". Officer B remained at Mr Caddick's cell. Ten seconds later they both walked away from the cells. Both officers went downstairs to the unit office to check that Mr Caddick was supposed to be in his cell and had not gone to hospital in the community.

66. Officer C said that he had just started work on the unit when he found Officer A and Officer B in the wing office. Officer C told the investigator that they seemed flustered and told him that they could not get a response from Mr Caddick. Officer A also told him that a prisoner in a cell opposite had said that he had taken a noose from Mr Caddick the day before. Officer C ran straight to Mr Caddick's cell with Officer A and Officer B behind him. Officer B radioed to ask the Orderly Officer (Oscar One)'s permission to unlock Mr Caddick's cell on the way there. Oscar One requested that they contact him and gave a telephone extension number. Officer C looked through the observation panel and unlocked the door. This was around one minute after the officers had left the cell and about four minutes after Officer A had first looked in the cell. Officer C opened Mr Caddick's bathroom door and found him hanged by a bedsheet from his shower frame.

67. Officer B immediately handed Officer C her anti-ligature knife. Officer B said she had "feared the worst" and therefore had taken the knife out of her belt before going into the cell. She radioed a code blue emergency (indicating that a prisoner is unconscious or having difficulty breathing). The incident log recorded the time as 7.48am. The control room immediately telephoned an ambulance.

68. Officer C tried to support Mr Caddick's weight and told the investigator that he felt warm. He asked Officer A to assist him, but he could not grip Mr Caddick due to his position and size. Officer C cut the ligature and Mr Caddick fell forward into the shower cubicle. Officer C removed the ligature from Mr Caddick's neck and, along with Officer A, they laid Mr Caddick on his back and checked for signs of life. Officer C began chest compressions.

69. More prison staff and a nurse quickly reached Mr Caddick's cell. The nurse had only just started her shift and had not heard the code blue call but was alerted to an emergency by staff running past her on the unit. She noted no signs of life

and immediately went to get the emergency bag, and asked an officer to fetch the defibrillator. Another nurse arrived at Mr Caddick's cell. The nurses inserted an airway, administered oxygen and attached the defibrillator while officers continued chest compressions. A nurse said that Mr Caddick felt cold. Fifteen minutes after Officer C first unlocked the door, at around 8.01am paramedics arrived at Mr Caddick's cell and took over Mr Caddick's care. They administered adrenalin and, with the assistance of prison and healthcare staff, took Mr Caddick to the ambulance. They pronounced Mr Caddick dead at 8.52am, before the ambulance had left the prison.

Contact with Mr Caddick's family

70. Mr Caddick did not nominate a next of kin when he arrived at Haverigg. However, the computerised record from an earlier period of imprisonment, had his partner recorded as his next of kin. The Head of Safety and Equalities, was assigned as family liaison officer (FLO). At 10.00am, he contacted HMP Doncaster to request that they provide a family liaison officer to inform Mr Caddick's mother of her son's death. This was due to the long travel distance involved.

71. At 11.10am, staff at Doncaster went to Mr Caddick's mother's home address and informed her of his death and offered their condolences. They drove her to Mr Caddick's aunt's house for support and told her that the FLO would call them later that day. Mr Caddick's mother said she did not want any calls that day but his aunt said she would take calls. The staff from Doncaster provided the FLO's contact details.

72. On 15 December, the FLO telephoned Mr Caddick's aunt and offered the family the chance to visit the prison. He confirmed that Mr Caddick's partner had been informed. The FLO said that he had not initially informed Mr Caddick's partner as he did not have a current address, also that some information in Mr Caddick's record indicated that he would not be returning to live with her once released.

73. On 18 December, Mr Caddick's aunt called the FLO. On 21 December, Mr Caddick's mother telephoned the prison and asked about funeral expenses. The FLO explained that the prison would offer up to £3,000 to cover the costs of the funeral. Mr Caddick's mother said that she did not want to visit the prison so the FLO said that Mr Caddick's belongings would be returned to her in person.

74. On 4 January, Mr Caddick's mother telephoned the prison to say that Mr Caddick's funeral was taking place the following day. The FLO and another member of staff attended. On 8 January, the FLO telephoned Mr Caddick's mother and asked if she would like his belongings delivered in person or by post. She said she did not mind so the FLO posted Mr Caddick's belongings. He arranged to call her the next day as she said she had some questions about her son. The FLO telephoned Mr Caddick's mother the next day. There was no reply and he was unable to leave a voicemail.

75. On 16 January, Mr Caddick's mother telephoned the Governor asking about correspondence in Mr Caddick's possession and a Christmas card she had sent him. The Governor located the card, of which he had previously been unaware, and returned it to her. The FLO was told Mr Caddick had no other correspondence in his possession when he died and informed his mother of this.

On 24 January, Mr Caddick's mother telephoned the prison to say that the police were holding correspondence from Mr Caddick's cell.

Support for prisoners and staff

76. After Mr Caddick's death, The Governor, debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.

77. Prison staff informed prisoners on Mr Caddick's unit in person in small groups. The prison posted notices informing other prisoners of Mr Caddick's 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 Caddick's death.

Post-mortem report

78. The coroner indicated that the preliminary cause of death was hanging. The toxicology report concluded that no drugs or alcohol were detected in Mr Caddick's bloodstream. The forensic scientist who wrote this report noted that most drugs are detected in the blood for up to 12 to 24 hours after they have last been used. They also noted that when a person's death occurs rapidly, such as in hanging, any drugs taken immediately before the person died may not have been fully absorbed into the blood and therefore may not be detected post mortem.

Findings

Assessment of risk

79. Mr Caddick had only been assessed as a risk to himself and subject to ACCT procedures for one day when he was initially sentenced in July 2016. Since then, he had not been assessed as being a risk to himself. Prison Service Instruction (PSI) 64/2011, *Safer custody*, lists several risk factors and potential triggers for suicide and self-harm. These include previous suicide attempts, mental health issues, drug and alcohol misuse, recall to custody, early days in a new prison and court appearances, especially when sentenced. All staff should be alert to the increased risk of suicide and self-harm posed by prisoners with these risk factors and should address any concerns, including starting Prison Service suicide and self-harm prevention procedures (known as ACCT), if necessary.

80. There is no evidence that these risk factors were properly considered when Mr Caddick was recalled to Preston, particularly in light of court staff's documented concerns that Mr Caddick was a risk to himself, or when he transferred to Haverigg, a geographically isolated prison where he was further away from his family. We recognise that Mr Caddick consistently said he had no thoughts of suicide and self-harm and seemed to be making plans for the future but it was apparent that his separation from his family troubled him. Mr Caddick largely hid his feelings from staff and prisoners, even when challenged by other prisoners as to why he had what appeared to be a noose in his cell. These concerns are heightened by the prison's failure to identify the extent of his drug use, a further and compounding risk factor (see below). We make the following recommendation:

    The Governors of Haverigg and Preston should ensure that staff consider and record all known risk factors when determining a prisoner's risk of suicide and self-harm.

Mental Health Care

81. The clinical reviewer concluded that overall Mr Caddick's clinical care was equivalent to that which he could have expected to receive in the community. He noted that Mr Caddick was well supported by mental health staff at Preston, with regular monitoring of his psychotic symptoms and the physical impact of his prescribed medication. By the time Mr Caddick transferred to Haverigg, he appeared to be in a stable condition and was offered appropriate support from mental health services there.

82. The head of mental health and substance misuse services said that, ideally, standard mental health referrals should be assessed within a week when the team at Haverigg was fully staffed. When asked about Mr Caddick's three-week wait for an appointment, he said that he would have liked this to have been less but the team needed more resources as they had a vacancy and mental health nurses were also providing cover for the substance misuse team, dispensing methadone. He said that if a prisoner needed to be seen urgently, this could be facilitated. While this wait seems unfortunate, it was unavoidable in the circumstances and does not seem to have impacted on Mr Caddick's death.

Psychoactive Substances (PS)

83. Evidence suggests that Mr Caddick was regularly using PS. While staff the investigator spoke to seemed largely unaware of this, every prisoner gave a consistent account that Mr Caddick smoked it regularly and was in debt as a result. He disclosed his PS use to a nurse at Preston, was segregated for using PS at Preston shortly before he transferred to Haverigg, had admitted to using it there, and, on 5 December, an officer suspected he was under the influence. Another officer suspected Mr Caddick was using PS due to his associates, and a recovery worker wrote in Mr Caddick's record that unit staff were concerned Mr Caddick was a "prolific user" of PS. It is unclear exactly where this information came from since it is not documented elsewhere.

84. We note the toxicology report did not detect any drugs in Mr Caddick's blood. The report author noted, though, that drugs usually remain in a person's bloodstream for between 12 and 24 hours after they have been taken. The report also noted that when death occurs very quickly, such as with hanging, if a person has taken drugs immediately before death, the drugs may not be detectable in the blood. These findings, therefore, do not contradict the evidence that Mr Caddick used PS while in prison. What is not clear is whether their use was material to his decision to kill himself, although it is hard not to draw that conclusion.

85. The clinical reviewer says that ideally the mental health team should have spoken to Mr Caddick about his PS use, particularly considering his recent drug-induced psychosis and the potentially harmful combination of taking PS and antipsychotic drugs at the same time.

86. The PPO's Learning Lessons Bulletin on PS, issued in July 2015, sets out why these substances have become a source of increasing concern in prisons. There is evidence that PS poses dangers to both physical and mental health. In addition, trading these substances can lead to debt, violence and intimidation. In our Annual Report for 2016-2017, we noted that the number of deaths where the use of PS may have played a part continued to rise and that there was a greater need than ever for more effective drug supply and demand reduction strategies, including better monitoring by drug treatment services and effective violence reduction strategies.

87. Haverigg's local policy, *Approach and Strategy for Tackling PS,* acknowledges that PS is currently the biggest single threat to the good order and discipline of the prison and the safety of prisoners and staff. It says that Haverigg takes a "zero tolerance" approach, combined with referral and support to Unity, the substance misuse service. It says that if staff suspect a prisoner has taken PS, the prisoner must be given a sobriety test and the IEP policy should be used to address a prisoner's PS use. A referral should also be made to healthcare staff for them to review a prisoner's prescribed medication and to Unity. Information should be logged in the observation book, a prisoner's computer record, staff should complete an intelligence report and an incident report which should be given to their manager.

88. We are concerned about the absence of consistent formal recording of what appears to have been apparent to prison staff about Mr Caddick's drug use.

Neither his electronic prison record (NOMIS) nor the intelligence system (Mercury) was consistently used to document what was apparent to a number of staff, as they should have been, and as a result, action was not taken. These deficits appear to have been compounded by Mr Caddick's transfer from Preston to Haverigg which meant that steps which could have been taken to address his known use of PS were not taken.

89. We recognise that Mr Caddick refused to engage with substance misuse services when he arrived at Haverigg, claiming that he had been drug-free for four years. This statement does not appear to have been challenged. It is also apparent that some unit staff knew Mr Caddick was using PS yet did not submit intelligence reports, refer him to substance misuse services for support or testing, or communicate this information directly with the mental health and substance misuse teams. The wing observation book from 1 December until Mr Caddick's death makes no reference of any staff suspicions that Mr Caddick had used PS.

90. It is also apparent that Mr Caddick was in debt as a consequence of his PS use, a further potential risk factor. The prison should have been aware of this and should have taken steps to address it, both to reduce Mr Caddick's potential risk and also to manage the risk of broader instability and violence within the prison.

91. Staff told the investigator that PS use was a particular problem on the unit where Mr Caddick lived. They also said it was hard to stop PS being smuggled in to the prison as most of it was supplied on impregnated paper in prisoners' mail. The head of mental health and substance misuse services. He said that since Mr Caddick's death, Haverigg has set up a PS support group. The custodial manager also said that Haverigg was intending to write a drug support plan which sought to encourage prisoners to abstain from using PS, rather than using punitive measures.

92. We are not satisfied that Haverigg has robust procedures in place to enforce its policy to manage PS use at the prison. We therefore repeat a recommendation we made following a death at Haverigg in 2016:

The Governor and Head of Healthcare should ensure that there are effective supply and demand reduction strategies to help eradicate the availability of PS and that staff are vigilant to signs of its use and take appropriate action. In particular, staff should ensure that signs of drug use are recorded in prisoners' records and all staff should submit intelligence reports when they are aware of suspected drug use.

Entering Mr Caddick's cell

93. There were around four minutes between Officer A first looking into Mr Caddick's cell and Officer C unlocking it. The CCTV shows Officer A and Officer B walking at a normal pace both towards and away from Mr Caddick's cell, even after a prisoner told them that he had recently removed a noose from Mr Caddick. Both Officer A and Officer B, along with an OSG said that they would never enter a cell on their own, or without permission from Oscar One (a manager with responsibility for running the prison and responding to emergency incidents),

even in an apparently life-threatening situation. In contrast, Officer C arrived on the unit and unlocked Mr Caddick's cell immediately.

94. We are also concerned that, when Officer B requested permission by radio from the Orderly Officer to enter the cell, he asked her to telephone him. A custodial manager, said that this was not in line with protocol and permission should have been granted instantly, subject to the officers' own risk assessment.

95. Instructions about night procedures (PSI 24/2011, *Management and Security of Nights*), and about safer custody (PSI 64/2011, *Safer Custody*) are clear that preservation of life takes precedence over the usual arrangements for opening cells. Where there appears to be immediate danger to life, prison staff can unlock cells by themselves without the authority of the night manager, subject to a personal risk assessment. Since the roll check had not yet been completed, the prison was essentially still in night state.

96. Following a death at Haverigg in 2016, when staff did not enter a prisoner's cell immediately, we made a recommendation about entering cells, which the prison accepted. We are therefore very disappointed to be repeating this recommendation.

The Governor should ensure that staff open cells as soon as possible when there is an immediate danger to life.

Family liaison

97. The Head of Safety and Equalities, said that he was told twice that Mr Caddick's mother had telephoned the Governor and he returned her call on both occasions. He said he left voicemail messages but did not want to be intrusive and continue to ring her. He was also aware that she had his contact details from Doncaster staff. He said he offered to take Mr Caddick's belongings to her in person but she said she did not mind.

98. The prison misinformed Mr Caddick's mother that he had no post in his possession. They should have checked this information first with the police, who often take letters as evidence following a death in custody. In addition, the prison should have been more proactive in ensuring that its contribution to Mr Caddick's funeral expenses had been paid rather than leaving it for Mr Caddick's mother to contact them. The prison could also have been more proactive in the weeks after Mr Caddick's death in contacting Mr Caddick's mother.

99. Mr Caddick had not nominated a next of kin when he arrived at Haverigg but his computerised record contained details of his partner. The head of safety and equalities, said that he had not contacted Mr Caddick's partner as there was conflicting information about whether they remained in a relationship, he was unsure of Mr Caddick's partner's current address, and Mr Caddick's last telephone call had been to his mother. Mr Caddick's mother confirmed that she had passed on the news and there was no need for the head of safety and equalities, to contact Mr Caddick's partner directly. The head of safety and equalities, said he had not considered calling her since that time. We recognise that this was a finely-balanced decision and, while we may not agree with his

conclusion, we are not critical of this decision. We make the following recommendation:

The Governor should ensure that prison staff offer appropriate support and information to a prisoner's next of kin and ensuring the information they communicate is accurate.

Implementation of PPO recommendations

100. We are concerned to be finding similar failings to those identified in previous investigations into deaths at HMP Haverigg and to be repeating making recommendations to address those failings which the prison has previously accepted and agreed to implement. Given the range of areas where we have these concerns – the effective identification of risk, actions to address the availability and misuse of PS and ineffective emergency response, we believe that this requires the attention of the Governor's line management. We make the following recommendation:

The Prison Group Director, Cumbria and Lancashire Group, should assure himself that meaningful, effective and sustained action is taken to implement recommendations from PPO investigations at HMP Haverigg.

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