Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Adam Peterson a prisoner at HMP Humber on 24 July 2017

A report by the Prisons and Probation Ombudsman

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Our Vision

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

Our Values

We are:

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

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 Adam Peterson was found hanged in his cell at HMP Humber on 20 July 2017. He was 27 years old. I offer my condolences to Mr Peterson's family and friends.

This is a sad story. Mr Peterson was a vulnerable man with complex personality disorder issues, a history of poly-substance misuse and limited coping mechanisms. He had significant risk factors for suicide and self-harm and had frequently self-harmed and tied ligatures. He attempted to hang himself in HMP Leeds in February 2017.

Our investigation identified some concerns about the management of ACCT procedures at Humber, despite significant input from a range of staff into Mr Peterson's care. There should also have been better continuity of mental health care between Hull and Humber and integrated treatment in the light of Mr Peterson's dual-diagnosis status.

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 **January 2019**

Contents

Summary

Events

1. Mr Adam Peterson had a significant history of self-harm and had attempted suicide in prison and in the community. He tied ligatures frequently in prison and harmed himself by cutting his arms. Mr Peterson had a history of alcohol and poly-drug misuse, attention deficit hyper-activity disorder (ADHD), borderline and dissocial personality disorder, anxiety and depression. He was under the care of a consultant forensic psychiatrist and the ADHD specialist services in his home area.

2. Mr Peterson had served a number of short prison sentences and was released on licence from HMP Leeds on 10 May 2017. His licence was revoked on 18 May after he failed to comply with conditions to live in Approved Premises (a probation hostel) and not to contact his girlfriend. Mr Peterson was remanded into custody the same day and taken to HMP Hull.

3. Mr Peterson was managed in the Wellbeing Centre, a unit with a higher level of staff supervision, before progressing to a standard wing. He had weekly sessions with a specific mental health nurse and intervention from substance misuse services. He was transferred to HMP Humber on 29 June. On 30 June, a multi-disciplinary healthcare team decided to allocate him to the mental health dashboard, which meant he was monitored by the mental health team but not allocated to the caseload of a specific nurse.

4. Staff began Prison Service suicide and self-harm monitoring (known as ACCT) on 1 July after Mr Peterson said he felt suicidal. Mr Peterson's complex mental health issues required and received considerable input from staff. Mr Peterson harmed himself and threatened to harm himself on several occasions. He was extremely anxious about his father's health and the wellbeing of his girlfriend. In the week leading to his death he was moved to a safer cell on a high number of observations and placed in alternative clothing (a tabard made from tear-resistant material) after becoming convinced his girlfriend was being held hostage in the prison.

5. On 17 July, Mr Peterson was allocated to the caseload of a senior mental health nurse who attended his ACCT review on 18 July. He was given back his own clothes and possessions because he was struggling to cope without them. He remained in the safer cell on a high number of observations. On 19 July, Mr Peterson returned to his cell on a standard wing at reduced observations following an ACCT review with no mental health nurse present. On 20 July he attended an appointment with the visiting psychiatrist and his named nurse.

6. At 9.17pm on 20 July, the night patrol officer found Mr Peterson hanging in his cell. Staff performed cardio-pulmonary resuscitation and called an ambulance. Mr Peterson was taken to hospital but died on 24 July.

Findings

7. Mr Peterson was a vulnerable man with complex personality disorder issues and limited coping mechanisms. His numerous risk factors and substantial mental

health problems meant that he should always have been considered at risk of suicide, although he did not have a history of serious attempts to kill himself.

8. Although we acknowledge that there was significant input from a range of staff into Mr Peterson's care, we identified some concerns about the management of ACCT procedures at Humber. A number of different staff chaired Mr Peterson's reviews, and there was no member of healthcare at the first case review. There was a lack of multi-disciplinary representation at many case reviews. Some caremap actions were poor and had been achieved before they were added. Mr Peterson's risk and level of observations were not reviewed after every incident of self-harm.

9. The decision to reduce Mr Peterson's observations on 19 July, was taken without input from his mental health nurse and she and the psychiatrist were unaware that his observations had been reduced when they spoke to him on 20 July.

10. Mr Peterson was a dual diagnosis patient (he had significant substance misuse and mental health needs) but did not receive appropriate integrated care at Humber.

Recommendations

- The Governor and Head of Healthcare should ensure that prison staff manage prisoners at risk of suicide or self-harm in line with national guidelines, including:
    - managing complex cases under the enhanced case management process;
    - managing all prisoners in alternative clothing under the enhanced case management process;
    - ensuring that the ACCT documentation accompanies prisoners to all medical and psychiatric appointments;
    - considering involving the family in the ACCT process;
    - setting effective ACCT caremap objectives which are specific and meaningful, aimed at reducing a prisoner's risk and which identify who is responsible for them.

- The Governor and Head of Healthcare should ensure that:
    - Prisoners with dual diagnosis receive appropriate integrated treatment.
    - New prisoners with complex mental health issues who have been on the caseload of a specific nurse at a previous prison are assessed in person.

The Investigation Process

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

12. The investigator visited Humber on 1 August 2017. She obtained copies of relevant extracts from Mr Peterson's prison and medical records. She watched CCTV from 20 July 2017.

13. The investigator interviewed 11 members of staff at Humber on 16, 17 and 24 August. She also obtained information from the head of healthcare and the head of the mental health team.

14. NHS England commissioned a clinical reviewer to review Mr Peterson's clinical care at the prison. The clinical reviewer spoke to a nurse on the telephone.

15. We informed HM Coroner for Kingston-upon-Hull and the East Riding of Yorkshire of the investigation who gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.

16. The investigation was suspended for nine months while we awaited the final post-mortem report and cause of death.

17. One of the Ombudsman's family liaison officers contacted Mr Peterson's parents, to explain the investigation and to ask if they had any matters they wanted the investigation to consider. They asked why Mr Peterson was in a single cell when he died and whether this was appropriate given his risk. They also asked whether he was on an appropriate level of observations and whether there were enough staff on duty at night to ensure prisoners at risk were safe. Mr Peterson's parents asked whether his transfer between prisons meant that:

    - He did not have the opportunity to complete a Visiting Order.
    - He suffered delayed access to his medication.
    - He did not have access to the money that they sent to him in prison.

18. We have answered these questions in separate correspondence.

Background Information

HMP Humber

19. HMP Humber is a medium security prison in Yorkshire that holds approximately 1,000 men. City Health Care Partnership (CHCP) provides healthcare services. There are healthcare staff on duty at all times and the mental health team work on weekdays. At the time of Mr Peterson's death, CHCP commissioned psychiatric services via locum doctors. A psychiatrist works one day a week.

HM Inspectorate of Prisons

20. The most recent inspection of HMP Humber was in December 2017. Inspectors reported high levels of self-harm that reflected the vulnerable nature of Humber's population. The prison's response to the Prisons and Probation Ombudsman's investigations into the four deaths in 2016 and the initial feedback to Mr Peterson's had been positive. The quality of ACCT documents was good. Case management was consistent, most reviews were multi-disciplinary, caremaps were meaningful and entries suggested good interaction with prisoners.

21. Inspectors identified shortcomings in the provision of ongoing mental health interventions. Although prisoners received prompt assessment and reasonable individual support, the range of interventions and staffing did not meet the high level of ongoing need for prisoners requiring longer term interventions.

Independent Monitoring Board

22. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report, for the year to December 2017, the IMB reported that, given the high number of prisoners with mental illness, they would like to see more full-time staff and fewer agency staff employed by the prison. The Governor had placed a strong emphasis on safer custody within the prison and new measures brought in had significantly improved the management of prisoners thought to be at risk of suicide or self-harm.

Previous deaths at HMP Humber

23. There were four apparently self-inflicted deaths at Humber in 2016. In three of them we found that ACCT procedures were inadequate or should have been started but were not. There have been four deaths since Mr Peterson died but none were self-inflicted and they have no significant issues in common with Mr Peterson's death.

Assessment, Care in Custody and Teamwork

24. 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.

25. 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.

26. 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.

Safer cells

27. Safer cells are designed to minimise ligature points and create a normalising environment for prisoners at high risk of suicide and self-harm.

Key Events

28. Mr Adam Peterson had a significant history of self-harm and attempted suicide in prison and in the community. He tied ligatures frequently in prison and harmed himself by cutting his arms. Mr Peterson had a history of alcohol and poly-drug misuse, attention deficit hyper-activity disorder (ADHD), borderline and dissocial personality disorder, anxiety and depression. He was under the care of a consultant forensic psychiatrist and the ADHD specialist services in his home area.

29. Mr Peterson had served a number of short prison sentences and was released on licence from HMP Leeds on 10 May 2017. His licence was revoked on 18 May after he failed to comply with conditions to live in Approved Premises (a probation hostel) and not to contact his girlfriend. Mr Peterson was remanded into custody the same day and was taken to HMP Hull.

HMP Hull 18 May – 28 June 2017

30. Reception staff began Prison Service suicide and self-harm monitoring procedures (known as ACCT) after Mr Peterson said he wanted to kill himself. He was put in a camera-monitored cell on the Wellbeing Centre (a unit with closer supervision than a standard wing).

31. On 20 May, Mr Peterson tied a ligature around his neck. Staff gave him alternative clothing (anti-ligature clothing consisting of a tabard made from tear resistant material) as an extra measure to keep him safe. Mr Peterson also banged his head against the wall because he said he thought his girlfriend had been raped.

32. On 22 May, Mr Peterson moved to a standard wing but tried to hang himself because he said he could not cope. On 23 May, he was admitted to the inpatient unit for a 72-hour assessment because he was behaving “bizarrely”. Mr Peterson told staff he would “cut up” if he was returned to a standard wing. He said he was unhappy in Hull because it was too far for his girlfriend to visit. Mr Peterson returned to the camera-monitored cell on the Wellbeing Centre after his assessment.

33. On 1 June, a mental health nurse telephoned Mr Peterson’s mother who told her that he could be chaotic and challenging, especially when fuelled by alcohol, and that his anxiety increased over issues with his girlfriend. On 2 June, Mr Peterson was assigned to the nurse’s caseload and thereafter he had weekly appointments with her.

34. On 3 June, Mr Peterson made cuts to his arms with a plastic knife. On 6 June, he self-harmed using drawing pins he had concealed in his buttocks. On both occasions he was upset about his father’s health and was missing his girlfriend. On 9 June, Mr Peterson moved to a standard cell after a period of more settled behaviour. On 15 June, his ACCT was closed and on 22 June, he was considered stable enough to move to a standard wing. Mr Peterson began working with substance misuse services. On 26 June, Mr Peterson was reported to be doing well on a standard wing, sharing a cell with a friend.

HMP Humber 29 June – 19 July 2017

35. On 29 June, Mr Peterson was transferred to HMP Humber. Before he left, he said he did not want to transfer to Humber because he was on controlled medication and had learning disabilities. A nurse reassured him that the Humber pharmacy was aware of his medication and their mental health team would look after him. The nurse telephoned a mental health nurse at Humber, and briefed her on Mr Peterson's background history, diagnosis and risk factors. Mr Peterson's prescription for Concerta (to treat his ADHD) was continued at Humber.

36. At an initial health assessment at Humber Mr Peterson told a nurse that he had recently been monitored under ACCT procedures and gave a history of self-harm, alcohol abuse and attempted suicide. He noted Mr Peterson appeared stable and interacted well. He was not anxious and was able to describe his self-harming behaviours and mental health needs. Mr Peterson said he had ADHD, personality disorder, anxiety, depression and psychosis. He said he did not have any current thoughts of suicide or self-harm. The nurse referred Mr Peterson to the mental health team for assessment. He went to a standard shared cell on the first night centre.

37. On 30 June, Mr Peterson was discussed at Humber's multi-disciplinary team meeting and was added to the mental health team dashboard for monitoring. This is means that he was managed by the mental health team in general rather than being on the caseload of a specific nurse.

38. The same day Mr Peterson told a prison chaplain that his father was terminally ill and he was very worried about him. The chaplain telephoned Mr Peterson's mother who said that Mr Peterson's father had chronic obstructive pulmonary disorder (COPD) but was not dying. The chaplain reassured Mr Peterson about his father's health.

39. On 1 July, an officer began ACCT procedures after Mr Peterson made cuts to his left arm and said he felt like killing himself. He said was worried that his father was terminally ill and he would never see him again.

40. A Supervising Officer (SO) said Mr Peterson came to the wing office very agitated and upset. Mr Peterson said his father was dying and he wanted to ring his mother. The SO let him telephone her in the wing office and Mr Peterson seemed much calmer afterwards. He gave the SO a razor blade that he had secreted in the waistband of his trousers and said, "Thank you, I was going to use that." ACCT observations were set at five times an hour, the mental health team were told and Mr Peterson was given another telephone call to his family.

41. Mr Peterson told a SO, the ACCT assessor, that he was not receiving visits from his family because Humber was too far away and his father was dying. He said he had scratched his arm to release stress and felt better as a result. He said he had no current thoughts of suicide or self-harm and had spoken to his parents on the telephone.

42. A SO held the first ACCT review on 2 July, with Mr Peterson and an officer. Mr Peterson was very talkative and more positive. He said he wanted to move

closer to home and wanted to work while at Humber. The SO reduced observations to two an hour. The SO added a single action to the ACCT care map, that Mr Peterson would complete a transfer application. As Mr Peterson had completed one of these on 1 July, he marked the action as complete.

43. The SO held a second ACCT review later the same day with Mr Peterson and another SO, after Mr Peterson's cellmate said he could not share with him because he repeatedly rang his cell bell and would not sit still. The SO increased Mr Peterson's observations to four times an hour and moved him to a single cell. The SO said he did not ask a member of the mental health team to attend either review. He said that, at the time, he followed the practice of other SOs that he had observed and was not aware that reviews needed to be multi-disciplinary. He said that he had since received the new Prison Service suicide and self-harm (SASH) training and the prison had introduced new measures to ensure multi-disciplinary attendance.

44. That evening, Mr Peterson complained of chest pains and a knot in his stomach. A healthcare assistant checked his blood pressure, oxygen levels and pulse, which were all in the normal range. Mr Peterson began making "wailing" noises but she saw him walking about the wing apparently well soon afterwards, so she took no further action.

45. A SO said Mr Peterson stayed on the first night centre (H Wing) for longer than usual because he needed a safe and stable environment in his first few days. Mr Peterson appeared vulnerable at times but could also be argumentative and aggressive and upset other prisoners. The SO said that he spoke to Mr Peterson every day when he was on duty. He said Mr Peterson would present with a problem and when this was resolved he would come back with a different problem. He needed a lot of reassurance and staff input.

46. On 3 July, an officer emailed Mr Peterson's Offender Supervisor after Mr Peterson spoke to her at length about his sentence and location. A chaplain also visited Mr Peterson and said that he was very upset about his father. Later the same afternoon, Mr Peterson made scratches to his right arm. A nurse examined him and the orderly officer, spoke to Mr Peterson. The ACCT was not reviewed as it should have been.

47. On 4 July, Mr Peterson moved to L Wing, a standard wing. At 7pm, he asked to speak to Listeners (prisoners trained by The Samaritans to offer support) but declined to go to the Listener's Suite to speak to them. At 9.30pm, Mr Peterson told the night orderly officer (the officer in charge of the prison at night), that he was worried about his father who he described as terminally ill. She spoke to Mr Peterson's parents and reassured Mr Peterson that they were fine. She raised Mr Peterson's observations to five times an hour.

48. A chaplain visited Mr Peterson on 5 July, and prayed with him about his father's health. Mr Peterson's offender supervisor agreed his sentence plan with him. He said Mr Peterson was clearly distressed at being at HMP Humber because of his father's illness. He contacted the Observation, Classification and Allocation (OCA) department about Mr Peterson and the same day the prison sent a transfer request to HMP Leeds on Mr Peterson's behalf.

49. A nurse saw Mr Peterson in the mental health clinic. He said Mr Peterson was "chaotic" in his presentation and was clearly worried about his father. He did not think that Mr Peterson was at risk of suicide.

50. Also on 5 July, a SO reviewed Mr Peterson with another SO, a safer custody manager, a nurse and the catholic chaplain. At first Mr Peterson was tearful and appeared sleepy with slurred speech, but over the course of an hour he brightened up and became more talkative. The nurse said she would arrange a social care assessment for Mr Peterson as he said he was not eating. She contacted the learning disabilities nurse the same day. Mr Peterson remained on five observations an hour pending another review the next day.

51. During the night, Mr Peterson threatened to hang himself because he was worried about his father's health and was not sleeping. The night orderly officer, telephoned Mr Peterson's father and was able to reassure Mr Peterson that his father was fine. Observations were increased to five an hour and Mr Peterson was settled for the rest of the night.

52. On 6 July, a SO held an ACCT review with Mr Peterson, an officer, a nurse and a chaplain. Mr Peterson was much happier and had been given credit to telephone his father using the prisoner telephone system. The nurse said he had made Mr Peterson an appointment with the visiting psychiatrist on 20 July. The record does not make it clear why this appointment was made but at interview two nurses confirmed it was for a medication review. Mr Peterson said he had a good relationship with wing staff and was feeling more settled. The chaplain telephoned Mr Peterson's mother to find out whether she had sent him any money. His observations were reduced to three an hour.

53. At about 10.30pm on 11 July, a nurse responded to a code blue emergency. Mr Peterson was grey with rapid breathing, fast and irregular pulse, a high temperature and he had vomited bile.

54. A mental health nurse also examined Mr Peterson. She said Mr Peterson was having an anxiety attack rather than suffering from psychosis. Mr Peterson said he was worried about his father's health and how his mother was coping. He was also worried about his girlfriend and his medication. The fact that he was in prison had increased his anxiety because he felt remote from his family. He was fixated about sugar and said repeatedly that he needed more sugar to help his breathing.

55. Mr Peterson was taken to hospital by ambulance. He was diagnosed with a chest infection, prescribed antibiotics and discharged the next day.

56. At 5.40pm on 12 July, Mr Peterson told an officer that he had had enough and wanted to die because he had not seen his girlfriend. His level of risk and observations were not reviewed as they should have been. At about 9.21pm, Mr Peterson pressed his cell bell and showed the night patrol, that he had made superficial cuts to his left arm. He said he wanted to move to the segregation unit so officers could kill him. He said staff were putting bleach in his water and had tied his girlfriend up ready to kill her. Mr Peterson's ACCT record showed that the night nurse attended to Mr Peterson's wounds but there is no corresponding entry in his medical notes.

57. The next morning, 13 July, a SO held an ACCT review with a nurse and an officer. Mr Peterson refused to leave his cell. His observations remained at three an hour.

Saturday 15 and Sunday 16 July

58. At 6.00pm on 15 July, Mr Peterson told an officer that his "head was going" and threatened to damage his cell unless he was taken to the segregation unit. At 7.10pm he made cuts to his arms. He thought his girlfriend was tied up in the segregation unit. A nurse dressed his cuts and Mr Peterson said he was struggling to cope as his father was in hospital "fighting for his life". Mr Peterson said he was worried that people wanted to kill him and threatened to hang himself. The nurse said Mr Peterson's cell was unkempt and he appeared to be self-neglecting. The nurse thought Mr Peterson was at high risk of suicide and made an urgent referral to the mental health team.

59. The night nurse checked Mr Peterson at the beginning of her shift. She said he was distressed and said he wanted to kill himself because he was not able to see his father. She returned to see Mr Peterson with the night orderly officer, at about 9.50pm. Mr Peterson was standing near his window with a noose around his neck demanding to see the night orderly officer. As soon as he realised the night orderly officer was there he took the noose off.

60. The night orderly officer held an ACCT review with Mr Peterson, a nurse and an officer. The night orderly officer gave Mr Peterson a television for his cell to help distract him. He also increased Mr Peterson's observations to four an hour. Mr Peterson later asked the night patrol, for the Samaritans telephone but she noted that when she checked him he did not appear to be using it. Between 2.30 and 3.30am, Mr Peterson repeatedly tried to smash his observation panel.

61. The next morning a SO and an officer held an ACCT review with Mr Peterson in his cell. Mr Peterson hid under his duvet and said he blamed wing staff for not supporting him. The SO increased his observations to five an hour. At 9.30am, the SO collected Mr Peterson to take him to get his medication. Mr Peterson threatened to attack staff as soon as he came out and threatened to hang himself. At 11.20am, Mr Peterson was moved to a safer cell on H Wing and watched continuously pending an ACCT review.

62. Two chaplains visited Mr Peterson for pastoral support. A chaplain said Mr Peterson was very agitated and talked constantly without appearing to listen to what they were saying to him. He was extremely concerned about his father. He looked like he had not had a shower for a while and he said he was not eating. The chaplain said they attempted to reassure Mr Peterson but he appeared too mentally unwell to engage with them. The chaplain described Mr Peterson as at the upper end on a scale of mental illness compared to other mentally ill prisoners she had seen. She said she was concerned that he was very vulnerable.

63. After their visit, a chaplain emailed the mental health team to ask them to review Mr Peterson. The chaplain also telephoned Mr Peterson's mother and girlfriend. Mr Peterson's mother explained that Mr Peterson's father was ill but not life-threateningly so and was about to start oxygen therapy for his COPD. Mr

Peterson's girlfriend was very stressed because she was unable to visit Mr Peterson as regularly as she would have liked.

64. At 1.00pm, a SO from the safer custody team, held an ACCT review with two other SOs and an officer. The chaplain did not attend but told a SO about her conversations with Mr Peterson's mother and girlfriend. A nurse confirmed on the telephone that a referral had been made to the mental health team and someone would visit Mr Peterson that afternoon. Mr Peterson hid under his bed and refused to take part. He was placed in alternative clothing because of his continuing threats to harm himself. No visit from the mental health team is recorded on Mr Peterson's medical record that afternoon.

Monday 17 July

65. At 12.27pm, a SO held an ACCT review with Mr Peterson and a mental health nurse. The SO had not met Mr Peterson before so he looked at Mr Peterson's prison record and asked the wing staff how Mr Peterson was before starting the review. The SO said Mr Peterson was erratic and spoke constantly without saying anything of much substance. It was difficult to gauge his level of risk as a result. He did not appear to be able to take in what was being said to him.

66. The SO said Mr Peterson appeared vulnerable. He said Mr Peterson had issues with other prisoners on the long corridor he had to walk down on L Wing to collect his medication and sometimes did not collect his medication. He said Mr Peterson had not realised that he could collect his medication upstairs on H Wing and had not been collecting it. (There is nothing on Mr Peterson's record about his issue with collecting medication and no evidence that the alleged bullying was investigated.) Mr Peterson said he wanted a transfer to Leeds. The SO said that he explained to Mr Peterson this was unlikely because Leeds is a local prison, but it might be possible to transfer him to Wealstun, a training prison like Humber. Mr Peterson reacted positively to this.

67. A nurse said that Mr Peterson had come from Hull on a high dose of Concerta and the mental health team were concerned that this was contributing to Mr Peterson's anxiety and erratic behaviour. Mr Peterson was fixated on his father being ill and it was hard to establish a level of understanding with him. They tried to talk about what could be done to support him but Mr Peterson did not appear to be able to retain what they were saying. He behaved erratically and appeared fixated on his medication and a dietary supplement because he was losing weight. He would not answer any questions about his safety and whether he felt suicidal or wanted to harm himself. This made it hard to assess his risk and so the nurse and a SO decided not to reduce the level of observations or change Mr Peterson's location.

68. Mr Peterson was removed from the mental health dashboard and was allocated to the caseload of a senior mental health nurse.

69. The night patrol officer said that Mr Peterson pressed his cell bell frequently that night. Mr Peterson thought his girlfriend was being held upstairs by "them" and was being tortured. The night patrol officer was aware that Mr Peterson had mental health problems and had received bad news about his father's health because she had read his ACCT document at the beginning of her shift. She

managed to calm Mr Peterson down but every time she returned to his cell they had the same conversation. She said Mr Peterson did not appear to be able to retain what she had said to him before. He banged on his window and shouted, "Stop it" over and over again. She said it was hard to have a conversation through the cell door because Mr Peterson was mumbling. Mr Peterson also gave her a letter for his girlfriend. At the end of the letter, Mr Peterson wrote, "Wish I could of made love to you before I die". She submitted an intelligence report.

Tuesday 18 July

70. At 10.00am, a SO held another ACCT review with Mr Peterson and a nurse. Mr Peterson said wearing alternative clothing in a cell without any of his possessions was distressing. He said his girlfriend was in the cell upstairs being sexually assaulted. The SO took Mr Peterson upstairs so he could see his girlfriend was not there. Mr Peterson then said that his girlfriend was in the wing office, so the SO took him on a tour of the wing to show Mr Peterson his girlfriend was not there either.

71. The nurse said Mr Peterson was very emotional and paranoid at the review. He was sobbing and his anxiety levels were high. His situation on H Wing appeared to be increasing his anxiety. They decided to allow Mr Peterson to wear his own clothes and to have letters, paper, pens and an activity pack in his cell. She said all he wanted to do was to speak to his parents and speak and write to his girlfriend.

72. Mr Peterson told the nurse that he could see his girlfriend out of his window and was worried someone was going to hurt her. She explored this with him and Mr Peterson acknowledged that this concern was a symptom of his anxiety rather than a real threat. The SO promised that he would be able to speak to his parents and girlfriend on the telephone later in the day. She said Mr Peterson calmed down but she had to repeat things to him and get him to paraphrase what she had said back to her so she could be sure he understood it.

73. Mr Peterson denied feeling suicidal and said that he had only put a ligature round his neck because he wanted the officers to listen to him and had taken it off as soon as an officer came to his cell. Mr Peterson seemed much happier at the end of the review. He was still anxious but was no longer crying and his fixation about speaking to his family and girlfriend had lessened. He knew he was seeing the psychiatrist on 20 July and the nurse said she would see him once a week for Cognitive Behavioural Therapy (CBT). She reassured him that he could see her more often if he wanted to.

74. The nurse said she was satisfied that Mr Peterson's risk had not increased and that he had no active plans for suicide or self-harm. She and the SO decided to keep Mr Peterson in the same cell on the same level of observations. She said they did not want to change too much at once and planned to see how Mr Peterson was the next day after having his own clothes and his letters back. That evening Mr Peterson went out on exercise.

Wednesday 19 July

75. A prison discipline hearing for breaking his observation panel was not proceeded with because the adjudicating governor considered Mr Peterson was not mentally well enough.

76. During the morning, Mr Peterson spoke to his mother on the telephone in the wing office. An officer was responsible for checking Mr Peterson that morning. She said the first time she checked Mr Peterson he appeared quite calm, however he became increasingly agitated as the morning went on and she noticed he was quite unkempt and his cell was dirty. He kept asking for a telephone call and about his medication. She let him call his mother from the wing office. Mr Peterson said he felt better after speaking to his mother but then asked to speak to his girlfriend as well. She did not allow this because it was not in his ACCT care plan but she told a SO that Mr Peterson had asked to speak to his girlfriend.

77. Mr Peterson returned to his cell but got progressively more anxious. He kept asking about his medication and he banged on his door during lunch time patrol state. The officer telephoned healthcare and spoke to a male nurse. He told her that Mr Peterson had not turned up to collect his medication for a couple of days but that he would be alright. The officer queried this but the nurse said he would be ok. The officer said she felt like she had hit a dead end. When she went to lunch Mr Peterson was still banging his door. There is no record of this conversation on Mr Peterson's medical record.

78. At 2.00pm, two SOs held an ACCT review with Mr Peterson and an officer. A nurse said a SO asked her to attend the review. She read a nurse's notes from the ACCT review the day before and noted that Mr Peterson had said he was not actively suicidal. She decided it was not necessary for her to attend the review that day but intended to go to one after Mr Peterson had seen the psychiatrist the following day. She assumed that no changes would be made to Mr Peterson's level of observations or location before he saw the psychiatrist. The main reason for Mr Peterson's appointment with the psychiatrist was a for a medication review because the mental health team were concerned that his high dose of Concerta was increasing his anxiety. She said Mr Peterson was not psychotic and would not therefore normally have psychiatric intervention. The nurse did not record the telephone conversation on Mr Peterson's medical record as she should have done.

79. A SO said Mr Peterson had kicked his door throughout lunchtime and had upset other prisoners as a result. He said he wanted to go back to L wing because that is where his property was and he wanted a television. The two SOs returned Mr Peterson to standard level on the IEP scheme because they thought it would benefit him to have a television to distract him.

80. They allowed Mr Peterson to use the office telephone again to call his mother because he had used up his phone credit. A SO said he tended to use his credit up quickly because he rang his mother and his girlfriend on their mobile phones. This had a calming effect on Mr Peterson and he said he was pleased to be moving back to his cell on L wing. Mr Peterson's observations were reduced

from five an hour to three an hour and he moved back to his cell on L Wing with all his property.

20 July 2017

81. During the morning Mr Peterson rang his cell bell several times and asked an officer about his medication. The officer told him that healthcare staff had told him they would be bringing them to the wing. Mr Peterson told the officer that he knew they had killed his girlfriend and father. He threatened to smash his cell and start a fire. At 1.15pm he used the Samaritans telephone in his cell.

82. Mr Peterson saw the visiting psychiatrist, with a nurse at 2.55pm. He said the nursing team had referred Mr Peterson to him for a medication review because they were concerned that Mr Peterson's dose of Concerta was contributing to his anxiety. Before the appointment, he read Mr Peterson's notes and saw that he had recently been transferred from Hull. His behaviour had been a bit chaotic there and this had continued since his transfer to Humber. He said he went through Mr Peterson's ACCT document to assess his risk of self-harm. He concluded that Mr Peterson was at moderate risk of self-harm.

83. Mr Peterson's mood was quite elevated. He asked for sugar tablets because he said he had ADHD and needed more energy. Mr Peterson said he was worried about his girlfriend and his father and wanted to be able to look after them outside prison. The psychiatrist said that Mr Peterson's personality disorder meant that he could have transient psychotic episodes, especially if he took substances, but he was not delusional during the appointment.

84. The psychiatrist said Mr Peterson had side effects consistent with his dose of Concerta, which was at the high end, but Mr Peterson was very resistant to having his dose reduced. Mr Peterson had the capacity to understand and had not obviously deteriorated since being at Humber, so he decided to leave him on the same dose. He referred Mr Peterson to the GP in case his weight loss had an underlying medical cause. He said Mr Peterson definitely understood that his medication was not going to be reduced when he left the appointment because he told him that he was happy with the plan not to reduce it. By the end of the appointment, Mr Peterson had calmed down and his emotional responses were appropriate.

85. The psychiatrist said Mr Peterson's personality disorder and history of substance misuse meant that he would always be at risk to himself and potentially to others. His risk would be heightened at times of change – for example, prison transfer or cell moves. He said that when he saw Mr Peterson, he was satisfied that he was on a high number of observations under the ACCT process and that this was appropriate to the risk he presented at that time. Mr Peterson did not present at increased risk during the appointment – he talked about the future and was much calmer at the end of their session. He said that because he was only contracted to work at Humber one day a week, he was not able to attend ACCT reviews.

86. A nurse said she was not aware that Mr Peterson had moved to a different cell on reduced observations when she saw him on 19 July. Mr Peterson was angry and kept repeating that he needed more sugar to boost his energy levels. He was very unhappy with the psychiatrist's suggestion that he reduce his Concerta

and shouted at the psychiatrist to keep away from his medication. The psychiatrist explained that he was not going to reduce the medication without Mr Peterson's consent. The nurse felt that Mr Peterson's high anxiety meant that his understanding of exactly the psychiatrist was saying about his medication was a bit hazy. She tried to calm Mr Peterson down but in her view, Mr Peterson had ended the appointment early by walking out of the room.

87. The nurse said she did not detect any signs that Mr Peterson was at an increased or imminent risk of suicide. She felt that Mr Peterson needed to feel in control of something and was therefore unwilling to engage with them properly about his medication. He denied feeling suicidal or having intent to harm himself when the psychiatrist explored this with him.

88. A chaplain saw Mr Peterson again briefly at 4.15pm when she bumped into him in the corridor. She said she was surprised to see him back on L Wing so soon because he had been so ill on 16 July. Mr Peterson seemed brighter and calmer but was not very talkative. She asked him if he had had a shower and he said, "Not yet". He told her he had managed to eat "a little bit". He told her about his father being ill as if he had not told her before and asked for a telephone call. She told him she would ask the wing staff for him. Mr Peterson was very persistent about his father and she tried to reassure him that she had spoken to his mother and his girlfriend. She told him his father was not having oxygen therapy yet but Mr Peterson insisted that he was. Mr Peterson showed signs of distress when speaking about his father.

89. Mr Peterson came out of his cell for social time at 6.00pm. CCTV showed he was locked into his cell for the night at 6.59pm. Records and CCTV showed he was observed reading and drawing in his cell at 7.14pm and 7.32pm. At 7.45pm and 8.00pm he was lying on his bed and sitting up on his bed.

Emergency response

90. The night patrol began night patrol duties on L Wing at about 8.00pm and received a handover from the evening duty officer. He told her Mr Peterson was on three ACCT checks an hour and he had last checked him at about 8.00pm. Mr Peterson rang his cell bell to ask the night patrol for a toilet roll at 8.13pm, during her initial checks. She responded immediately and brought him a toilet roll. She said he did not appear to recognise her from Monday night but seemed brighter in mood. He told her he was on three checks an hour and had moved from H Wing. He said he was going to have a cigarette and asked her to shut the observation flap on his door. She said this was not unusual as most prisoners ask for their flaps to be shut at night. (Mr Peterson's ACCT record showed that he often asked the night patrol officers to close his observation flap.) CCTV showed she checked Mr Peterson a second time at 8.25pm.

91. The night patrol checked Mr Peterson again at 9.16pm and saw him suspended from the ceiling by a sheet. She radioed "urgent message code blue Lima Wing" and waited for assistance. She said night patrol officers are allowed to enter cells to preserve life if they feel safe to do so. She decided not to open the cell and go in alone because Mr Peterson's behaviour had been so bizarre and changeable during the week. She also knew that the orderly officers were already on their way to L wing to collect Listeners from the Listeners' suite. The

communications officer telephoned an ambulance as soon as she heard the code blue. The ambulance service told her that the nearest ambulance would take 24 minutes to reach the prison.

92. An officer said he, and two other officers were on the roadway between the Everthorpe side of the prison and The Wolds side of the prison when they heard the code blue. CCTV showed they entered Mr Peterson's cell as soon as they arrived on L Wing at 9.19pm. An officer opened the cell and saw Mr Peterson hanging from the electrical conduit on the ceiling. He was fully suspended by a sheet and his feet were two or three feet off the floor. An officer cut the ligature with his cut-down tool while the two other officers supported Mr Peterson.

93. The officers laid him on his bed while an officer cut the ligature from around his neck. Mr Peterson was not breathing but was still warm and not stiff so they moved him to the floor and began cardio-pulmonary resuscitation (CPR). Shortly afterwards a Custodial Manager (CM) and an officer arrived. The night patrol brought a defibrillator at 9.25pm and this advised no shock. A nurse, the only nurse on duty in the prison at night, fitted a bag and mask to give Mr Peterson oxygen. The defibrillator checked Mr Peterson at intervals and said to continue CPR. The oximeter attached to Mr Peterson's finger showed his oxygen levels were rising.

94. The first ambulance paramedics arrived at 9.46pm and took over. They attached their own equipment and gave Mr Peterson adrenaline. At 10.22pm, Mr Peterson was taken to hospital. He remained there in intensive care but died on 24 July.

Contact with Mr Peterson's family

95. The Duty Governor telephoned Mr Peterson's parents at 10.40pm and sent two family liaison officers (FLO) to collect his mother and take her to the hospital by car. Mr Peterson's family were with him when he died on 24 July. The prison offered a financial contribution to Mr Peterson's funeral in line with national policy.

Support for prisoners and staff

96. After Mr Peterson's death, the Governor and the staff care team spoke to the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support.

97. The prison posted notices informing other prisoners of Mr Peterson'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 Peterson's death.

Post-mortem report

98. Toxicological tests showed Mr Peterson had not taken any illicit substances before he died. The pathologist gave the cause of death as:

> "1(a) Hypoxic brain injury with broncho-pneumonia and pulmonary thrombo-embolism
> (b) Cardiac arrest (resuscitated)
> (c) Hanging."

Findings

ACCT procedures

99. Mr Peterson was a vulnerable man with complex personality disorder issues and limited coping mechanisms. He had a high number of factors that indicated he was at risk of suicide and self-harm and his mental health meant that this risk fluctuated according to context but was never absent. There were some very good entries on Mr Peterson's on-going ACCT record that evidence good care and meaningful interaction with staff. In particular, staff appear to have made it possible for him to contact his family on several occasions when he was very anxious and had used up his prisoner phone credit. However, it does not seem that they considered involving Mr Peterson's family in the ACCT process as they could have done.

100. We identified some concerns about the management of ACCT procedures at Humber. A number of different staff chaired Mr Peterson's reviews, and there was no member of healthcare at the first case review, which is a mandatory requirement of the national instruction PSI 64/2011. There was a lack of multi-disciplinary representation at many case reviews. Some caremap actions were poor and had been achieved before they were added. Mr Peterson's risk and level of observations were not reviewed after every incident of self-harm. Mr Peterson was put on the basic level of the IEP scheme several times because he repeatedly rang his cell bell for non-emergencies but there was no obvious consideration of the effect this would have on his mental health. We note that SO Bryant did return his television to him in recognition that this would provide much needed distraction for Mr Peterson.

101. Prison Service Instruction 64/2011, Chapter 6, contains the mandatory requirement that "*placing at an-risk prisoner in alternative clothing must trigger an enhanced case management review".* Chapter 8 of PSI 64/2011, says that the enhanced case review team will involve all relevant disciplines and include more specialist and a higher level of operational management than a typical ACCT case review team.

102. Mr Peterson was placed in alternative clothing on 16 August, but this did not prompt enhanced case management. We consider that Mr Peterson's high number of risk factors for suicide and self-harm together with his dual diagnosis (mental health issues and poly-substance misuse) should have prompted enhanced case management at the outset in Humber.

103. In addition, because Mr Peterson was added to a nurse's case load on 17 July, enhanced case management would have required attendance by the mental health team at the 19 July review. We consider that a mental health nurse should have attended the review on 19 July. A nurse and an SO's strategy for a gradual return to a standard cell and reduction in observation was sound but was not effectively communicated in the ACCT documentation. As a result, the strategy broke down as soon as different staff held the review on 19 July. We consider that this decision was premature and that there should have been a more gradual reduction in observations. Moving Mr Peterson back to his cell with

all his possessions was not unreasonable but we consider that observations should have remained the same until Mr Peterson had settled back on L Wing.

104. On 20 July, Mr Peterson should have been observed at least three times an hour. The period we have seen on CCTV from 6.59pm, shows checks about every 15 minutes until 8.13pm. The night patrol checked Mr Peterson again at 8.25pm but then not until 9.17pm. However, the instruction to check Mr Peterson three times an hour is interpreted, we consider this is too long a gap between checks to be considered sufficiently regular monitoring.

105. We recognise that in response to Mr Peterson's death, Humber have made efforts to improve safer custody and ACCT procedures. We are pleased that HMIP found in December 2017 that ACCT reviews were multi-disciplinary with consistent case management and commented that it was unusual to find such thorough ACCT procedures. There have been no apparently self-inflicted deaths at Humber since Mr Peterson's. It is important that they maintain these high standards. We make the following recommendation:

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

- **managing complex cases under the enhanced case management process;**
- **managing all prisoners in alternative clothing under the enhanced case management process;**
- **ensuring that the ACCT documentation accompanies prisoners to all medical and psychiatric appointments;**
- **considering involving the family in the ACCT process;**
- **setting effective ACCT caremap objectives which are specific and meaningful, aimed at reducing a prisoner's risk and which identify who is responsible for them;**
- **observations are carried out as directed.**

Mental health and substance misuse

106. Dual diagnosis is the co-existence of mental health and substance misuse problems. The NHS Guide for the Management of Dual Diagnosis for Prisons advises prisons to adopt a protocol for a coordinated approach to managing prisoners with dual diagnosis which should address methods of assessment, referral, joint care planning, reviews and release arrangements. This is vital to ensure communication between the different teams working with the prisoner on the separate aspects of their care.

107. The PPO published a learning lessons bulletin on 'Prisoner Mental Health' in January 2016. In this bulletin, we identified that difficulties in coping with mental health problems can be made worse when a prisoner also has to cope with difficulties of battling substance dependence. We recommended that mental health and substance misuse services should work together to provide a coordinated approach to prisoner care which should involve the use of agreed

dual diagnosis tools to assess prisoner needs and regular meetings to discuss and plan join care.

108. Mr Peterson arrived at Humber after receiving weekly support from a nurse at Hull and intervention from substance misuse services. The reception nurse referred Mr Peterson appropriately for a mental health assessment and a multi-disciplinary team from mental health discussed his case the next day. They did not assess Mr Peterson in person and did not take him on to the caseload of a specific nurse. Mr Peterson had a period of relatively stable behaviour towards the end of his time in Hull with the support of a specific nurse. He was not added to a nurse's caseload until 17 July despite demonstrating chaotic behaviour from arrival at Humber. We consider that this did not offer continuity of care and, given his complex mental health issues, he should have been assessed in person.

109. Mr Peterson did not see a member of the substance misuse team at all in Humber. There is no evidence that he used illicit substances in Humber but poly-drug misuse was a feature of his life in the community and he was engaging well with substance misuse services at Hull with a view to managing his substance misuse issues on release. We make the following recommendation:

The Governor and Head of Healthcare should ensure that:

- **Prisoners with dual diagnosis receive appropriate integrated treatment.**
- **New prisoners with complex mental health issues that have been on the caseload of a specific nurse at a previous prison are assessed in person.**

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