Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Wayne Boughen, a prisoner at HMP Leeds, on 17 November 2018

A report by the Prisons and Probation Ombudsman

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Our Vision

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

Our Values

We are:

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

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 Wayne Boughen died in hospital on 17 November 2018, after being found hanging in his cell at HMP Leeds the day before. He was 40 years old. I offer my condolences to Mr Boughen's family and friends.

Mr Boughen was supported under suicide and self-harm prevention procedures, known as ACCT. There was some good practice but the overall management of the ACCT, in terms of recording case reviews, updating, frequency of prescribed observations and ensuring legible and meaningful entries, was poor.

I am concerned that although Mr Boughen was on hourly observations, the last check was completed an hour and 12 minutes after the previous check. While we cannot say for certain that earlier intervention would have made a difference to Mr Boughen, it might have improved his chances of survival, and in future cases, it might prove crucial.

I am not satisfied that the care Mr Boughen received in relation to his mental health was equivalent to that which he could have expected to receive in the community. His care was reactive and was managed mostly through the ACCT process or in response to concerns raised by wing officers. There is no evidence of any planned interventions to review Mr Boughen's condition outside the ACCT process.

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**

Contents

Summary

1. On 9 October 2018, Mr Wayne Boughen was remanded to HMP Leeds after being found guilty of being in possession of an offensive weapon, assault on a police constable, possession of class A drugs and criminal damage. Mr Boughen was known to staff at Leeds, having spent time there on several occasions since 2010.

2. During his initial reception screen, it was recorded that Mr Boughen had a history of illicit drug use and mental health issues. Mr Boughen denied any thoughts of suicide or self-harm.

3. During a secondary health screen, the next day, Mr Boughen told a nurse that he had attempted to hang himself the previous evening. The nurse started suicide and self-harm prevention procedures, known as ACCT. The ACCT was closed on 11 October after Mr Boughen said he was feeling better and had no thoughts of suicide or self-harm.

4. On 28 October, another ACCT was opened after Mr Boughen told staff he had swallowed broken glass. The following day he told staff he was hearing voices and feeling paranoid, but had no thoughts of suicide or self-harm. ACCT observations were reduced to irregular hourly observations.

5. On 30 October, Mr Boughen was sentenced to 11 months imprisonment.

6. On 2 November, Mr Boughen was assessed by the mental health team. It was recorded that he had been diagnosed with schizophrenia and had a personality disorder.

7. On 6 November, Mr Boughen's behaviour became erratic and he smashed the fixtures and fittings in his cell. Mr Boughen told staff that he believed the water had been poisoned.

8. On 7 November, Mr Boughen was seen by a visiting psychiatrist who recorded that he was experiencing a relapse in his paranoid schizophrenia and increased his medication. The psychiatrist said that a transfer to a secure psychiatric hospital should be considered prior to his release.

9. On the night of 8 November, Mr Boughen smashed his cell again. A nurse spoke to him and recorded that he was uncommunicative. As a result, ACCT observations were increased to four an hour for the remainder of the night.

10. An ACCT review was held the next morning, and staff put in place irregular hourly observations. Later that afternoon, Mr Boughen made superficial cuts to his legs and the observations were increased to two an hour. No case review took place. Observations remained at two an hour, for the next few days'

11. On 13 November, Mr Boughen was reviewed by a mental health nurse at the request of staff. Mr Boughen said he was hearing voices and was trying to drown out the sound by stuffing tissues in his ears and making a noise with his toothbrush. The nurse recorded that Mr Boughen said that he had had thoughts of suicide but that he would not act on these because of his family.

12. An ACCT review was held shortly afterwards, but those present were not aware that Mr Boughen had just been reviewed by a mental health nurse. Observations were reduced to irregular hourly checks.

13. On the evening of 15 November, an officer conducting the night roll check spoke to Mr Boughen who was standing watching television and said that he was okay. The officer continued to check on Mr Boughen throughout the night as part of the ACCT procedures and recorded that Mr Boughen had a restless night, sometimes attempting to sleep and sometimes watching television. The last check was at 11.31pm.

14. When the officer returned to check Mr Boughen at 12.43am on 16 November, he saw Mr Boughen suspended by a ligature made from a jumper tied round his neck. The officer immediately called a medical emergency code blue over his radio. He went into the cell and began to cut the ligature.

15. Officers and nursing staff responded quickly and assisted the officer. Attempts to resuscitate Mr Boughen continued until paramedics arrived at 12.49am.

16. The paramedics took over resuscitation and at 1.20am, they got a slight pulse. Mr Boughen was immediately transferred to the intensive care unit at a hospital and he was placed on life support. Prison staff escorted Mr Boughen to hospital. No restraints were used.

17. At 1.23pm on 17 November, hospital staff decided to withdraw life support due to Mr Boughen's serious condition. At 4.18pm, it was confirmed that Mr Boughen had died. Mr Boughen's family were at his bedside.

18. The coroner gave the cause of death as insufficient blood flow to the brain caused by a heart attack as a result of hanging.

Findings

19. The investigation has identified some failings in the operation of the ACCT process. Mr Boughen did not always receive an appropriate or prescribed level of support. Case reviews were not always held when they should have been, and staff failed to make records clearly and accurately in the ACCT document, which led to observations not being carried out as they should have been at times.

20. While observations were completed properly much of the time, there were occasions when observations were not completed within the required timeframe. This included the final observation at 12.43am on 16 November, which was conducted an hour and twelve minutes after the previous check.

21. The clinical reviewer found that that Mr Boughen received a good standard of care for his drug and alcohol withdrawals, and this was equivalent to that which he could have expected to receive in the community.

22. However, the clinical reviewer concluded that the care Mr Boughen received in relation to his mental health, was not equivalent to that which he could have expected to receive in the community. We agree.

23. Mr Boughen had a lengthy history of severe mental health issues with a history of attempted suicide and self-harm by way of ligatures and overdose. Although mental health staff were responsive and caring towards Mr Boughen, his care was reactive rather than proactive and was managed mostly through the ACCT process or in response to concerns raised by the wing officers. There is no evidence of any planned interventions to review Mr Boughen's mental health outside the ACCT process.

Recommendations

- The Governor should ensure that staff manage prisoners at risk of suicide or self-harm in line with national guidelines, including in particular that:
    - staff have a clear understanding of their responsibilities when conducting ACCT observations;
    - observations are carried out at unpredictable intervals and within the prescribed timeframe;
    - ACCT reviews are held whenever an event occurs that could mean a prisoner is at increased risk; and
    - all case reviews are included in the ACCT documentation.
- The Head of Healthcare should ensure that the care provided for prisoners with severe and enduring mental health problems is delivered in line with NICE guidance NG66, including ensuring that the prisoner is allocated a care co-ordinator and detailed care plans are established.

The Investigation Process

24. The investigator issued notices to staff and prisoners at HMP Leeds informing them of the investigation and asking anyone with relevant information to contact him. One prisoner responded.

25. The investigator obtained copies of relevant extracts from Mr Boughen's prison and medical records.

26. The investigator interviewed ten members of staff at Leeds and one prisoner between 28 November 2018 and 22 January 2019.

27. NHS England commissioned a clinical reviewer to review Mr Boughen's clinical care at the prison. The clinical reviewer attended interviews with the investigator on 22 January.

28. We informed HM Coroner for Wakefield of the investigation. The coroner gave us the results of the post-mortem and toxicology examinations. We have sent the coroner a copy of this report.

29. We contacted Mr Boughen's next of kin to explain the investigation and to ask if they had any matters they wanted the investigation to consider. The next of kin did not raise any issues, although they asked to receive a copy of our investigation report, which we have provided.

Background Information

HMP Leeds

30. HMP Leeds is a local prison holding a maximum of 1,218 men on remand, convicted or sentenced. The prison serves the courts of West Yorkshire. Care UK provides health services, including mental health services. The prison has 24-hour primary healthcare cover.

31. In August 2018, Leeds was selected to be part of the "10 Prisons Project", which seeks to improve safety, security and decency in the prison. The project is focusing on reducing violence, improving living conditions, preventing drugs from entering the establishment and enhancing the leadership and training available to staff.

HM Inspectorate of Prisons

32. The most recent published inspection of HMP Leeds was conducted in November 2017. Inspectors found that incidents of self-harm were higher than at similar establishments and had increased since the last inspection. There had been four self-inflicted deaths since the previous inspection and a fifth occurred during the inspection.

Independent Monitoring Board

33. 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 December 2017, the IMB found that significant issues had been reported in the 2016 IMB annual report, and the Board remained concerned that many prisoners felt unsafe, particularly those on recall or in the vulnerable category.

34. The IMB recognised that the new Safer Custody Team had been actively addressing these issues with efforts being made to reduce the incidents of self-harm and suicide.

Previous deaths at HMP Leeds

35. Mr Boughen's was the 10th self-inflicted death at Leeds since January 2016. We have previously made recommendations about the management of suicide and self-harm monitoring, and the provision of mental health care.

Assessment, Care in Custody and Teamwork (ACCT)

36. Assessment, Care in Custody and Teamwork (ACCT) is the Prison Service care-planning system 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 risk and how best to monitor and supervise the prisoner. After an initial assessment of the prisoner's main concerns, levels of supervision and interactions are set according to the perceived risk of harm. Checks should be irregular to prevent the prisoner anticipating when they will occur. There should be regular multidisciplinary review meetings involving the prisoner. As part of the process, a caremap (a

plan of care, support and intervention) is put in place. The ACCT plan should not be closed until all the actions on the caremap have been completed.

37. All decisions made as part of the ACCT process and any relevant observations about the prisoner should be written in the ACCT booklet, which accompanies the prisoner as they move around the prison. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011, Management of prisoners *at risk of harm to self, to others and from others (Safer Custody).*

Psychoactive Substances (PS)

38. Psychoactive substances (formerly known as 'new psychoactive substances' or 'legal highs') are a genuine problem across the prison estate. They are difficult to detect and can affect people in several 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.

39. In July 2015, we published a Learning Lessons Bulletin about the use of PS (still at that 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.

40. 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

41. On 9 October 2018, Mr Wayne Boughen was remanded to HMP Leeds, after being found guilty of being in possession of an offensive weapon, assault on a police constable, possession of class A drugs and criminal damage. Mr Boughen was known to staff at Leeds, having spent time there on several occasions since 2010.

42. On his arrival at Leeds, a nurse conducted Mr Boughen's initial health screen. He recorded that Mr Boughen had a history of schizophrenia and illicit drug use. No immediate concerns were recorded and Mr Boughen denied any thoughts or intent to self-harm. The nurse made a referral to the prison mental health team.

43. A separate drug and alcohol screening was completed by a nurse. She noted Mr Boughen's history of using heroin and crack cocaine and of alcohol misuse. An alcohol screening tool was completed and Mr Boughen scored 37 (a score over 20 would indicate probable alcohol dependence). Mr Boughen told the nurse that he had drunk at least nine cans of lager daily. Mr Boughen also scored ten on the Clinical Institute Withdrawal Assessment for Alcohol (CIWA) indicating he needed support with withdrawal symptoms.

44. A urine screen for drugs was completed and Mr Boughen tested positive for opiates and cocaine. He said that he previously used about £150 worth of illicit drugs daily. Mr Boughen scored ten on the Clinical Opiate Withdrawal Scale (COWS), which indicated mild withdrawal. The nurse prescribed co-codamol (for back pain), diazepam (for alcohol withdrawal), thiamine (vitamin therapy for alcohol withdrawal) and methadone (for opiate withdrawal). The nurse referred Mr Boughen to the Drug and Alcohol Rehabilitation Service (DARS) for further monitoring.

45. Mr Boughen was located on the first night centre (FNC). An officer completed an FNC assessment. It was recorded that on previous sentences, Mr Boughen had been in a single cell because of his ongoing mental health issues, and it was agreed again, that a single cell would be most suitable.

46. The next day, a healthcare assistant (HCA) completed a second health screen with Mr Boughen. Mr Boughen told her that he had attempted to hang himself using the flex from his kettle the previous evening, but the flex had snapped. The HCA immediately started suicide and self-harm prevention procedures and opened an ACCT. She also made a further referral to the mental health team.

47. 11 October, an ACCT review was conducted and chaired by a custodial manager (CM). The review was attended by a mental health nurse, who completed an initial mental health assessment alongside the ACCT review.

48. The mental health nurse recorded that Mr Boughen had history of attempted hanging and had been diagnosed with schizophrenia and personality disorder. He completed a generalised anxiety disorder assessment (GAD7). The GAD7 is a 7-point assessment tool designed to determine the level of anxiety a person is experiencing. The mental health nurse also completed the patient health questionnaire (PHQ) designed to identify levels of depression. Mr Boughen's

scores showed that he had no issues with anxiety but he had mild depressive symptoms.

49. The CM recorded that Mr Boughen told the review that he was feeling much better, despite his mental health issues. He said that his head had been 'a mess' when he arrived at the prison and he was 'gutted' to be back in prison. Mr Boughen said that he was maintaining contact with his mother and brother who were good support for him. He denied having any further thoughts of suicide or any intent to self-harm and said that he would tell staff if his feeling or thoughts changed. It was agreed that the ACCT would be closed.

50. The prison received confirmation of the medications that Mr Boughen had been prescribed in the community and on 12 October, a prison GP prescribed aripiprazole (anti-psychotic medication) and valproic acid (a mood stabiliser).

51. On 16 October, an officer visited Mr Boughen to introduce herself as his keyworker. Mr Boughen told the officer that he had several issues, but it was mainly his mental health. He said that he also had a drug habit and it was this, and his mental health problems, that had led him being back in prison.

52. On 28 October, Mr Boughen smashed the observation panel in his cell door and told staff that he had swallowed some of the broken glass. He was taken to hospital where an x-ray confirmed that he had swallowed glass. The x-ray also showed that Mr Boughen had swallowed a razor blade and part of a vape cartridge. Staff at the hospital advised Mr Boughen and the escorting staff that these items would pass through the body naturally and he was discharged back to Leeds.

53. On his return to Leeds, staff opened an ACCT and on 29 October, a review was conducted and chaired by a CM, attended by his keyworker. The CM recorded that Mr Boughen said that he had been feeling paranoid and complained of hearing voices and, as a result, he swallowed pieces of the broken glass. He also said that he had recently used Psychoactive Substances (PS) to help him sleep. However, Mr Boughen told the review that he was fully aware that this was not the way he should deal with things and said that he was still getting good support from his mother and brother who would visit him while in prison.

54. The CM recorded that Mr Boughen appeared agitated during the review but he denied any thoughts or intent of suicide or self-harm, and said that he did not want to die. In view of his presentation and recent behaviour, it was agreed that the ACCT would remain open to provide Mr Boughen additional support, but observations would be reduced to irregular hourly observations. The caremap was updated with a referral made to the drug and alcohol rehabilitation team. A further review was scheduled for 8 November.

55. On 30 October, Mr Boughen was sentenced to 11 months in prison.

56. On 2 November, Mr Boughen's brother phoned the safer custody department at the prison and said that he had concerns about Mr Boughen. He said that he had visited the previous day and Mr Boughen did not appear his usual self, and he felt that his mental health had deteriorated. He said that Mr Boughen had complained of hearing voices and needed his medication to be reviewed. The

safer custody team e-mailed the mental health team and the CM, who was managing Mr Boughen's ACCT, to ensure that they were all aware of the concerns raised by the family.

57. Later that day, because of the telephone call from his family, Mr Boughen was seen and assessed by a mental health nurse. The nurse told the investigator that she completed a full assessment and Mr Boughen was happy to engage with her. The nurse recorded Mr Boughen's history of schizophrenia and personality disorder. Mr Boughen told the nurse that he had been admitted to a psychiatric hospital in the community and had been detained under the Mental Health Act several times.

58. Mr Boughen also told the nurse that he was hearing voices and these were constantly talking to him, telling him that people were against him or that his food had been tampered with, and this was affecting his behaviour. Mr Boughen said that he felt as though things were under his skin, and that he had swallowed glass to deal with the poisoned food and then made cuts to his stomach to release it all. The nurse recorded that although psychotic, Mr Boughen had denied any suicidal thoughts or intent to self-harm further. The nurse referred Mr Boughen to the secondary care mental health team and listed him as a priority to be seen by a psychiatrist on 7 November.

59. On 4 November, prison staff asked, a mental health nurse to see Mr Boughen as they had concerns about him. The nurse told the investigator that Mr Boughen had not been eating his meals and when she checked on him, he had several uneaten meals in his cell and he was unkempt. She said that she was aware that he was being supported by way of the ACCT process and was seeing a psychiatrist on 7 November. No ACCT review was requested or completed and no change was made to the frequency of Mr Boughen's observations.

60. On 6 November, Mr Boughen smashed the sink in his cell. He told staff that the voices in his head had told him to do it as the water was polluted. A mental health nurse assessed Mr Boughen following the incident, but recorded that Mr Boughen would not engage with him. The mental health nurse recorded that Mr Boughen had smashed his sink twice, had moved cells, and was experiencing paranoid ideation about the water supply.

61. While on the wing, the mental health nurse spoke with a prisoner and relative of Mr Boughen. The prisoner told the mental health nurse that the pattern of paranoid thinking was common and that Mr Boughen had a history of violent behaviour.

62. Staff told the investigator that prisoners would usually be placed on report if they damaged prison property. However, they were aware of Mr Boughen's mental health issues and no action was taken against him.

63. On 7 November, the mental health nurse visited Mr Boughen. Mr Boughen complained of having a painful ear as he had been pushing toilet paper in it to block out the voices. The mental health nurse recorded that during the conversation, Mr Boughen sat on the floor cross-legged, he appeared quite unsettled, was rocking back and forth and his eye contact was poor. Mr Boughen said that he felt that the nurse and the staff were 'smirking' at him and

said that his food and water were being tampered with. The nurse asked Mr Boughen whether he had used any illicit substances and Mr Boughen said that he had used PS 'weeks ago'. Mr Boughen had no history of PS use.

64. Mr Boughen was assessed by a consultant psychiatrist, later that day. The mental health nurse told him what he had discussed with Mr Boughen.

65. The consultant psychiatrist assessed Mr Boughen in the presence of a mental health nurse. He recorded that Mr Boughen claimed to have experienced increased auditory hallucinations in the last three to four weeks, and they were causing him distress, and making him miserable and angry. Mr Boughen spoke of paranoid ideas that fellow prisoners and staff were part of a conspiracy against him. He said that he had been using rolled up toilet paper pushed into his ears to stop the voices.

66. When the consultant psychiatrist asked Mr Boughen if he had been using any illicit drugs, Mr Boughen said no, but he had been a regular user in the community. The consultant psychiatrist concluded that Mr Boughen was experiencing a relapse in his paranoid schizophrenia, which was possibly triggered by stress or illicit drug use. He increased Mr Boughen's medication and prescribed a short course of sleeping medication. He also recorded that a possible referral to a secure hospital would be considered prior to his release. He planned to see Mr Boughen again on 20 November.

67. The consultant psychiatrist also attended Mr Boughen's ACCT review following his assessment, chaired by a CM and attended by another CM and a nurse. Mr Boughen's current mental health problems were discussed and the consultant psychiatrist updated the review on what was planned in terms of medication and support. It was agreed that the observations should remain at hourly, because it was felt that increasing them would increase Mr Boughen's paranoia. Caremap actions included provision of distraction materials, such as books and word searches, and to maintain contact with his family. It was recorded that a further review would take place on 12 November.

68. A nurse was on night duty on 8 November, and received a request from staff to see Mr Boughen at around 2.30am on 9 November, after he again smashed his sink. The nurse told the investigator that when she went to the wing, Mr Boughen was uncommunicative, but he did not appear distressed and he was not threatening self-harm. However, as a precautionary measure and due to the reduced staff numbers, observation levels were increased to four times an hour for the remainder of the night.

69. Mr Boughen was due to be transferred to HMP Wealstun but due to his ongoing mental health problems, Mr Boughen was placed on a four-week medical hold to allow for assessment and monitoring by the mental health team to continue.

70. At around 10.30am, the CM chaired an ACCT review with Mr Boughen. The CM recorded that the previous day was the first day that Mr Boughen had received the higher dose of his anti-psychotic medication, and this was set to increase gradually for another week. He recorded that Mr Boughen had also been prescribed a sleeping tablet and he would receive this for the first time that evening.

71. The mental health nurse, who attended the review, said that although Mr Boughen was displaying some psychotic symptoms, which was confirmed by the psychiatrist, he believed that Mr Boughen was in control of some of his behaviours. A referral was made to the DARS team and a request was made for Mr Boughen have a mandatory drug test to check whether he was using any drugs that might be affecting his mental health. There is no evidence that a drug test was carried out prior to 16 November. Observations were reduced to irregular hourly.

72. Later that afternoon, Mr Boughen made cuts to his leg. A HCA went to the wing to provide treatment. She recorded that Mr Boughen had used a piece of porcelain from his broken sink and a pen to make injuries to his legs. She recorded that the wounds were not bleeding, but she applied dressings and completed the self-harm documentation. The CM recorded that Mr Boughen had self-harmed to relieve stress and recorded on the ACCT cover that he had increased the observations to twice hourly. However, no review was recorded in the ACCT document.

73. At 11.06am on 13 November, an officer who knew Mr Boughen well, contacted the mental health team and asked for someone to see him because she was concerned about him. The officer told the investigator that Mr Boughen was always friendly and nice to staff. She said that she had never had any issues with him being aggressive or violent, but in her opinion, he did not seem very stable emotionally. She said that when she had spoken with Mr Boughen in the morning, he seemed quite positive and chatty but when she returned later to complete an ACCT observation, Mr Boughen appeared very withdrawn and would not engage with her.

74. At 11.15am, a mental health nurse reviewed Mr Boughen. She said that when she saw Mr Boughen, he complained of hearing voices and was holding a toothbrush in his mouth and using it to create a noise to drown out the voices. He also had tissue paper in his ears for the same reason. Mr Boughen told her that he did not trust other prisoners, except for two, who he said were being very supportive towards him.

75. Despite his presentation, Mr Boughen told the mental health nurse that he had been feeling better than he had been for ages and he could not understand why he was struggling that day. She recorded that Mr Boughen said that he had had thoughts of suicide but that he would not act on these, citing his family as protective factors that would prevent him from harming himself.

76. At 11.50am, the CM chaired a further scheduled ACCT review, attended by a mental health nurse. There is no evidence that the mental health nurse was aware that Mr Boughen had just been seen by another mental health nurse, or what concerns or issues he had raised. Neither the original mental health nurse or the officer attended the ACCT review.

77. The CM recorded that Mr Boughen appeared less animated compared to previous reviews and discussed his issues in a positive way. The CM also recorded that Mr Boughen had not been associating much on the wing and he was encouraged to leave his cell more often and take exercise, this was also added to his caremap. It was recorded that Mr Boughen had good support from

a couple of friends on the wing and he also had support from his mother and brother, who were due to visit that week. Mr Boughen was concerned that his family would not be visiting, and a mental health nurse contacted his mother on his behalf to confirm that they would be coming. It was agreed that the ACCT document should remain open, but observations were reduced to irregular hourly.

78. The mental health nurse told the investigator that she was asked to see Mr Boughen again by the officer at 5.30pm. The mental health nurse said that the officer was concerned that Mr Boughen was not eating so she spoke to Mr Boughen through the cell door as the wing was in patrol state (when all prisoners are locked in their cells and doors are only opened in an emergency).

79. The mental health nurse said that she had no concerns about Mr Boughen and told officers on the wing that if they had further concerns, she would be happy to attend a further ACCT review to consider increasing his observation levels, but that time was needed to allow for the increase in his medication to take effect. There were no further documented contacts between Mr Boughen and primary care or mental health nursing staff.

Events of 15-16 November

80. Mr Boughen was on irregular hourly observations day and night, following the last ACCT review on 13 November. On evening of 15 November, an officer was on night duty.

81. At the start of his shift, the officer completed a roll check and a night welfare check. He said that when he arrived at Mr Boughen's cell, Mr Boughen was out of bed and was standing watching television. The officer said that he said 'hello' to Mr Boughen and asked him if he was okay. The officer said that on previous shifts, Mr Boughen had been in bed asleep at this time. Mr Boughen came to the door and asked the officer what he had said, and the officer repeated himself, to which, Mr Boughen said "yeah". The officer said that Mr Boughen was 'very despondent' and said that he 'seemed confused', but he said that this was not unusual as Mr Boughen had often displayed this kind of behaviour due to his mental health problems.

82. During the night, the officer continued to check on Mr Boughen as part of the ACCT observations and recorded that when he checked Mr Boughen, he had been in and out of bed, often standing in his cell looking at his belongings, and watching television. The officer said that Mr Boughen had seemed to attempt to go to sleep and appeared asleep at certain times, but had then been back up again.

83. The officer completed an observation at 11.31pm, when Mr Boughen was lying on his bed.

84. At 12.43am on 16 November, the officer returned to do another check. When he opened the observation panel and shone his torch towards Mr Boughen's bed, he could not see Mr Boughen at first and moved his torch towards the back of the cell. He saw Mr Boughen, but did not immediately realise he was suspended by a ligature, but then noticed a ligature made from a jumper around Mr Boughen's neck.

85. The officer immediately called an emergency code blue (which indicates that a prisoner is unconscious or has breathing problems) over his radio. The officer then broke the seal on his emergency key pouch and entered the cell. (Staff do not carry keys at night for security reasons, however, they are provided with a sealed pouch containing a single cell key for use in emergency situations.) The officer said that he ran to the back of the cell and started to cut the ligature using his fish knife.

86. CCTV footage shows a clear image of Mr Boughen's cell. Staff responded quickly. Another officer was the first to attend and said that when she arrived at the cell, the officer had almost cut the ligature and she assisted him in lowering Mr Boughen to the floor. Both officers checked for signs of a pulse but could not find one, and found no sign of breathing. Cardiopulmonary resuscitation (CPR) was started with a CM who was overseeing the prison that night.

87. Two nurses arrived with the emergency medical equipment. A nurse said that when she arrived she confirmed that no signs of life were present, and no breathing had been noted. She said that there was a ligature mark evident around Mr Boughen's neck. He was cold to touch and his pupils were fixed and dilated.

88. A nurse, supported by the other nurse, inserted an airway and attached an ambu-bag to Mr Boughen to deliver oxygen. An Automated Electronic Defibrillator (AED) was attached and indicated that no shockable rhythm had been detected, advising staff to continue with CPR.

89. Paramedics from Yorkshire Ambulance Service arrived at 12.49am, and connected their own equipment to Mr Boughen. They delivered advanced life support, administering fluids and drugs through an intraosseous cannula (a needle inserted directly into the bone marrow to allow rapid absorption of drugs).

90. Paramedics continued to try to resuscitate Mr Boughen, and at 1.20am, they found a pulse. Mr Boughen was immediately transferred to the intensive care unit at a hospital. Prison staff escorted Mr Boughen to hospital, but no restraints were used.

91. On arrival at the hospital, Mr Boughen was placed on life support. He had a computerised tomography (CT) scan, which showed that there was severe brain damage.

92. At 1.23pm, on 17 November, hospital staff decided to withdraw life support due to his serious condition. At 4.18pm, it was confirmed that Mr Boughen had died. Mr Boughen's family was at his bedside.

Contact with Mr Boughen's family

93. On 16 November, a supervising officer was appointed as the prisons family liaison officer (FLO). The FLO initially went to the prison and he was told what had happened and that Mr Boughen had been transferred to hospital. The FLO was also told that Mr Boughen's family had been contacted and had been advised to attend the hospital as Mr Boughen's prognosis was poor.

94. At 7.05am, the FLO and a member of the safer custody team went to the hospital and introduced themselves to Mr Boughen's family. The FLO told Mr Boughen's family that he had been appointed as the FLO. The family asked several questions about the process Mr Boughen died, and the FLO explained the process to them. The prison staff escorting Mr Boughen were moved into a side room to give the family privacy.

95. At 3.15pm on 17 November, the FLO contacted Mr Boughen's family, and they informed him that life support had been stopped and that Mr Boughen was being made comfortable with pain relief.

96. The FLO remained in contact with the family following Mr Boughen's death, and assisted in returning property and liaising with funeral directors. The prison contributed to the costs of the funeral, in line with national policy.

Support for prisoners and staff

97. After the incident on 16 November, a duty manager 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.

98. On 17 November, the prison posted notices informing other prisoners of Mr Boughen'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 Boughen's death.

Post-mortem report

99. The post-mortem gave the cause of Mr Boughen's death as:

1a – Cerebral Ischemia (insufficient blood flow to the brain)

1b – Cardiac Arrest

1c – Hanging

100. Toxicology test showed that no illicit drugs were present in Mr Boughen's system.

Findings

Management of ACCT

101. Mr Boughen had been assessed as a risk of suicide and self-harm and was appropriately subject to ACCT monitoring from 28 October 2018 until he died two weeks later. Staff held 5 case reviews during that time. Most of the case reviews were multidisciplinary, involving prison staff, nurses, psychiatrists, and managers. The case reviews indicate that staff made concerted efforts to work together to reduce Mr Boughen's risk to himself. Staff were aware of Mr Boughen's mental health problems and demonstrated understanding, compassion and careful consideration in trying to assist him in reducing his distress.

102. However, despite some positive work, the investigation has identified some failings in the operation of ACCT which meant that Mr Boughen did not always receive an appropriate level of support.

103. Prison Service Instruction (PSI) 64/2011 states that caremap actions should be detailed and time-bound and aimed at reducing risk. They should reflect the prisoner's needs, level of risk, and the triggers of his distress. There were eight actions on Mr Boughen's caremap, ranging from being encouraged to interact with his peers, referral to the DARS and maintaining family ties, and these were added following case reviews when additional needs were identified. The caremap actions were signed off as completed, although were in fact ongoing.

Frequency of observations

104. Mr Boughen's observations were initially set at four times an hour and then fluctuated between irregular hourly and half-hourly checks as his risk was judged to have increased and decreased.

105. Between 29 October and 9 November hourly observations were mostly carried out as prescribed, although there were around five occasions when timings slipped and observations were completed up to 15 minutes late (that is, with a gap of up to an hour and 15 minutes between observations).

106. During the afternoon of 9 November, observations were increased to twice hourly, and remained at this level until the following case review on 13 November. The ACCT document shows that staff completed checks during this period in line with the prescribed frequency, apart from the nights of 11 November and 12 November, where observations were made hourly. No explanation for this discrepancy is provided, although the entry on the front of the ACCT setting out the required frequency of observations, is not as clear as it should be.

107. PSI 64/2011 says that, in addition to planned case reviews, a case review should be held when there are additional concerns. On the afternoon of 9 November, Mr Boughen made superficial cuts to his legs, and as a result a CM increased the level of observations from irregular hourly to twice hourly. However, there was no case review, and the only indication that observations had been increased was the annotation of 'x2' on the front cover of the document. A new front cover

was then added, which did not include the 'x2', and only said irregular hourly observations.

108. At interview, the CM could not remember why no case review had been held but accepted that he had updated the front cover of the ACCT document. He was not able to say for definite when he added the new front cover.

109. The officer told the investigator that he had been employed in the Prison Service for 13 months, and had completed his training in October 2018. He said that he knew Mr Boughen from working on D wing, and said that he knew he was a person who had mental health issues, and had displayed some worrying behaviour which was being addressed through the ACCT process.

110. The officer said that he was aware that Mr Boughen had been paranoid and that Mr Boughen appeared very confused, and always seemed very puzzled when spoken to, and was not very interactive. The officer told the investigator that he was about three nights into his seven-night shift pattern on 15 November, and had not had any issues with Mr Boughen earlier that week.

111. On 15 November, Mr Boughen was on irregular hourly observations. The officer conducted observations at 9.21pm, 10.26pm, 11.31pm and then finally at 12.43am, when he found Mr Boughen. The officer told the investigator that his understanding of the ACCT observations, was that they had to be unpredictable and within each hour (i.e. a check between 12am and 1pm, 1pm and 2pm, and so on). In fact, observations should be within an hour of the last one performed, so when the officer checked at 11.31pm, the expectation would be that his next observation would be before 12.31am. By completing his check at 12.43am, it was in fact one hour and 12 minutes after the last. While we cannot say for certain that earlier intervention at the correct time would have altered the eventual outcome for Mr Boughen, this might be critical in future cases.

112. We make the following recommendations:

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

- **staff have a clear understanding of their responsibilities when conducting ACCT observations;**
- **observations are carried out at unpredictable intervals and within the prescribed timeframe;**
- **ACCT reviews are held whenever an event occurs that could mean a prisoner is at increased risk; and**
- **all case reviews are included in the ACCT documentation.**

Clinical care

113. The clinical reviewer concluded that the overall care Mr Boughen received was of variable quality and not fully equivalent to that which he could have expected to receive in the community.

114. The clinical reviewer found that that Mr Boughen received a good standard of care for his drug and alcohol withdrawals, and this was equivalent to that which he could have expected to receive in the community. We agree.

115. However, we agree with the clinical reviewer's concerns that the care Mr Boughen received for his mental health was not equivalent to that which he could have expected to receive in the community.

116. There were some positive aspects. Mental health staff were responsive and caring towards Mr Boughen, and recognised that he had an acute relapse of a severe and enduring mental health problem. Referral to a psychiatrist was appropriate and the plan to review Mr Boughen's condition after increasing his medication was reasonable, with a view to consider a gatekeeping referral for transfer to hospital under the Mental Health Act if his condition had not improved, was appropriate. Healthcare involvement with the ACCT process was good.

117. However, overall Mr Boughen's mental health care was reactive, managed mostly through the ACCT process or in response to concerns raised by wing officers.

118. The clinical reviewer considers that a named care co-ordinator should have been identified and care plans produced to ensure that Mr Boughen's mental health care was proactive and not reactive. There is no evidence of any planned interventions outside the ACCT process to review Mr Boughen's condition. Staff told the investigator that mental health staff were under significant pressure and the model of care appeared to be mostly reactive in nature and squeezed around the demands of managing the ACCT process.

119. We make the following recommendation:

The Head of Healthcare should ensure that the care provided for prisoners with severe and enduring mental health problems is delivered in line with NICE guidance NG66, including ensuring that the prisoner is allocated a care co-ordinator and detailed care plans are established.

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