Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Charlie March, a prisoner at HMP Bure, on 17 May 2020

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.

Our 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 Charlie March died on 17 May 2020, after he was found hanging in his cell at HMP Bure. He was 42 years old. I offer my condolences to Mr March's family and friends.

Mr March self-harmed seriously four times at Bure after his mental health deteriorated. The first time he cut his neck and he took an overdose of his medication on three further occasions. Each time, staff monitored him under Prison Service suicide and self-harm prevention procedures (known as ACCT). The last period of monitoring ended in March 2020.

Around a week before Mr March died, wing staff raised concerns about his mental health and a mental health nurse saw him. Staff assessed that Mr March needed more support but did not need to be monitored under ACCT. He was not being monitored when he was found hanging in his cell on 17 May.

The investigation found that when ACCT procedures were opened, they were well managed. However, we are concerned that ACCT procedures were not opened in May 2020 when Mr March's mental health again deteriorated, even though the circumstances were very similar to those that had preceded his previous acts of serious self-harm. We consider that staff gave too much weight to Mr March's assertions that he had no thoughts of suicide or self-harm and did not give enough weight to his risk factors and previous patterns of behaviour.

I am also concerned that some healthcare staff thought that Mr March could not work in the kitchen, a job which he enjoyed, and which provided a distraction for him, and be monitored under ACCT at the same time. This was not the case, but the misunderstanding may have played a part in the decision not to start ACCT monitoring before Mr March's death.

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 2021**

Contents

Summary

Events

1. In July 2017, Mr Charlie March was sentenced to seven and a half years in prison for rape. He was moved to HMP Bure on 4 August.

2. Mr March had a history of mental illness and was prescribed antipsychotic medication and antidepressants, as well as painkillers. Initially, he kept his medication in his possession.

3. In June 2019, Mr March failed a medication compliance check, so staff stopped him having in-possession medication. Eight weeks later, Mr March cut his neck. He told a psychiatrist that queuing up to collect his medication made him anxious and his mental health had deteriorated as a result and he was hearing voices.

4. Staff allowed Mr March to have in-possession medication again but, in October, he overdosed. He said afterwards that he had been feeling paranoid. Staff again stopped him having in-possession medication but reinstated this in November after healthcare staff decided that there was a risk that Mr March would self-harm if he had to collect his medication.

5. On 7 December, Mr March overdosed again. He said afterwards that he had been feeling paranoid. Staff again stopped him from keeping his medication in-possession and while he had to go back to collecting it, staff arranged for him not to have to queue.

6. In January 2020, staff allowed Mr March to keep some of his medication in his possession. On 26 February, he said he thought his mental health was deteriorating and he was feeling paranoid, although he said he had no plans to end his life. Two days later, he overdosed again. He told staff that he was anxious about being released in October 2020. Staff again stopped him holding any medication in his possession.

7. Staff monitored Mr March under suicide and self-harm prevention procedures (known as ACCT) after Mr March cut his neck and after each of his three overdoses. Staff stopped the last period of ACCT monitoring on 12 March.

8. On 8 May 2020, prison staff became concerned about Mr March and asked a mental health nurse to assess him. Mr March told the nurse his mental health was deteriorating, and he was hearing voices and feeling paranoid, but said that he had no thoughts of suicide or self-harm. She assessed that Mr March needed more mental health support but she and the wing Supervising Officer (SO) agreed that he did not need to be monitored under ACCT.

9. At 8.16am on 17 May, staff unlocked Mr March and found him hanging from a ligature behind the cell door. Staff and paramedics tried to resuscitate Mr March, but paramedics pronounced his death at 9.03am.

10. Mr March left a note in his cell which said his life was hell and getting worse, his mind was broken, and he was being psychologically bullied by other prisoners.

Findings

11. ACCT procedures were opened on four occasions after Mr March had made serious suicide attempts when his mental health deteriorated. We found that staff at Bure managed the ACCT procedures well.

12. We are, however, concerned that when Mr March's mental health deteriorated again in May 2020, a mental health nurse and a SO decided not to open an ACCT, even though the circumstances were very similar to those that had preceded Mr March's previous acts of serious self-harm. We consider that they gave too much weight to Mr March's assertions that he had no thoughts of suicide or self-harm and did not give enough weight to his risk factors and previous patterns of behaviour.

13. We are also concerned that the mental health nurse, and some other healthcare staff, thought Mr March could not continue to work in the kitchen, a job he enjoyed and which provided a distraction for him, if he was being monitored under ACCT. This was not the case, but it may have influenced the nurse's view that an ACCT should not be opened.

14. Staff had to balance the risk of overdose if Mr March kept his medication in his possession against the risk of increasing his anxiety, and him potentially self-harming in other ways, if they made him collect his medication. We accept that this was a delicate balancing act and we consider that the compromise staff reached was a reasonable one in the circumstances.

15. We found no evidence that Mr March had been bullied at Bure.

16. The clinical reviewer concluded that the mental and physical healthcare Mr March received at Bure was equivalent to that he could have expected to receive in the community.

Recommendations

- The Governor and Head of Healthcare should ensure that all staff are aware that they should take account of a prisoner's risk factors and previous behaviour when assessing risk and should not rely on a prisoner's assertions that he has no thoughts of self-harm.
- The Governor should ensure that staff consider opening Enhanced ACCT Case Management procedures where there has been a pattern of serious self-harm.
- The Head of Healthcare should ensure that staff are aware that prisoners can continue to work when they are subject to ACCT monitoring.
- The Governor should share this report with SO A and arrange for a senior manager to discuss the Ombudsman's findings with him.
- The Head of Healthcare should share this report with Nurse A and discuss the Ombudsman's findings with her.

The Investigation Process

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

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

19. NHS England commissioned a clinical reviewer to review Mr March's clinical care at the prison. The investigator and clinical reviewer jointly interviewed 12 staff on 11 and 15 June. Due to coronavirus restrictions, the interviews were conducted by telephone.

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

21. One of the Ombudsman's family liaison officers contacted Mr March's family to explain the investigation and to ask if they had any matters they wanted the investigation to consider. They raised no issues.

22. We shared our initial report with HM Prison and Probation Service (HMPPS). They raised a factual inaccuracy which has been corrected.

23. We provided Mr March's next of kin with a copy of our initial report. They did not raise any issues or comment on the factual accuracy of the report.

Background Information

HMP Bure

24. HMP Bure is a medium security prison near Norwich. It holds approximately 650 men, convicted of sexual offences. Healthcare services are provided by Care UK.

HM Inspectorate of Prisons

25. The most recent inspection of Bure was in March and April 2017. Inspectors found that Bure remained an overwhelmingly safe and respectful prison. Few prisoners self-harmed, but support for those with complex or ongoing issues was weak.

26. Inspectors found a weakness in the prison's approach to resettlement. As a national resource for sex offenders, the prison had very limited resources to support a prisoner's reintegration and resettlement. Too few prisoners had current risk assessments ahead of their release and contact with their offender supervisor was intermittent and reactive. Too little was done to ensure that all resettlement needs were identified and addressed well enough, ahead of release.

Independent Monitoring Board

27. 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 ending 31 July 2019, the IMB recognised the continuing problems regarding preparing prisoners for their release. Both staff and prisoners were frustrated about securing accommodation in the community and plans for the future. The IMB hoped the introduction of OMiC (Offender Management in Custody) on 30 September 2019, would improve the uncertainty.

28. The prison had improved arrangements for prisoners to collect their medication, and the pharmacist randomly checked prisoner's medication compliance.

Previous deaths at HMP Bure

29. Mr March was the second prisoner to die at Bure since May 2018. The previous death was from natural causes.

Assessment, Care in Custody and Teamwork

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

Key Events

31. On 21 July 2017, Mr Charlie March was sentenced to seven and a half years in prison for sexual offences. He had been in prison before. He was moved to HMP Bure on 4 August.

32. Mr March was prescribed amitriptyline (used to treat pain and depression), meloxicam (an anti-inflammatory), and quetiapine (an antipsychotic). He kept his medication in his possession.

2019

33. On 25 June 2019, Mr March failed a medication compliance check (an unannounced check where healthcare staff check a prisoner has the correct medication in their possession). He said he had been prescribed nefopam (a painkiller) but it had made him feel unwell, so he had flushed the rest of the tablets down the toilet. Staff also noted that Mr March had taken more amitriptyline than prescribed. He said this was to help him sleep. Staff decided that Mr March should collect his medication from the pharmacy in future, rather than hold it himself.

34. On 19 August, Mr March made a deep cut to his neck. Staff started suicide and self-harm prevention procedures (known as ACCT). Mr March said he was feeling low, that people at Bure were getting him down and that he was hearing voices. He said he had not intended to take his life, but he felt mentally unwell after being stable for the past two years.

35. A psychiatrist saw Mr March on 20 August. He noted that Mr March had a long history of auditory hallucinations and paranoia and had previously been diagnosed with emotionally unstable personality disorder. He also had a history of illicit substance misuse. Mr March told him that his anxiety and paranoia had worsened since being monitored under ACCT and having to collect his medication from the pharmacy. Following discussion with the mental health team, the psychiatrist agreed that Mr March could hold his own medication again and started a switchover from quetiapine to aripiprazole (another antipsychotic). A mental health nurse took Mr March onto her caseload.

36. Staff stopped ACCT procedures on 30 August, after Mr March said his medication had been changed and healthcare staff had been supporting him and helping him through his issues.

37. On 11 September, Mr March failed another medication compliance check. He was warned about taking too much of his medication and told he would now be checked more frequently.

38. The psychiatrist and the mental health team manager met with Mr March on 8 October. Mr March said he felt mentally more stable, was not experiencing too many intrusive thoughts and was feeling more optimistic about the future. The psychiatrist increased Mr March's prescription of aripiprazole and reduced quetiapine.

39. On 24 October, Mr March told staff he had taken an overdose of 15 amitriptyline, five quetiapine and five aripiprazole tablets. Staff sent him to hospital, and he returned to Bure later the same day. Staff started ACCT procedures. Mr March said he did not feel safe on the wing and thought other prisoners were talking about him. Staff reassessed Mr March's in-possession medication risk and required him to collect his medication from healthcare daily, rather than keep it himself.

40. On 26 October, Mr March told staff he had not been taking his medication because he did not like to queue for it in the healthcare department as it made him feel anxious. Healthcare staff agreed to look at other ways he could obtain his medication. They allocated him a mental health key worker nurse who would meet with him regularly to explore his thoughts and feelings. The psychiatrist would also continue to see him.

41. On 4 November, Mr March seemed in good spirits and said things had settled down, he was collecting and taking his medication, had no thoughts of suicide or self-harm and felt supported by staff and prisoners. Staff stopped ACCT procedures.

42. On 12 November, the mental health team discussed Mr March's risk of holding his own medication. While they acknowledged that he had taken overdoses in the past, they agreed that Mr March was visibly anxious and agitated when he queued for his medication, which could increase his risk of self-harm. They considered that Mr March might look at other methods of self-harm if he was denied in-possession medication. Although not all primary healthcare staff agreed that Mr March should resume in-possession medication, and raised concerns about this, it was decided that Mr March's in-possession medication should be reinstated, but with increased compliance checks.

43. The psychiatrist met with Mr March on 26 November, and he said he was stable with no thoughts of self-harm. He said he felt much better not having to collect his medication. He asked to revert to quetiapine and so his aripiprazole was stopped, and he went back on a full dose of quetiapine.

44. On 7 December, Mr March took an overdose. He told healthcare staff he had taken all his medication, had felt paranoid recently and did not want to carry on. He was treated at hospital. He had left a note in his cell which said he had taken his medication because he had been terrorised into doing so. He said he had not been well, and his head hurt. He wrote that he was sorry to staff and left a message to his mother that he had no choice. Staff started ACCT procedures when Mr March returned from hospital, and initially placed him on constant supervision in the segregation unit.

45. On 9 December, staff moved Mr March back to the wing and put him on two observations an hour. Staff gave him a letter, so he did not have to queue up to get his medication, though he still had to collect it daily. Staff stopped ACCT monitoring on 30 December. Mr March had returned to work in the kitchen and on the servery, had a good relationship with staff and was now happy collecting his medication.

2020

46. A mental health nurse met Mr March on 20 January 2020, for a mental health review. She noted in his medical record that Mr March appeared flat in mood and anxious. Mr March told her he continued to struggle with thoughts and emotions, described his paranoia as slightly improved, but believed he was still being talked about. They discussed his intermittent suicidal thoughts and intrusive thoughts of self-harm. They spoke about ways to overcome this and discussed Mr March's protective factors, such as his mother. Mr March said he felt nervous about his release, and that because he was not allowed to keep his own medication, he often took it too early at the hatch, meaning he fell asleep and woke up early. She noted she would discuss alternative antidepressants and arranged a medication review. It was agreed Mr March could collect his day's medication in one go, to reduce his trips to the pharmacy. Mr March was also prescribed ramipril medication to lower his blood pressure.

47. The psychiatrist and mental health nurse met with Mr March on 4 February. They noted that he seemed brighter in mood and Mr March said he felt better, probably the best he had felt in a while. Mr March said he still experienced intermittent intrusive thoughts of self-harm, but they were less intense and less frequent. His antidepressant had been changed to mirtazapine, which he felt had helped him, and his sleep had improved. He said his self-harm thoughts were worse when he was standing in the pharmacy queue and he continued to think people were talking about him. However, he had collected his medication daily and felt better able to manage these thoughts.

48. The mental health nurse and Nurse A, who was taking over the mental health nurse's caseload, met with Mr March on 26 February. Mr March said he felt his mental health had deteriorated and he was having paranoid thoughts. Mr March said he still felt anxious when he queued daily for his medication and had not been thinking about his release in October, thinking more about suicide, although he had no plan or intent to take his life. Mr March said he was worried about his safety after release.

49. On the morning of 28 February, Mr March told staff he had taken an overdose of his in-possession medication (quetiapine and ramipril). Staff sent Mr March to hospital and started ACCT monitoring. Mr March returned to Bure that evening. Staff held an ad-hoc ACCT case review in reception and set Mr March's level of observations at hourly. Mr March said he had felt low, but had no thoughts of suicide or self-harm, though these thoughts came to him very quickly. Staff removed the remaining medication from his cell, as well as two razor blades.

50. At his ACCT case review on 29 February, Mr March said that although he had been feeling low, he now felt slightly better. He said he thought there were a lot of people who wanted to harm him when he was released from prison. He said he felt scared on the wing, where he had lived for two and a half years, despite knowing he was safe. As Mr March had had his in-possession medication taken away, he said he would work with healthcare staff about collecting his medication from them. Mr March said he was engaging with the mental health team and did want to feel better. Staff changed Mr March's observations to two conversations

each morning, afternoon and evening and one check an hour throughout the night.

51. The psychiatrist saw Mr March in his cell on 3 March. Mr March said he felt bad about his recent overdose but felt unable to control his behaviour. The psychiatrist noted Mr March had written "Do it" on his mirror. He agreed to replace it with a positive affirmation, such as 'Be kind to yourself' or 'Mum'.

52. At the ACCT review on 4 March, Mr March said he still felt tired from the overdose but had no thoughts of suicide or self-harm. Mr March agreed to work with the healthcare department about picking up his medication, and staff agreed to move him to a quieter cell on the wing, as he was struggling where he currently was. Staff reduced the number of conversations to one conversation three times a day and an observation every morning and afternoon, with five observations during the night. At the next ACCT review, on 12 March, staff assessed that Mr March's risk of self-harm remained the same, and he was still hearing voices. Mr March had asked for more shifts in the kitchen, as it took his mind off things. He had moved to a quieter landing on the wing, which had helped. Staff stopped ACCT monitoring.

8 to 15 May 2020

53. On 8 May, SO A noted in Mr March's prison record that staff on the wing had noticed Mr March appeared to be struggling with his mental health. The SO noted that he asked Mr March how he was feeling, what he felt was going wrong, and how staff could help him. Mr March said he just did not feel right but was not at the stage of having suicidal or self-harm thoughts. The SO asked whether Mr March had stockpiled any medication in his cell, as he had taken overdoses in the past, but he said he had not. He asked to speak to a member of the mental health team, and the SO said he would arrange this.

54. Nurse A visited Mr March at work in the kitchen that afternoon. He told her he was struggling, hearing voices and felt paranoid, although he had no thoughts of harming himself. Mr March said he wanted to stop taking his medication, as he did not think it was helping him, but she persuaded him to continue to take it and to let staff know how he was feeling. Mr March agreed to take an afternoon off work that weekend, so he could talk to her.

55. Nurse A noted in Mr March's medical record that she had discussed Mr March with SO A, and that it was agreed that he did not need to be monitored by ACCT at that time, but he would need support. The SO noted in Mr March's electronic record that Mr March had told Nurse A that he was confident he would not self-harm, and that she was content he was not currently a risk to himself but that she would monitor the situation closely. He recorded that they had agreed that they did not need to open an ACCT but that he would monitor this.

56. Nurse A saw Mr March on 10 May, with a wing officer. Mr March said he thought he was going downhill, and something was not right with himself. Mr March said the voices he heard were calling him names like "nonce" and "rapist" and telling him that he was going to die. He said he was having nightmares and waking up two or three times during the night. He said he had no current thoughts of suicide or self-harm. She noted that she would request a medication review with

the psychiatrist. She also noted that a member of the mental health team would see Mr March every Friday afternoon when he would have the afternoon off work and that someone would see him briefly in between.

57. Nurse A saw Mr March on 15 May. She noted that he had a good understanding of his mental health and that it was deteriorating, but he was engaging well with the mental health team. He said he was still hearing voices but said he had no thoughts of suicide or self-harm. She noted that his mood presented as stable.

17 May 2020

58. At 8.16am on 17 May, Officer A unlocked Mr March for work. He could only open the door a few inches, his curtains were drawn which was unusual, and he could smell excrement. The officer thought Mr March was using the toilet and shouted out that it was time for work. He had no reply so repeated this twice more. He managed to push the cell door a little further open and could see Mr March's legs behind the cell door and thought he had collapsed. The officer immediately radioed an emergency code blue call. He pushed the door further and looked round it to see Mr March suspended by a ligature.

59. Officer B arrived at the cell and both officers pushed their way into the cell. He lifted Mr March to try to support his weight, while Officer A used his anti-ligature knife to cut the ligature between Mr March's neck and where it was fixed, on the door. The cell was very slippery as Mr March had smeared his legs and the cell floor with some sort of lotion. They laid Mr March on the floor. Officer B immediately started chest compressions, while Officer A cut the rest of the ligature which was around Mr March's neck. Mr March had also bound his hands behind his back, so Officer A cut the binding and checked for a pulse. He could not find one.

60. Two nurses arrived at Mr March's cell at 8.20am. One nurse took over chest compressions, whilst the other looked to insert an airway. One nurse noted that Mr March's lips had a blue tinge and he had a deep ligature mark around his neck, but he did not feel cold. The other nurse attached defibrillator pads to Mr March's chest. No shock was advised.

61. Ambulance paramedics arrived at the cell at 8.36am. They inserted an airway into Mr March's mouth and attached it to oxygen and switched to their own, automatic, defibrillator. Despite their attempts to resuscitate Mr March, he was pronounced dead at 9.03am.

62. Mr March had left a letter in his cell. He wrote that his life was hell and getting worse every day. Mr March wrote that his mind was broken and that he was being psychologically bullied by other prisoners. He said people thought he could not hear them, but he could. Mr March said he felt depressed and had been pushed too far and that people were saying he had done things which he had not. He wrote that when he was released, he would be "taken off the streets and tortured" and that he was "a dead man walking".

Contact with Mr March's family

63. The prison appointed a SO as the family liaison officer. In line with COVID-19 guidance, police visited informed Mr March's mother and next of kin to inform her of his death. The SO then took over all family contact.

64. The prison contributed to the cost of Mr March's funeral, in line with national guidelines.

Support for prisoners and staff

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

66. The prison posted notices informing other prisoners of Mr March'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 March's death.

Post-mortem report

67. Mr March's post-mortem concluded he had died by hanging. The toxicology report said there was no indication that Mr March had taken any illicit drugs or alcohol, only his prescribed medication.

Findings

Assessment of Mr March's risk

68. Prison Service Instruction (PSI) 64/2011, *Management of prisoners at risk of harm to self, to others and from others (Safer Custody)*, sets out the procedures (known as ACCT) that staff should follow when they identify that a prisoner is at risk of suicide and self-harm.

69. Mr March was monitored under ACCT four times while at Bure: after he cut his neck in August 2019 and after each of his three overdoses in October and December 2019 and February 2020. These all appear to have been serious attempts to end his life and the last three required hospital admission. We consider that the ACCT procedures were well managed. Staff held multidisciplinary case reviews, completed meaningful care maps, and carried out ACCT observations correctly. Staff gave Mr March the opportunity to involve his family in the ACCT process, but he declined.

70. However, we are concerned that a mental health nurse and a wing SO decided that Mr March did not need to be monitored under ACCT around a week before Mr March hanged himself.

71. This is not a case where staff ignored warning signs and gave no thought to opening an ACCT. However, although we recognise that the mental health nurse carried out a thorough assessment before concluding that Mr March did not need to be monitored under ACCT, and that the wing SO agreed with her, we consider that it was a mistake not to open an ACCT at this point. Wing staff were concerned that there had been a deterioration in Mr March's mental health, and Mr March told the nurse that his mental health had deteriorated and that he felt low and was hearing voices and feeling paranoid - exactly the conditions that had preceded previous suicide attempts. Although Mr March told the nurse that he had no thoughts of suicide or self-harm, experience indicated that his assertions could not be relied upon as he had said the same thing shortly before his previous suicide attempts. All the evidence therefore suggested that when Mr March's mental health deteriorated, his behaviour was unpredictable, and he was at genuine risk of harming himself.

72. We note that the nurse had only taken Mr March onto her caseload two days before his last act of self-harm, and that she did not, therefore, have experience of how he presented before he self-harmed. This may have led her to place too much confidence in his assurances that he had no thoughts of self-harm.

73. Although the nurse planned to put additional support in place for Mr March, this consisted of a medication review (which had not taken place before Mr March's death) and a weekly meeting with someone from the mental health team. If an ACCT had been opened, however, Mr March would have had additional support and monitoring from prison staff as well as mental health staff. All the previous ACCTs had been put in place after Mr March had self-harmed. This was an opportunity to try to prevent a further act of self-harm.

74. We recognise that the decision not to open an ACCT in May was made by conscientious people acting in what they thought was Mr March's best interests.

However, given Mr March's history of serious self-harm/suicide attempts and the complex problems he presented, we are concerned that the decision not to open an ACCT was made at a relatively junior level, by a mental health nurse and an SO. Although Mr March was not a prolific self-harmer, he had self-harmed seriously on four occasions and there was no reason to believe that he would not continue doing so in the future. We therefore consider that more senior staff should have been involved in considering his risk when his mental health deteriorated again. We consider that staff might reasonably have considered at this point whether Mr March should be managed under 'enhanced' ACCT case management (in which multi-disciplinary reviews are chaired by someone of at least Custodial Manager grade).

75. We are also concerned that some healthcare staff thought that if he was subject to ACCT monitoring, Mr March could not continue to work in the kitchen (a job that he enjoyed and which provided a distraction for him). Nurse A said that when ACCT monitoring was stopped in March, one of the considerations was that Mr March would not be able to go to work if ACCT monitoring was continued. A prison GP also said at interview that Mr March would not have been able to work if he had been monitored under ACCT. This is not the case. There is no policy that says a prisoner being monitored under ACCT cannot continue to work. This misunderstanding may have played a part in Nurse A's assessment that an ACCT should not be opened.

76. We recommend:

The Governor and Head of Healthcare should ensure that all staff are aware that they should take account of a prisoner's risk factors and previous behaviour when assessing risk and should not rely on a prisoner's assertions that he has no thoughts of self-harm.

The Governor should ensure that staff consider opening Enhanced ACCT Case Management procedures where there has been a pattern of serious self-harm.

The Head of Healthcare should ensure that staff are aware that prisoners can continue to work when they are subject to ACCT monitoring.

The Governor should share this report with SO A and arrange for a senior manager to discuss the Ombudsman's findings with him.

The Head of Healthcare should share this report with Nurse A and discuss the Ombudsman's findings with her.

Medication

77. Mr March overdosed on three occasions when he was holding in-possession medication. However, when Mr March was required to collect his medication from the pharmacy, he became anxious and his mental health deteriorated. Healthcare staff were concerned that denying Mr March in-possession medication could increase his risk of self-harm, possibly by more reckless and dangerous methods.

78. We accept that the decision on whether Mr March should hold medication in-possession was not a straightforward one. We consider that healthcare staff considered the risks carefully and the decisions they reached were reasonable in the circumstances.

Bullying

79. Bure carried out an investigation into Mr March's allegations about bullying but found no evidence to support this. Mr March said on many occasions that he was hearing voices and was paranoid. Mr March seemed to have positive relationships with staff and the wing, and no issues with other prisoners had been recorded.

Clinical care

80. The clinical reviewer found that the care Mr March received for his physical and mental health was equivalent to that he could have expected to receive in the community.