

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Nicholas Casley a prisoner at HMP Exeter on 18 July 2018

A report by the Prisons and Probation Ombudsman

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 Nicholas Casley was found hanged in his cell at HMP Exeter on 18 July 2018. He was 59 years old. I offer my condolences to Mr Casley's family and friends.

Mr Casley arrived at Exeter on 31 May 2018 after being remanded in custody on charges of sexual offences against a family member. He had attempted suicide shortly before being charged. Prison staff appropriately monitored him under suicide and self-harm prevention procedures (known as ACCT) from the day he arrived until 12 June.

The investigation found that Mr Casley was initially well supported by the ACCT procedures and by the mental health team at Exeter.

However, I am concerned that when Mr Casley returned from court on 6 July after pleading guilty, staff failed to review the suicide and self-harm warning form that accompanied him and no one started ACCT monitoring. I consider they should have done. Also, no one updated Mr Casley's custodial status to show that it had changed from remand prisoner to convicted prisoner. As a result, Mr Casley was not seen or assessed by healthcare staff as he should have been. I am concerned that opportunities to recognise that Mr Casley was at increased risk of suicide and self-harm, and to put appropriate measures in place, were missed.

I am also concerned that he did not receive the mental health support that had been planned for him during his court appearances.

We have expressed concerns about deficiencies in the management of suicide and self-harm procedures at Exeter in previous investigations. I am, therefore, copying this report to the Prison Group Director for Devon and North Dorset so that she can satisfy herself that action is taken to remedy these deficiencies.

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

June 2019

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Summary

Events

1. Mr Nicholas Casley was remanded in custody on 31 May 2018 after being charged with sexual offences against a family member. He was sent to HMP Exeter. This was his first time in prison.
2. Mr Casley had attempted suicide shortly before he was charged. Staff monitored Mr Casley under Prison Service suicide and self-harm prevention procedures (known as ACCT) from the day he arrived at Exeter until 12 June.
3. On 14 June, Mr Casley saw his mental health keyworker. She wrote in his medical record that he had been offered the support of a Care Programme Approach (CPA), an enhanced package of care for those with mental health problems, and she would see him twice a month for one-to-one support. There is no record that Mr Casley saw his keyworker again.
4. On 6 July, Mr Casley attended court where he pleaded guilty to the charges against him. When he was returned to Exeter, a suicide and self-harm (SASH) warning form accompanied him because court staff had noted he was upset and his solicitor was concerned about him. Reception staff did not start ACCT monitoring. He was due to attend court for sentencing on 19 July.
5. On 18 July at 3.06am, Mr Casley's cellmate pressed his cell bell after finding Mr Casley hanging from the window bars in the toilet area of their cell. Staff attended immediately, cut Mr Casley down and started cardiopulmonary resuscitation (CPR). Staff called a medical emergency code blue over the radio and the control room called an ambulance. Healthcare staff arrived shortly afterwards and took over resuscitation until the ambulance arrived at 3.15am. Ambulance staff were unsuccessful in resuscitating Mr Casley and at 3.35am, they pronounced he had died.

Findings

6. We consider that prison staff should have started ACCT monitoring when Mr Casley was returned to Exeter from court on 6 July. It appears that the reception officer failed to review the SASH warning form, although we have been unable to establish exactly what went wrong as the prison was unable to identify the officer who saw Mr Casley in reception that evening. Whatever the reason, we consider that the reception process was inadequate as staff failed to consider all the risk information available on Mr Casley and properly assess his risk.
7. Staff also failed to note that when Mr Casley was returned to Exeter from court on 6 July, his status had changed from a remand prisoner to a convicted prisoner. Because of this oversight, he was not assessed by healthcare staff as he should have been. This was another missed opportunity to assess his risk of suicide and self-harm.
8. There is no record that Mr Casley's mental health keyworker saw him after 14 June. She told us that she saw Mr Casley at the beginning of July, but this was not documented. We found that she did not offer him support in accordance with

his agreed care plan, as well as failing to record all her contacts with him. The clinical reviewer considered that the care Mr Casley received was not equivalent to that which he could have expected to receive in the community.

Recommendations

- The Governor and Head of Healthcare should ensure that staff assess risk based on all known risk factors rather than on the prisoner's presentation, and ensure that triggers are appropriately recorded.
- The Governor should ensure that reception staff are fully trained in reception procedures and are aware of the relevant national and local policies, in particular staff should:
 - assess all prisoners arriving in reception and check all accompanying documentation to identify any immediate needs and risks;
 - consider starting ACCT procedures if there is an indication of a risk of suicide or self-harm, such as when the prisoner is accompanied by a SASH warning form; and
 - clearly record any key risk information, alerts and decisions made in the prisoner's record.
- The Governor should ensure that prisoners are assessed by healthcare staff when there has been a change in their custodial status, in accordance with the prison's Safer Custody policy.
- The Head of Healthcare should ensure that mental health services meet the needs of prisoners by ensuring that:
 - care plans are adhered to and that prisoners have regular face-to-face contact with their keyworkers; and
 - staff clearly record all contacts with prisoners.
- The Prison Group Director for Devon and North Dorset should satisfy herself that effective action is taken at Exeter to remedy the deficiencies in the operation of ACCT procedures identified in this and previous PPO investigations.

The Investigation Process

9. The investigator issued notices to staff and prisoners at HMP Exeter informing them of the investigation and asking anyone with relevant information to contact her. No one responded.
10. The investigator obtained copies of relevant extracts from Mr Casley's prison and medical records.
11. NHS England commissioned a clinical reviewer to review Mr Casley's clinical care at the prison.
12. The investigator interviewed five members of staff at HMP Exeter. Four of these interviews were carried out jointly with the clinical reviewer. The investigator and an Assistant Ombudsman also interviewed one prisoner. The interviews took place between July and December 2018.
13. We informed HM Coroner for Exeter and Greater Devon of the investigation. The coroner gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.
14. The investigator contacted Mr Casley's wife to explain the investigation and to ask if the family had any matters they wanted the investigation to consider. His wife wanted to know if Mr Casley's mental health had been properly assessed and whether the prison had taken appropriate steps to reduce his risk of suicide and self-harm.
15. Mr Casley's family received a copy of the initial report. They did not raise any concerns regarding factual accuracy of this report.

Background Information

HMP Exeter

1. HMP Exeter is a Victorian city-centre prison which covers the courts of Devon, Cornwall and Somerset. It holds up to 561 adult men and young offenders. Care UK provide primary healthcare and commission Devon Partnership NHS Trust to provide mental health care.

HM Inspectorate of Prisons

2. The most recent inspection of HMP Exeter was in May 2018. Inspectors found that, despite a significant increase in staffing since the last inspection in August 2016, there had been a sharp deterioration in the outcomes for prisoners. They noted that many of their previous recommendations had been ignored. They were particularly concerned to find that the key area of prisoner safety attracted their lowest possible grading of poor. Inspectors reported that two-thirds of prisoners did not feel safe, there had been a 40% increase in incidents of self-harm and six self-inflicted deaths since their last inspection, prisoner on prisoner assaults was at the highest levels seen in the past three years, and the availability of illicit drugs continued to be prevalent. The inspectors were also concerned about poor living conditions.
3. Following the inspection, HM Chief Inspector of Prisons invoked the Urgent Notification protocol and wrote to the Secretary of State on 30 May 2018 setting out his significant concerns about the treatment of prisoners and the conditions in which they are held.

Independent Monitoring Board

4. 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 Exeter for the year to December 2017, the IMB reported that prisoners were treated fairly and humanely. They recognised that there had been an improvement in staffing numbers since their last report, but felt more needed to be done to increase staffing to the required levels. The IMB expressed concerns about delays in appropriate mental health provision for some prisoners as well as poor living conditions.

Previous deaths at HMP Exeter

5. Mr Casley was the 31st prisoner to die at Exeter since July 2015. Eleven of the previous deaths were self-inflicted. Previous investigations have identified concerns with the reception process, including the failure of reception staff to identify risk issues and to make timely referrals for mental health assessments.

Assessment, Care in Custody and Teamwork

16. ACCT is the Prison Service care-planning system used to support prisoners at risk of suicide or self-harm. The purpose of ACCT is to try to determine the level of risk, how to reduce the risk and how best to monitor and supervise the prisoner. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011.

17. After an initial assessment of the prisoner's main concerns, levels of supervision and interactions are set according to the perceived risk of harm. Checks should be irregular to prevent the prisoner anticipating when they will occur. There should be regular multi-disciplinary review meetings involving the prisoner. As part of the process, a caremap (plan of care, support and intervention) is put in place. The ACCT plan should not be closed until all the actions of the caremap have been completed.
18. All decisions made as part of the ACCT process and any relevant observations about the prisoner should be written in the ACCT booklet, which accompanies the prisoner as they move around the prison.

Key Events

19. On 31 May 2018, Mr Nicholas Casley was remanded in custody after being charged with sexual offences against a family member. He was sent to HMP Exeter. This was his first time in prison.
20. Mr Casley arrived at Exeter with a suicide and self-harm warning form as he had told court staff and the police that he wanted to end his life. The Person Escort Record (PER - a risk assessment document that accompanies prisoners between police custody, court and prisons) recorded that Mr Casley had recently attempted to take his life with an overdose of drugs and alcohol and he had been sectioned under the Mental Health Act. The PER stated that Mr Casley was tearful and anxious.
21. An officer saw Mr Casley in reception and started suicide and self-harm prevention monitoring (known as ACCT).
22. A nurse carried out Mr Casley's reception healthcare screening. She noted the details about his recent self-harm and sectioning and that he had no previous history of mental health issues. She recorded that Mr Casley engaged well throughout the assessment, although she noted minimal eye contact and tearfulness at times. Mr Casley told her that he had no current thoughts of suicide or self-harm and that he was not brave enough to take his own life. She referred Mr Casley to the mental health team. She also offered Mr Casley the support of substance misuse services, but he declined.
23. Following the reception process, staff placed Mr Casley in a shared cell on the Vulnerable Prisoners' Unit (VPU) on B Wing and monitored him under ACCT procedures twice an hour.
24. An officer conducted an ACCT assessment interview with Mr Casley on 1 June. Mr Casley told the officer that he had tried to take his life on 8 May following questioning by the police. He said he felt that, due to the nature of the offences, he had brought shame on his family and he could not cope. Mr Casley said he was anxious and overwhelmed at being in prison, but he wanted to settle into the regime and he had no thoughts of suicide or self-harm.
25. Mr Casley attended his first ACCT case review later that morning. The review was chaired by a Supervising Officer (SO) and attended by a mental health keyworker. Mr Casley repeated much of what he had said previously but he also said he would face up to what he had done and that he had no intention of taking his own life. The SO and the mental health keyworker assessed his risk as low and reduced the frequency of his observations.
26. The mental health keyworker wrote up an assessment of Mr Casley's mental health needs in his medical notes with a view to taking him onto the mental health team caseload. She also referred Mr Casley to the GP for an urgent appointment to discuss his feelings of depression. On 4 June, following a multidisciplinary team meeting, she took Mr Casley onto her caseload.

27. On 7 June, Mr Casley had his second ACCT review which was chaired by a SO and attended by an officer. The mental health keyworker was unavailable, but a verbal update was provided from the mental health team saying that Mr Casley was on their caseload. An officer noted that Mr Casley had missed an appointment with the GP on 6 June as he had not been unlocked, but the appointment had been rearranged. Mr Casley said he would see the GP but he did not want to take medication. The officer noted that Mr Casley seemed to have settled into the prison regime but still seemed low in mood. Mr Casley said he was anxious about his court appearance but he said he intended to stay alive to face the charges as he did not want to put his family through any more pain. Staff assessed Mr Casley's risk of harm as low and agreed to continue ACCT monitoring.
28. On 8 June, Mr Casley had a review with his mental health keyworker. She noted that Mr Casley was pleased to have the support of the mental health team. He reported feeling better and said he had a supportive cellmate. She noted that Mr Casley expressed an acceptance of the eventual outcome of his trial and that he said he had no thoughts of suicide or self-harm.
29. Mr Casley had his third ACCT case review on 12 June. The review was chaired by a SO and attended by his mental health keyworker. Mr Casley said that he had attended court by video link that day after his case was brought forward, but the hearing had been adjourned to 6 July. The SO said that he initially thought Mr Casley's court appearance would be a trigger factor for him but, due to his apparent acceptance of the length of sentence he faced and the fact that he said he did not want to cause his family any more pain, he felt that the court appearance itself was no longer a trigger. The mental health keyworker also agreed, based on Mr Casley's presentation and what he said, that his court appearance was not a trigger factor for him. The SO and the mental health keyworker assessed Mr Casley's risk as low. They agreed to stop ACCT monitoring but to consider ACCT monitoring again once Mr Casley was sentenced. An ACCT post-closure review was scheduled for 20 June.
30. On 13 June, Mr Casley attended an appointment with a prison GP. The GP noted that Mr Casley was tearful about what he had done to his family but he told her he was coping better than he thought he would. She diagnosed low mood and noted that Mr Casley declined any medication. She agreed to see him again in two weeks.
31. On 14 June, Mr Casley's mental health keyworker met with him to agree his care plan. She offered Mr Casley the support of a Care Programme Approach (CPA - an enhanced package of care for those requiring extra support) during the time he was on remand and post-sentencing. She noted that the aim of the care plan was to monitor his mood, level of activity, self-care, wellbeing, family contact and his court case. She agreed to see him twice a month to offer one-to-one support. Mr Casley agreed with the care plan.
32. On 20 June, Mr Casley attended an ACCT post-closure interview with a SO. He noted that Mr Casley said he was no longer feeling depressed. Mr Casley said he had settled down, had a good cellmate and had had contact with his wife and son. Mr Casley said he knew how to access the Listeners and Samaritans. He

said he wanted to apply for work and was interested in using the gym and the library. Mr Casley wrote on the ACCT questionnaire that he was being treated well by staff and he was getting the help he needed.

33. On 27 June, Mr Casley had another appointment with a prison GP. She noted that Mr Casley was much better and he continued to decline medication. She said that Mr Casley was prepared for his court appearance on 6 July. Mr Casley said he felt fine if he did not think about his family and kept himself busy.
34. On 6 July, Mr Casley attended court where he pleaded guilty to the charges against him. He was returned to the prison at 6.50pm with a suicide and self-harm (SASH) warning form from the court which stated that he was depressed and upset and that his solicitor was concerned he may self-harm. The PER also said that Mr Casley had pleaded guilty at court and was due to return to court for sentencing on 19 July. However, the escort contractor did not include a “significant event code” on the form to show that Mr Casley’s status had changed from a remand prisoner to a convicted prisoner awaiting sentence.
35. An operational support grade (OSG) who was working in reception, received Mr Casley back into the prison at approximately 6.55pm. The OSG told the investigator that, as an OSG, he would only have been responsible for receiving Mr Casley and signing for his property. He said he would have seen the PER but he would not have seen the SASH warning form as this would have been passed to an officer to complete the second part of the reception process. He said the reception officer would carry out a more in-depth assessment of Mr Casley’s immediate needs and would look more closely at the accompanying paperwork, including the SASH warning form. He said that he would not have been aware of any change in Mr Casley’s custodial status as this would also be the responsibility of the reception officer.
36. The OSG said he could not remember who the reception officer was that evening. The duty rota shows that six officers were on reception that evening but it has not been possible to establish exactly which officer was responsible for receiving Mr Casley back into the prison as there is no written record and the documentation was not signed.
37. Mr Casley’s mental health keyworker was away on holiday when he attended court on 6 July. She told the investigator and the clinical reviewer that she had seen Mr Casley at the beginning of July but she could not remember the exact date. She did not document this contact so there is no record of contact between her and Mr Casley after 14 June. She said that she had spoken to Mr Casley about his court appearance and they had agreed that she would see him when she returned from her holiday. She said that she had no concerns about him and, although she had arranged for other clients on her caseload to be seen by colleagues while she was away, she did not think it necessary for Mr Casley to be seen in her absence.

Events of 17/18 July

38. Mr Casley’s cellmate told the investigator that he had no concerns about Mr Casley during the evening of 17 July. He said they both spent a lot of time in their cell and enjoyed each other’s company. He said that he had received some

letters from his family and had been reading them that evening. He said he had a headache and fell asleep around 8.30pm, leaving Mr Casley watching television.

39. On 18 July at 3.06am, Mr Casley's cellmate woke up and went to the toilet area where he found Mr Casley hanging from the window bars. He pressed his cell bell and staff attended immediately. An officer called a medical emergency code blue over his radio and cut down Mr Casley. Another officer and a custodial manager attended along with a nurse the first medical responder, and a healthcare assistant. Staff started cardiopulmonary resuscitation (CPR) promptly and continued until the ambulance arrived at 3.15am. Ambulance staff were unsuccessful in resuscitating Mr Casley and at 3.35am, pronounced he had died.
40. Mr Casley left a note in his cell. It said that he had received his victim's statement that day and he apologised to her. He said he understood that his wife wanted a divorce and he could not blame her, but he wanted to make sure she could move on with her life and keep their family home. Mr Casley said goodbye to his wife and children and said he loved them all.

Contact with Mr Casley's family

41. Mr Casley's wife was listed as his next of kin. The Governor and a prison manager visited Mr Casley's wife at her home on 18 July at approximately 6.55am to tell her about her husband's death. The prison contributed to the cost of Mr Casley's funeral, in line with Prison Service instructions.

Support for prisoners and staff

42. A prison manager spoke individually to all staff involved in the emergency response. Staff said that they were offered support by the prison's care team and felt supported by managers and other colleagues.
43. The Governor posted a notice for prisoners informing them of Mr Casley's death and offering support. Staff reviewed all prisoners assessed as at risk of suicide and self-harm, in case they had been adversely affected by Mr Casley's death. Mr Casley's cellmate said he had been well-supported by staff.

Post-mortem report

44. The post-mortem report concluded that Mr Casley's death was due to hanging. The results of toxicology tests were not available at the time of issuing this initial report.

Findings

Identifying Mr Casley's risk of suicide and self-harm

45. Prison Service Instruction 64/2011, *Safer Custody*, sets out a list of triggers that may increase the risk of suicide and self-harm. These include offences against family members, family breakdown, previous suicide attempts, mental health issues, court appearances and changes in status, all of which were relevant for Mr Casley during his time at Exeter. The prison's Safer Custody policy makes it clear that the level of risk assessment at reception should be the same for those who are returning after a temporary absence, such as after attending court, as for those entering the establishment for the first time.
46. When Mr Casley arrived at Exeter on 31 May, there were clear indications that he was at risk of suicide and self-harm and staff rightly started ACCT monitoring. We found that the identification and management of his risk during this time was of a good standard. We found that Mr Casley was well supported by the ACCT process and by the mental health team.
47. Despite his initial low mood and overwhelming feelings at being in prison for the first time, Mr Casley told staff that he had settled in to the prison regime and intended to face up to what he had done. He said he would plead guilty at court as he did not want to put his family through any more pain. He said he knew he faced a long sentence. Two SO's, his mental health keyworker and a prison GP all recorded information in Mr Casley's notes at various times that showed they believed Mr Casley was prepared to face up to what he had done and that he had no thoughts of suicide or self-harm. This was based on his presentation and what he had said to them.
48. In a thematic report about risk factors in self-inflicted deaths published by the Prisons and Probation Ombudsman in 2014, we identified that too often reception assessments place too much weight on staff's perception of the prisoner's behaviour and demeanour and insufficient weight on known risk factors. We reinforced these lessons in another learning lessons bulletin, issued in February 2016, about early days and weeks in custody.
49. A prisoner's presentation can reveal something of their level of risk. However, 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 must be collated and considered to ensure that a prisoner's level of risk is judged holistically.
50. Following a previous death at Exeter, we commended the prison for their use of a database to record potential triggers and risk factors for individual prisoners. This enabled staff to offer appropriate support to prisoners at the relevant time, helping to reduce their risk of suicide and self-harm. No triggers were added to this database for Mr Casley.
51. We consider that Mr Casley's court appearances were potential triggers because he had committed sexual offences against a close family member, he had attempted suicide before being charged, and he was facing a long sentence. We found that staff put too much weight on Mr Casley's presentation and what he

said to them rather than these clear risk factors. We therefore make the following recommendation:

The Governor and Head of Healthcare should ensure that staff assess risk based on all known risk factors rather than on the prisoner's presentation, and ensure that triggers are appropriately recorded.

52. When Mr Casley was returned to Exeter from court on 6 July, there were clear indications that he was at risk. He was accompanied by a suicide and self-harm (SASH) warning form from court. The PER stated that he had pleaded guilty at court and he would be returning for sentencing on 19 July which meant that his custodial status had changed.
53. PSI 07/2015: *Early Days in Custody* states that the PER and any other available information, including SASH warning forms, must be examined by reception staff and the prisoner must be interviewed to assess their risk of suicide and self-harm. Exeter's own Safer Custody Policy also makes it clear that reception staff should inform the first night centre or prison wing if someone is returning from court with a change of custodial status so that they can be assessed by healthcare and offered appropriate support. We found no evidence that staff took any of these actions when Mr Casley returned from court on 6 July.
54. The OSG working in reception said that he would not have seen the SASH warning form as this would have been passed to an officer, along with any other relevant paperwork, to enable the officer to carry out an assessment of Mr Casley's immediate needs. He did not know who the reception officer was that evening and the prison has been unable to tell us which of the six officers on reception duty saw the paperwork and risk information for Mr Casley as there is no written record. Furthermore, the SASH warning form was not signed by any of the officers. The prison has suggested that the escort staff may not have handed the SASH warning form to reception staff and may have left it in the PER.
55. While we accept that escort staff may not have specifically drawn attention to Mr Casley's SASH warning form and change in custodial status, we consider that this information was clearly recorded in the PER and accompanying documentation for reception staff to see. It appears that the SASH warning form was overlooked by the reception staff. As a result, Mr Casley's risk of harm was not properly assessed and no one started ACCT monitoring. We consider that, with the information available to them, reception staff should have started ACCT procedures which could have reduced the likelihood of Mr Casley taking his life. We are also concerned that he was not referred to healthcare staff for assessment given the change in his custodial status. We make the following recommendations:

The Governor should ensure that reception staff are fully trained in reception procedures and are aware of the relevant national and local policies, in particular staff should:

- **assess all prisoners arriving in reception and check all accompanying documentation to identify any immediate needs and risks;**

- **consider starting ACCT procedures if there is an indication of a risk of suicide or self-harm, such as when the prisoner is accompanied by a SASH warning form; and**
- **clearly record any key risk information, alerts and decisions made in the prisoner's record.**

The Governor should ensure that prisoners are assessed by healthcare staff when there has been a change in their custodial status, in accordance with the prison's Safer Custody Policy.

56. Previous PPO investigations into self-inflicted deaths at Exeter have also identified concerns with the reception process, including the failure of reception staff to identify risk issues. We, therefore, make the following recommendation:

The Prison Group Director for Devon and North Dorset should satisfy herself that effective action is taken at Exeter to remedy the deficiencies in the operation of ACCT procedures identified in this and previous PPO investigations.

Mental health care

57. Mr Casley's mental health keyworker assessed his mental health needs and discussed his case at a multidisciplinary team meeting where it was agreed he would be supported through a Care Programme Approach (CPA). We consider that the assessment was thorough and fully documented, as was the proposed care plan. However, after his keyworker met with Mr Casley on 14 June, we found no record of any further contact between them before he died.
58. Mr Casley's mental health keyworker was supposed to see him twice a month. She told the investigator at interview that she had seen Mr Casley in early July before she went on holiday, but this contact was not documented. Furthermore, part of the CPA was to monitor and offer support around his court appearance but this did not happen. She was on holiday at the time and did not arrange for anyone else from the mental health team to offer him support in her absence.
59. The clinical reviewer concluded that, due to the mental health keyworker's failure to document her contact with Mr Casley in early July, Mr Casley's mental health care was not equivalent to that which he could have expected to receive in the community. We therefore make the following recommendation:

The Head of Healthcare should ensure that mental health services meet the needs of prisoners by ensuring that:

- **care plans are adhered to and that prisoners have regular face-to-face contact with their keyworkers; and**
- **staff clearly record all contacts with prisoners.**

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