Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Peter Reeves a prisoner at HMP Swaleside on 17 January 2017

A report by the Prisons and Probation Ombudsman

PO Box 70769
London, SE1P 4XY
Email: mail@ppo.gsi.gov.uk
Web: www.ppo.gov.uk
T | 020 7633 4100
F | 020 7633 4141

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*

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.

We carry out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

Mr Peter Reeves was found dead in his bed at HMP Swaleside on 17 January 2017. He had cut a vein in his arm and the post mortem report stated that his cause of death appeared to be due to blood loss. Mr Reeves was 37 years old. We offer our condolences to his family and friends.

It is troubling that Mr Reeves appears to have become isolated in the weeks leading up to his death. It is particularly troubling that he appears to have been able to access and take hard drugs with ease.

While there was no obvious indication that Mr Reeves was at imminent risk of suicide and self-harm, there were a number of signs that, together, indicated rising risk. He told a prison doctor in late November that he had had thoughts of self-harm. He had been, appropriately, sanctioned, was known to be involved in the prison's drug culture and was due to attend an adjudication hearing on the morning of his death that might have resulted in his prison sentence being extended.

Had all these signs been considered collectively, as they would have had suicide and self harm protection measures been in place, they could have allowed closer monitoring and mitigation of risk to have been put in place.

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

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

Contents

Summary

Events

1. On 30 September 2013, Mr Peter Reeves was remanded to HMP High Down charged with grievous bodily harm. He was on licence at the time, following a previous conviction for importation of controlled drugs. He was sent to HMP Swaleside in April 2015.

2. In April 2016, Mr Reeves took an overdose of an unknown substance, which staff and prisoners said led to him becoming less outgoing.

3. In November 2016, Mr Reeves told a prison doctor that he had been feeling irritable and anxious for the previous two months and that he had had thoughts of self-harm. (Mr Reeves had a history of depression.)

4. In December 2016, Mr Reeves was found in possession of a large number of illicit items, including mobile telephones and improvised weapons. His access to privileges was reduced, he lost his prison job and was referred to the independent adjudicator for consideration of possible further punishment, including potentially having up to 42 days added to his sentence.

5. During evening association on 16 January 2017, Mr Reeves chatted with several of his friends. None of them noticed anything untoward in Mr Reeves' behaviour although several of them said that Mr Reeves had been smoking heroin that evening and that he had marks on his neck.

6. Mr Reeves' adjudication hearing was set for 17 January. When his cell was unlocked that morning, an officer saw blood on the cell floor, on the bed cover and on Mr Reeves. The officer radioed an emergency call but checks found that Mr Reeves was already dead and that rigor mortis had set in. His cause of death was blood loss from a severed artery in his arm.

Findings

7. While there was no single obvious indication that Mr Reeves was at potential risk of imminent suicide, there were a number of factors that if considered in the round suggested there was some risk. Most significantly, Mr Reeves had told a prison doctor in late November that he had had past thoughts of self-harm.

8. We are concerned at the reports from other prisoners that smoking of heroin during evening association is widespread and obvious.

9. Although the clinical reviewer concluded that Mr Reeves received appropriate care at Swaleside, he considered that there was a need to explore further Mr Reeves' mental health. The clinical reviewer has also commented on medication prescribing practices.

Recommendations

- The Governor and Head of Healthcare should ensure that staff manage prisoners at risk of suicide and self-harm in line with national guidelines, including that staff begin ACCT procedures in accordance with PSI 64/2011 when there is a risk or threat of suicide or self-harm.
- The Governor should ensure that there is an effective and well-implemented strategy to:
  - Reduce the availability, demand and explicit use of illicit substances.
  - Ensure important information about risk is recorded in prisoners' P-NOMIS records and wing observation books.
  - Ensure all staff understand the need to submit intelligence reports when they become aware of potential risk.

The Investigation Process

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

11. The investigator visited Swaleside on 20 January 2017. He obtained copies of relevant extracts from Mr Reeves' prison and medical records.

12. The investigator interviewed ten members of staff and eight prisoners at Swaleside between February and March 2016.

13. NHS England commissioned a clinical reviewer to review Mr Reeves' clinical care at the prison. The clinical reviewer conducted three interviews jointly with the investigator.

14. We informed HM Coroner for Mid Kent and Medway of the investigation. The Coroner supplied us with a copy of Mr Reeves' post-mortem and toxicology reports, which showed that his cause of death would appear to have been due to blood loss from a wound to his inside left elbow. Toxicological examinations showed the presence of codeine and morphine in Mr Reeves' urine. We have sent the Coroner a copy of this report.

15. One of the Ombudsman's family liaison officers, contacted Mr Reeves' mother and on 22 February 2017 spoke to her husband. The family liaison officer explained the investigation process and asked if the family had any matters they wanted the investigation to consider. Her husband said that Mr Reeves had sent his mother a number of text messages in October and December 2016 in which he said that he was under pressure to convert to Islam.

16. Mr Reeves' family received a copy of the draft report but they have not provided any response to our findings.

Background Information

HMP Swaleside

17. HMP Swaleside, on the Isle of Sheppey, can hold up to 1,112 men. Swaleside's main function is to hold life-sentenced prisoners, but it also holds prisoners serving determinate sentences.

18. IC24 Integrated Care provides primary healthcare at Swaleside. There is 24-hour nursing cover, which includes a qualified nurse and a healthcare assistant at night. There is a 17-bed inpatient unit. Minster Medical Group provides GP cover from 9.00am to 5.00pm on Monday to Friday, while Medoc provides an out of hours GP service. Oxleas NHS Foundation Trust provides mental health services.

19. In the early evening of 22 December 2016, around 60 prisoners took control of one of the landings on A Wing. The disturbance was confined to that landing and by the early hours on the following day, officers regained control and all prisoners were returned to their cells.

HM Inspectorate of Prisons

20. The most recent inspection of Swaleside was in April 2016. Inspectors noted that at the time of the inspection levels of violence and disorder were far too high. Contributory factors were noted to be the changed demographic of the population with the departure of over 300 category C prisoners and the use among prisoners of drugs and new psychoactive substances (NPS). Inspectors noted the high percentage of prisoners reporting that it was easy to obtain drugs and the high percentage of prisoners providing positive drug test results. However, Inspectors also commented on the meaningful action plan produced by a recently convened drug strategy committee while noting a need for improved attendance at the meeting by staff from key departments. In his overall summary, the Chief Inspector noted that Swaleside had been a struggling prison for some time but he was optimistic that the prison had started to stabilise with the new Governor appearing to have a very clear understanding of the challenges that he and his team were facing.

Independent Monitoring Board

21. Each prison in England and Wales has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community, who help ensure that prisoners are treated fairly and decently. In its most recently published annual report for the year ending April 2016, the IMB was concerned about the number of inexperienced officers, which they considered had in part contributed to the prevalence of prisoners holding weapons, drugs and mobile phones. The IMB noted that the new Governor had introduced a number of initiatives including a three-day lockdown to allow a large team of security officers to make searches of illicit items that led to a large number of finds.

Previous deaths at HMP Swaleside

22. Mr Reeves' death was the third self-inflicted death at Swaleside since August 2012. In a previous investigation, we recommended that Swaleside needed to ensure they had an effective substance misuse strategy to help reduce the availability and demand for new psychoactive substances and for staff to know how to respond when prisoners appeared to be under the influence of such substances.

Assessment, Care in Custody and Teamwork

23. Assessment, Care in Custody and Teamwork (ACCT) is the care planning system the Prison Service uses for supporting and monitoring prisoners assessed as at risk of suicide and self-harm. The purpose of the ACCT process is to try to determine the level of risk posed, the steps that might be taken to reduce this and the extent to which staff need to monitor and supervise the prisoner. Levels of supervision and interactions are set according to the perceived risk of harm. There should be regular multidisciplinary case reviews involving the prisoner. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011.

Incentives and Earned Privileges scheme

24. Each prison has an Incentives and Earned Privileges 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 three levels, basic, standard and enhanced.

Key Events

25. On 30 September 2013, Mr Peter Reeves was remanded into custody at HMP High Down having been arrested for an offence of grievous bodily harm (GBH). He was on licence at the time following a previous conviction and prison sentence for importation of controlled drugs. During a first reception healthscreen assessment, Mr Reeves said that he had a history of depression, but had no thoughts of self-harm or suicide.

26. Mr Reeves was convicted and sentenced for GBH on 4 March 2014 and was taken to HMP Belmarsh. His earliest release date was 19 July 2017.

27. On 2 April 2015, Mr Reeves was transferred from Belmarsh to HMP Swaleside. During a healthscreen assessment, Mr Reeves said that he had no thoughts of self-harm or suicide.

28. At around midday on 22 April 2016, wing staff radioed a code blue (indicating a medical emergency) for Mr Reeves who was behaving strangely. A nurse noted that Mr Reeves had ingested an unknown substance. She noted that he was able to give yes and no answers to questions but that he was not orientated.

29. On 10 May, a member from the mental health in-reach team assessed Mr Reeves. She noted that there was no evidence of any thought disorder, although wing staff had noticed a significant change in Mr Reeves' behaviour during the past few weeks, changing from a cheerful outgoing person to becoming withdrawn and seeking isolation. Mr Reeves agreed to a period of help and monitoring by a support worker offering practical support to people with mental health or learning difficulties.

30. On 12 May, Mr Reeves was told of his support worker and that she would support him over the following few weeks. The support worker noted that Mr Reeves was pleasant, but seemed reluctant to disclose any information. He did say though that he was not feeling his usual self and was low in mood. He also said that staff on the wing were trying to make him "crazy" by moving many prisoners to new cells. She told Mr Reeves that she would see him again for a follow-up appointment.

31. A person from the drug and alcohol team saw Mr Reeves on 17 May, but he said that he did not need help from the team.

32. His support worker saw Mr Reeves again on 23 May. She noted that Mr Reeves engaged slightly more at this appointment. He said he had been "feeling weird" a few weeks before but was feeling better now.

33. At their next meeting on 8 June, his support worker noted that Mr Reeves was in a talkative mood. He said that he was feeling more like himself, although he was still having some paranoid thoughts. She noted that Mr Reeves denied that he had used spice (a new psychoactive substance: NPS) a few weeks earlier.

34. On 29 June, his support worker noted that Mr Reeves had started going to the gym again and was cooking with other prisoners. She told Mr Reeves that she could offer him more structured therapeutic work through a coping skills course and she said she would send him some literature about the course.

35. When his support worker saw Mr Reeves again on 18 July, he told her that he had read the literature but he did not want to do the coping skills course. She told Mr Reeves that she would discharge him from her caseload but he would be able to refer himself again in the future if he needed help.

36. On 14 October, Mr Reeves sent his mother a number of illicit text messages. He asked her to find out the meaning of the term 'Sharia Law'. In another message, he wrote that he could not talk to her as "there are vents in all cells joined up, so they listen".

37. On 18 October, Swaleside's security team recorded that Mr Reeves had received a letter from his mother who had written:

    "… Enclosed [is the £100] you asked for, this is a one off, do not ask again ... stop smoking [it is] a waste of money … You must speak to someone about these Muslims and the threats they are making …"

38. A Supervising Officer (SO) told the investigator that he spoke to Mr Reeves about the letter from his mother. He said that he could not specifically recall the conversation but his standard practice would have been to ask Mr Reeves directly whether he was under threat, which Mr Reeves denied. The SO said that he recorded the information in the wing observation book to ensure that the wing officers were aware of the discussion. The wing observation book contained no such entry, nor did the SO submit an intelligence report.

39. On 28 November, Mr Reeves saw a prison GP saying that he had been feeling irritable and anxious for the previous two months. Mr Reeves said that he had had thoughts of self-harm but had been able to distract himself. He said that he occasionally self-medicated by smoking heroin, but had not used NPS (the prison GP would have been able to submit an intelligence report about Mr Reeves' use of heroin, but he did not do so). He noted that Mr Reeves was well kempt, his speech was normal, he engaged well, his mood and thought processes were normal and he had no suicidal ideation or thoughts of self-harm. He diagnosed stress and anxiety and he prescribed sertraline and promethazine. He referred Mr Reeves to the in-reach team and arranged to review him in two weeks time.

40. The in-reach team saw Mr Reeves for a triage assessment on 9 December. The in-reach team member noted that Mr Reeves was pleasant and cooperative but he reported a number of frustrations with the prison including cancelled gym sessions and spending more time locked in his cell. Mr Reeves said that he was struggling to remain calm. She noted that the prison GP referral to the in-reach team was intended to address Mr Reeves' previous thoughts of self-harm.

41. At interview with the investigator and the clinical reviewer, the in-reach team member said that Mr Reeves engaged well during the assessment and he gave no indications of any significant emotional disturbance. She said that she asked him if he had any thoughts of self-harm or suicide and he said that he did not. She said that she had had no cause to doubt Mr Reeves' response and if she had had any doubts, she would have opened an ACCT.

42. A prison GP saw Mr Reeves for a follow-up appointment on 12 December. He noted that Mr Reeves was still feeling anxious but as he had only been receiving

sertraline for two weeks it was possible the medication had not yet taken effect. Mr Reeves said he had no present thoughts of self-harm.

43. Mr Reeves used the gym on 16 December but he did not use the gym again after that day.

44. On 20 December, an officer alerted an SO that Mr Reeves was acting suspiciously. The officers went into Mr Reeves' cell and discovered a large number of illicit items including two mobile telephones, three SIM cards, three improvised weapons and a hypodermic needle and syringe. Mr Reeves was charged with contravening prison rules and was reduced from enhanced level to basic level on the incentives and earned privileges (IEP) scheme (the lowest level of the scheme). As a consequence his television was taken away and he lost his job on the waste management team. (Mr Reeves would have been able to apply for a new job after 28 days.)

45. On 22 December, Mr Reeves attended a preliminary adjudication hearing with one of Swaleside's operational managers, in relation to the discovery of the illicit items on 20 December. He told Mr Reeves that due to the serious nature of the charges he would refer the case to the independent adjudicator. (Independent adjudicators are district judges and, if warranted, can add up to 42 days to a prisoner's sentence.)

46. On 14 January 2017, a prison Imam met Mr Reeves to discuss the teachings of Islam and Mr Reeves asked for some literature about Islamic worship. The prison Imam told the investigator that Mr Reeves wanted to find out more about the Islamic faith but he had not decided at that time whether he would convert. He said that he did not believe that there was any pressure on prisoners to convert to Islam and he did not believe there was any bullying between Muslims and non-Muslims.

47. The investigator spoke to eight of Mr Reeves' friends on B Wing. Most said that Mr Reeves had become more isolated in the weeks leading up to his death: in particular, that he stopped going to the gym and stopped using the kitchen to make biscuits. Most of the prisoners noticed cuts or marks to Mr Reeves' neck and several of them believed that the officers saw the marks. A prisoner said that a mental health in-reach worker had also seen the marks, but had taken no action. (Mr Reeves' post-mortem report recorded a two centimetre scratch mark on the right side of his neck and a small abrasion to the left side: there was no indication of the age of these injuries and no suggestion that they contributed to Mr Reeves' death.)

48. Three of the prisoners said that they had spoken to Mr Reeves on the late afternoon of 16 January. The first prisoner said that he chatted with Mr Reeves up to the time of lock-up at just after 6.00pm. He said that there was nothing unusual about Mr Reeves and he did not seem downcast. Although Mr Reeves was not happy at the prospect of having additional days imposed at his adjudication hearing the next day, the prisoner believed that Mr Reeves would "just get on" with those days.

49. The second prisoner said that Mr Reeves had been "in good form" that evening and they had been laughing and joking together. Mr Reeves had asked to borrow his hair clippers to smarten-up for his adjudication hearing the following day.

50. The third prisoner said he had chatted to Mr Reeves up to the time that prisoners were locked up for the night. He said that Mr Reeves had been his usual self and he did not see any signs that Mr Reeves might harm himself. He also said that Mr Reeves had been smoking heroin during association and he added that the wing "stinks" of drugs during the evening.

51. None of Mr Reeves' friends thought that he had been put under any pressure to convert to the Islamic faith and several said that Mr Reeves got on well with most of the other prisoners, both Muslims and non-Muslims.

17 January 2017

52. At around 7.30am on 17 January, an officer completed a roll check on B Wing and noticed nothing untoward.

53. At 8.30am, an officer went to Mr Reeves' cell to tell him that he needed to go to the segregation unit ahead of his adjudication hearing that morning. When the officer looked through the observation panel, he thought that Mr Reeves was still asleep. He unlocked the cell door and with the cell illuminated from the landing light, he could see blood on the floor, on the bed covering and on Mr Reeves. He radioed a code red emergency alarm to indicate that a prisoner has lost a significant amount of blood and he then checked Mr Reeves' body, which he found cold to the touch.

54. A healthcare assistant arrived within around two minutes and when he checked Mr Reeves, he noted that his body was very cold and that rigor mortis was present. He checked Mr Reeves with a defibrillator, which instructed that no shock should be given. Other nurses arrived and, as it was clear that Mr Reeves was dead, they did not attempt cardiopulmonary resuscitation (CPR). An ambulance had been called in response to the code red and the paramedics arrived at the cell at 8.57am. One of the prison doctors, officially certified death at 9.01am.

Contact with Mr Reeves' family

55. Mr Reeves had named his mother as his next of kin with an address in Worthing. However, since giving those details she had changed her name on remarrying and moved to a new address. The prison contacted the police for assistance and, by the afternoon, the police confirmed her new name and her address in mid-Wales. Swaleside contacted HMP Usk and staff from that prison visited Mr Reeves' mother at 5.30pm to inform her of her son's death.

56. Mr Reeves' mother visited Swaleside on 6 February 2017 when she met the Governor and attended a memorial service for her son. Prisoner friends had made a collection to buy a floral tribute. Mr Reeves' funeral was held on 15 February 2017, and the Governor and prison's family liaison officer attended. The prison contributed to the funeral costs, in line with national instructions.

Support for prisoners and staff

57. The Head of Safer Custody 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.

58. Prisoners on B Wing were informed of Mr Reeves' death by officers going from cell to cell and were each given a letter from the senior management team. Listeners went to B Wing to speak to any prisoners needing support. (Listeners are prisoners trained by the Samaritans to offer confidential support to other prisoners.)

59. The prison posted notices informing prisoners of Mr Reeves' 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 Reeves' death.

Post-mortem report

60. Mr Reeves' post-mortem report showed a wound to his inside left elbow that had penetrated his brachiocephalic vein with his death appearing to be due to blood loss from that wound. The report noted presence of codeine and morphine in Mr Reeves' urine and liver. The pathologist did not indicate that these substances contributed to Mr Reeves' death. The post-mortem report also noted that naproxen had been detected in Mr Reeves' urine and liver (naproxen is a non-steroidal inflammatory drug used as a painkiller).

61. A separate toxicology report noted that Mr Reeves' urine was screened for 42 different new psychoactive substances (NPS) but no such substances were detected. The toxicology report contained an analysis of levels of morphine that have been found to cause overdose. This showed that the level found for Mr Reeves was within the lower range of the level that can cause overdose, although the report did not discuss this point.

Items found in cell

62. Items found in Mr Reeves' cell after his death included a cutting tool fashioned from a comb and razor and a letter dated 10 November 2016 from Her Majesty's Revenue and Customs stating that he owed them £730.80. There is no record that Mr Reeves spoke to anyone about this debt.

Findings

Assessment and management of risk

63. When Mr Reeves saw a prison GP on 28 November 2016 he disclosed that he had had recent thoughts of self-harm, although he had been able to distract himself from acting on those thoughts. He noted that Mr Reeves had no present thoughts of self-harm or suicide.

64. The prison GP told the investigator and the clinical reviewer that he had not explored with Mr Reeves how far in the past he had had thoughts of self-harm. He said that he did not consider at the time that it was appropriate to open an ACCT, but he accepted at interview that it might have been more appropriate to have done so, or otherwise have informed officers about Mr Reeves' comment.

65. Prison Service Instruction (PSI) 64/2011, which covers safer custody, instructs that any member of staff who receives information or observes behaviour, which may indicate a risk of suicide or self-harm must open an ACCT. Prison Service suicide and self-harm prevention procedures rely on staff using their experience and skills, as well as local and national assessment tools, to determine risk. It is not an exact science. While a prisoner's presentation is obviously important and reveals something of their level of risk, it is only a reflection of their state of mind at the time they are seen by the member of staff and should be considered as a single piece of evidence used to make a judgement of risk. All risk factors should be collated and considered to ensure that a prisoner's level of risk is assessed holistically.

66. Several prisoners told the investigator that Mr Reeves had visible cuts or scratches to his neck in the days before his death. None of the prisoners informed staff about the marks, although one said that an in-reach nurse had seen the marks. He said that this nurse had attended Mr Reeves' memorial service. Mr Reeves' post-mortem report confirmed that he had two small marks to his neck but all the officers that the investigator spoke to denied seeing the marks and the investigator was also told that there was no in-reach nurse with the name the prisoner gave and that none of the in-reach staff attended the memorial service.

67. Had the prisoner GP opened an ACCT, an ACCT assessor would then have explored the matters more thoroughly with Mr Reeves covering both his static and dynamic risk factors.

68. These included a history of depression, use of heroin, a change in personality following drug use in April 2016, increased isolation, self-confessed paranoia and anger with the prison regime, thoughts of self-harm, problems with debt, reduction to basic IEP, an impending adjudication and possible addition of days to his sentence, and the marks on his neck.

69. No single member of staff was aware of all these risk factors but they would have been explored in the case of a multidisciplinary ACCT assessment.

70. We make the following recommendation:

The Governor and Head of Healthcare should ensure that staff manage prisoners at risk of suicide and self-harm in line with national guidelines, including that staff begin ACCT procedures in accordance with PSI 64/2011 when there is a risk or threat of suicide or self-harm.

Drugs, NPS, Security and Intelligence

71. At the time of Mr Reeves' death, Swaleside had a drug and alcohol strategy, which relied on input from all sectors in the prison, including security, healthcare and operational staff. A number of tactics were employed to control the supply of, and demand for, drugs in Swaleside. These included random deployment of a drug detection dog, searching of both official and unofficial visitors and systematic searching of all prisoners, and random tests, along with targeted searching of prisoners based on intelligence. Prisoners who provided positive drug tests were referred to the substance misuse team.

72. Mr Reeves was suspected of taking NPS in April 2016 but he consistently denied this and he declined an offer to engage with the substance misuse team. Post-mortem investigations found no evidence that Mr Reeves had taken NPS in the recent past but confirmed presence of morphine in his urine. Mr Reeves did indeed admit to a prison GP that he sometimes 'self-medicated' with heroin and his friends said that he had been smoking heroin on the evening before his death. His friends also said that smoking of drugs during association periods was widespread and obvious.

73. Following an inspection in April 2016, HM Inspector of Prisons commented on the high percentage of prisoners who reported on the ease of obtaining drugs and also commented on the high percentage of prisoners providing positive results on the mandatory drug-testing programme. We understand that the drug strategy committee, referred to positively by HMIP, has yet to be properly established at the prison.

74. We make the following recommendation:

The Governor should ensure that there is an effective and well-implemented strategy to:

- **Reduce the availability, demand and explicit use of illicit substances.**
- **Ensure important information about risk is recorded in prisoners' P-NOMIS records and wing observation books.**
- **Ensure all staff understand the need to submit intelligence reports when they become aware of potential risk.**

Mental health care

75. The overall conclusion reached by clinical reviewer, was that Mr Reeves' care at Swaleside was generally in keeping with that which he might have expected to receive in the community. While he considered that Mr Reeves' death was

unexpected and unforeseen, he did identify the need to explore further Mr Reeves' mental health.

76. The clinical reviewer noted that Mr Reeves had experienced episodes of anxiety and depression during his time in prison custody and had received treatment from the mental health in-reach team. He noted that Mr Reeves' clinical consultations on 28 November 2016 with the prison GP and 9 December 2016 with the in-reach support worker both supported the diagnosis of an acute stress reaction on the background of a person with a past history of mild depression. While Mr Reeves had not been assessed to be at risk of suicide at these consultations, the clinical reviewer noted that Mr Reeves had spoken about past thoughts of self-harm which were not explored further at these consultations.

77. The clinical reviewer acknowledged that the prison GP covered significant detail during the consultation on 28 November, which he did within the context of the limited amount of time available for GP consultations. Despite this, the clinical reviewer considered that Mr Reeves' comment about past thoughts of self-harm could have been explored further. He has also made recommendations about prescribing medication practices which the head of healthcare will need to address.

Prisons & Probation Ombudsman
Independent Investigations

PO Box 70769
London, SE1P 4XY

Email: mail@ppo.gsi.gov.uk
Web: www.ppo.gov.uk

T | 020 7633 4100
F | 020 7633 4141